CHAPTER 38

HEALTH MAINTENANCE ORGANIZATIONS

Authority

N.J.S.A. 26:2H–1 et seq.

Source and Effective Date

R.1997 d. 68, effective January 17, 1997.
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

Executive Order No. 66(1978) Expiration Date

Chapter 38, Health Maintenance Organizations, expires on January 17, 2002.

Chapter Historical Note

Chapter 38, Health Maintenance Organizations, was adopted as R.1974 d.320, effective November 20, 1974. See: 6 N.J.R. 8(b), 6 N.J.R. 473(a). Pursuant to Executive Order No. 66(1978), Chapter 38 expired on April 3, 1994.

Chapter 38, Health Maintenance Organizations, was adopted as R.1994 d.365, effective July 18, 1994. See: 26 N.J.R. 1624(a), 26 N.J.R. 2896(a). Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, was adopted as R.1996 d.194, effective April 15, 1996. See: 27 N.J.R. 4981(a), 28 N.J.R. 1981(c).

Pursuant to Executive Order No. 66(1978), Subchapter 14, Indemnity Benefits Offered by a Health Maintenance Organization, of Chapter 38, was readopted as R.1997 d.68, effective January 17, 1997. See: Source and Effective Date. As a part of R.1997 d.68, effective February 18, 1997, Subchapter 1, General Provisions, was repealed and a new Subchapter 1, Scope and Definitions, was adopted; Subchapter 2, Establishment of Health Maintenance Organizations, was repealed and a new Subchapter 2, Establishment of Health Maintenance Organizations, was adopted; Subchapter 3, Issuance of Certificate of Authority, was repealed and a new Subchapter 3, General Requirements, was adopted; and Subchapter 4, Medical Director, Subchapter 5, Health Care Services, Subchapter 6, Provider Network, Subchapter 7, Continuous Quality Improvement, Subchapter 8, Utilization Management, Subchapter 9, Member Rights and Responsibilities, Subchapter 10, Medical Records, Subchapter 11, Financial Standards and Reporting, Subchapter 12, Rehabilitation, Conservation and Liquidation, Subchapter 13, Licensing of Representatives and Advertising, and Subchapter 15, Provider Agreements and Risk Transference, were adopted as new rules. New rules 8:38–3.5(a)4; 8:38–3.6(e); 8:38–4.1(b); 8:38–5.3(b)5; 8:38–6.3(a)3i; 8:38–8.1(a)7; 8:38–8.2(a) and (c); 8:38–8.3(b) and (d); 8:38–8.4(b); 8:38–8.6(f); 8:38–8.7; 8:38–8.8; 8:38–9.1(c)1, 8 and 12; and 8:38–13.4, became operative March 15, 1997; all repeals, amendments, and other new rules became operative July 1, 1997.

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SUBCHAPTER 1. SCOPE AND DEFINITIONS

8:38–1.1 Scope

(a) The rules in this chapter were developed by the Commissioner of Health and Senior Services in collaboration with the Commissioner of Banking and Insurance and govern the establishment and operation of health maintenance organizations in New Jersey pursuant to the authority set forth in N.J.S.A. 26:2J–1 et seq. These rules are only applicable to managed care plans that constitute a health maintenance organization as defined herein and in N.J.S.A. 26:2J–1 et seq.

(b) The provisions of these rules shall apply, except where in conflict with:

1. Any individual contract issued by a health maintenance organization (HMO) to the extent that the contract is formulated in accordance with the provisions of the New Jersey Individual Health Coverage Program established pursuant to N.J.S.A. 17B:27A–1 et seq.; or

2. Any contract issued to a small employer by a HMO to the extent that the contract is formulated in accordance with the provisions of the New Jersey Small Employer Health Coverage Program established pursuant to N.J.S.A. 17B:27A–17 et seq.

(c) The provisions of these rules shall apply to any services of the HMO which are subcontracted to other entities.

(d) Nothing contained in these rules shall be construed to limit the authority of the Division of Medical Assistance and Health Services of the Department of Human Services to impose, in any contract to provide HMO services to New Jersey Medicaid recipients, standards that exceed those set forth in this chapter.

8:38–1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Authorized payor" means a person licensed and authorized to transact business in this State as a health maintenance organization, an insurer doing a health insurance business, a hospital service corporation, a medical service corporation, a health services corporation, a dental service corporation, a dental plan organization or a fraternal benefit society.

"Basic comprehensive health care services" means the following services: preventive care, emergency care, inpatient and outpatient hospital and provider care, diagnostic laboratory and diagnostic and therapeutic radiological services and other services set forth in N.J.A.C. 8:38–5, including all services listed at N.J.A.C. 8:38–5.2.

"Capitation" means a fixed payment for the provision of medical services not based on frequency or severity of services or supplies provided.

"Carrier" means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17–4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48–1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A–1 et seq., or a health service corporation transacting business in accordance with N.J.S.A. 17:48E–1 et seq.

"Claims" means a request for payment of charges for services rendered or supplies provided by a provider to a member.

"Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim.

"Commissioner" means the State Commissioner of Health and Senior Services or his or her designee.

"Commissioner of Banking and Insurance" means the Commissioner of the New Jersey Department of Banking and Insurance or his or her designee.

"Consumer Price Index" or "CPI" means the medical component of the Consumer Price Index for All Urban Consumers, as reported by the United States Department of Labor, shown as an average index for the New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton region combined as published by the Commissioner of Banking and Insurance in the New Jersey Register.

"Contested claim" means a claim that has not been adjudicated because it has a material defect or impropriety.

"Continuous quality improvement" means an ongoing and systematic effort to measure, evaluate, and improve an organization's process to continually improve the quality of health care services provided to members.

"Contract holder" means an employer or organization which purchases a contract for services.

"Department" means the New Jersey Department of Health and Senior Services.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that absence of immediate attention could reasonably be expected to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Evidence of coverage" means a statement of the essential features and services of the HMO coverage which is given to the subscriber by the HMO or by the group contract holder.

"External quality review organization (EQRO)" means an organization approved by the Department pursuant to this chapter to perform external quality audits of HMOs.

"Financial incentive arrangement" means a formal mechanism instituted by an HMO or a secondary contractor that exposes a provider, or group of providers, to risk or reward based upon meeting or failing to meet prescribed standards.

"Financial risk" means participation in financial gains or losses accruing pursuant to a contractual arrangement, based on aggregate measures of medical expenditures or utilization.

"GAAP" means Generally Accepted Accounting Principles.

"Gatekeeper system" means a system in which a member is permitted to access service and/or obtain indemnity benefits for covered services only when the service is rendered by the member's primary care provider, or the member's access to services and/or benefits is approved by the primary care provider or the HMO, as specified under the HMO's contract with the subscriber or contractholder.

"Group health contract" means a contract, filed by or with the New Jersey Department of Banking and Insurance or the Small Employer Health Benefits Program Board of Directors, as appropriate, issued by a carrier to a group of persons for the provision of indemnity benefits for expenses for covered services incurred in preventing or treating acute or chronic injury or illness of members, as specified in the contract. The term "group health contract" shall not include any contract issued on a form which has been disapproved or withdrawn from filing by the Department of Banking and Insurance, or determined incomplete by the Small Employer Health Benefits Program Board of Directors, as appropriate.

"Health care expenditures" means the cost, on an incurred basis, of health care services and supplies rendered by a participating provider or a nonparticipating provider which are the responsibility of the HMO in accordance with the contracts the HMO has issued to contract holders.

"Health center" means a facility owned or leased by an HMO, used by members to receive medical and ancillary services including but not limited to: lab, radiology, and pharmacy.

"Health maintenance organization (HMO)" means any individual or entity that undertakes to provide or arrange for basic comprehensive health care services through an organized system that combines the delivery and financing of health care on a prepaid basis to enrollees.

"Indemnity" means the payment of expenses, in whole or in part, as they are incurred by a member for the delivery of covered services, in which the level of payment for expenses

incurred, and the charge made for the expenses incurred, is not negotiated between the health care provider and the HMO, and there is no contractual arrangement between the health care provider and the HMO holding the enrollee harmless for any amount of the expense not paid by the HMO. Payment of the expense may be made directly to the health care provider upon assignment by the member, or the member may be reimbursed for the expense incurred.

"Independent utilization review organization (IURO)" means an organization with which the Department contracts in accordance with N.J.A.C. 8:38–8.8 to conduct independent reviews of final decisions by the HMO to deny, reduce or terminate covered benefits, which are contested by the member or provider on behalf of the member.

"Insurer" means any insurance company authorized to transact the business of insurance in New Jersey."

"Managed hospital payment" means agreements between the HMO and a hospital under which the financial risk primarily related to the degree of utilization rather than to the cost of services is transferred to the hospital.

"Master policy" means the document issued by a carrier to an HMO evidencing coverage of the subscribers and members of the HMO, or a class of subscribers and members of the HMO, under a group health contract.

"Medicaid marketing representative" means any person who is registered as a limited insurance representative pursuant to N.J.S.A. 17:22A–16 and who is authorized to solicit, negotiate or effect contracts with Medicaid recipients as an agent for a Medicaid-contracting HMO, and performs no other service for the HMO that would otherwise require that person to be authorized and licensed as an insurance producer.

"Medical screening examination" means an examination and evaluation within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel pursuant to requirements in N.J.A.C. 8:43G–12, which are necessary to determine whether or not an emergency medical condition exists.

"Member" means an individual who is enrolled in an HMO.

"Network" means all participating providers under contract or other agreement acceptable to the Department to furnish health care services to members of the HMO.

"Net worth" means the excess of the admitted assets over total liabilities of an HMO.

"Out-of-network covered services" means indemnity benefits for covered services rendered to an HMO member by someone other than the HMO's contracted health care providers.

"Participating provider" means a provider which, under contract or other arrangement acceptable to the Department with the HMO or with its contractor or subcontractor, in accordance with the provisions of this chapter, has agreed to provide health care services to members with an expectation of receiving payment, other than a copayment or deductible, directly or indirectly from the HMO.

"Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

"Point of service contract" means a contractual arrangement between an HMO and a member, subscriber or contract holder whereby the HMO makes provision for the rendering of covered services to its members through a network of health care providers as well as an out-of-network covered services option.

"Primary care provider (PCP)" means an individual participating provider who supervises, coordinates and provides initial and basic care to members and maintains continuity of care and meets the qualifications in N.J.A.C. 8:38–6.2.

"Primary contractor" means a provider that agrees directly with an HMO to provide one or more services or supplies directly to an HMO's members.

"Provider" means any physician, hospital, facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

"Reinsurance-type contract" means a contract between an insurer and an HMO whereby the insurer agrees to indemnify the HMO for all expenses incurred by the HMO's members under a POS contract for out-of-network covered services, and further, the insurer agrees that it will indemnify the HMO's members for expenses incurred for out-of-network covered services for the duration of the period for which premiums are or have been paid by the contract holders or subscribers to the HMO, should the HMO be placed into conservation, rehabilitation or liquidation."

"SAP" means Statutory Accounting Practices.

"Secondary contractor" means a person who agrees to arrange for the provision of one or more services or supplies for an HMO's members. A primary contractor may also be a secondary contractor when acting as a broker or administrator for the rendering of services or supplies that, in scope of licensure, type or quantity, the primary contractor (provider) alone could not offer directly to members.

"Service area" means the geographic area for which the HMO has been issued a certificate of authority, in accordance with this chapter.

"Subscriber" means, in the case of a group contract, an individual whose employment or other status, except family status, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued.

"Uncovered health care expenditures" means costs to the HMO for health care services that are the obligation of the HMO for which a member may be liable in the event of an HMO's insolvency and for which no alternative arrangements (that guarantee, insure or provide assumption by a person or organization other than the HMO for the provision of services or benefits) have been made that are acceptable to the Commissioners of Health and Senior Services and Banking and Insurance.

"Urgent care" means a non-life-threatening condition that requires care by a provider within 24 hours.

"Utilization management" means the prospective, concurrent or retrospective assessment of the necessity and appropriateness of clinical services provided, or proposed to be provided, to a member.

Public Notice: Increase in medical component of the Consumer Price Index.
See: 29 N.J.R. 2484(b).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 30 N.J.R. 1330(a).
Amended by R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).
Inserted "Claims", "Clean claim" and "Contested claim".
Public Notice: Increase in medical component of the Consumer Price Index.
See: 31 N.J.R. 801(a).
Public Notice: Increase in medical component of the Consumer Price Index.
See: 32 N.J.R. 1259(a).

Case Notes

Health maintenance organization's (HMO's)asset purchase agreement with for-profit corporation and health services agreement with limited liability corporation that was to facilitate administration of medical services to HMO enrollees were not contracts with providers as required for confidentiality under the HMO Act; corporations not "providers" since they were not authorized to furnish health care services and internal management of HMO still maintained ultimate responsibility for the affairs of the HMO. HIP of New Jersey, Inc. v. New Jersey Dept. of Banking and Ins., 707 A.2d 1044, 309 N.J.Super. 538.

SUBCHAPTER 2. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

8:38–2.1 Certificate of need and licensing

Any health maintenance organization (HMO) which proposes the establishment and/or operation of a health care facility or any change in or expansion of a health care facility, or the institution of new health care services as defined in the Health Care Facilities Planning Act (N.J.S.A. 26:2H–1 et seq.) shall comply with all pertinent provisions of the Act, as amended and N.J.A.C. 8:33, Certificate of Need application and Renewal process, and all applicable health planning and licensing rules and regulations.

8:38–2.2 Application for a certificate of authority

(a) Any person, organization or corporation desiring to establish and/or operate an HMO shall apply to the Commissioner for a certificate of authority, pursuant to N.J.S.A. 26:2J–1 et seq. Applications for a certificate of authority may be obtained from:

New Jersey State Department of Health and Senior Services
Office of Managed Care
PO Box 360
Trenton, NJ 08625–0360

or

New Jersey Department of Banking and Insurance
Managed Care Bureau
Division of Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

1. Two copies of the entire application shall be submitted to the Department at the above address;

2. One copy of the entire application (excluding signed provider agreement pages) shall be submitted to the Department of Banking and Insurance at the above address; and

3. If the application proposes to be a Medicaid program participant, one copy shall be submitted to:

New Jersey Department of Human Services
Office of Managed Health Care
Division of Medical Assistance and Health Services
PO Box 712
Trenton, NJ 08625–0712

(b) The applicant shall submit to the Department a nonrefundable fee of $100.00, or as specified in N.J.S.A. 26:2J–23, as may be amended, payable to the New Jersey Department of Health and Senior Services for the filing of an application for a certificate of authority as an HMO, or for any renewal or amendments thereto.

(c) The application for a certificate of authority shall be deemed complete only when filed on forms prescribed by the Department and when accompanied by the following:

1. A copy of the basic organizational documents of the applicant such as the articles of incorporation, articles of

association, partnership agreement, trust agreement or other applicable documents and all amendments thereto;

2. A copy of the bylaws, rules and policies or similar documents regulating the conduct of the internal affairs of the applicant;

3. A list of persons who are to be responsible for the conduct of the affairs of the HMO including names, addresses, official positions and biographical information;

4. A copy of the signed contract between the HMO and each participating provider in accordance with N.J.A.C. 8:38–15, including a description of any compensation program involving incentive or disincentive payment arrangements. As required by N.J.S.A. 26:2J–26, copies of any contract made between the HMO and any provider, insurer, hospital or medical service corporation shall be considered confidential;

5. A copy of the form of evidence of coverage to be issued to the subscriber;

6. A copy of the form of the individual and group contract, if any, which is to be issued to subscribers and contract holders;

7. The most recent audited financial statements (or other documentation as specified by N.J.A.C. 8:38–11 for newly-formed applicants) showing the applicant's assets, liabilities, sources of financial support, a statement as to the sources of funding and all other financial requirements as delineated in N.J.A.C. 8:38–11;

8. A description of the proposed method of marketing and financing;

9. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his or her successors in office, and duly authorized designees, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served;

10. A description and map of the geographic area to be served, identified by county. If sub-areas of counties are to be proposed as boundaries of the service area, the map should also include zip codes;

11. Enrollment projections presented on a quarterly basis for the first three years of operation for each county or sub-area proposed as the service area. The enrollment projections should be accompanied by a description of the demographic characteristics of the population, including at least sex and age;

12. A description of the methods used by the HMO to facilitate access to services for culturally and linguistically diverse members;

13. A description of the complaint and appeal procedures delineated in N.J.A.C. 8:38–3.6;

14. A description of the continuous quality improvement program delineated in N.J.A.C. 8:38–7;

15. A description of the utilization management program, including the process for appealing utilization management determinations delineated in N.J.A.C. 8:38–8;

16. A list of all participating providers by county, municipality and zip code, accompanied by maps of the service area identifying the location of these providers. This list shall include all PCPs, specialists, hospitals and ancillary providers. The list of PCPs and specialists shall include the individual's name, address and, if applicable, hospital affiliation;

17. The criteria regarding geographic accessibility and availability of its health care provider network and why the applicant believes these criteria meet or exceed the rules in this chapter. This shall be related to the applicant's enrollment projections, the access guidelines contained in this chapter, and the applicant's experience;

18. The criteria to be used to maintain the appropriate numbers and types of providers as enrollment increases in accordance with N.J.A.C. 8:38–6;

19. The criteria used to ensure access to specialized services identified in N.J.A.C. 8:38–6;

20. A description of the method of informing affected members and providers of changes in the health care delivery network, as delineated in N.J.A.C. 8:38–3.5;

21. A description of the mechanism by which members and providers will be afforded an opportunity to participate in matters of policy and operation through establishment of advisory panels, by the use of advisory referendum on major policy decisions, or through the use of other mechanisms;

22. A statement from the applicant attesting that it or any affiliated entity operating as an HMO or regulated health insurance business has been in substantial compliance with all applicable state and Federal regulations for the last 12 months in any state in which approval to operate has been granted by the official state licensing and/or certification agency. A description and explanation of any enforcement action or settlement thereof affecting the HMO or its affiliate must be submitted including and not limited to fines, suspension of marketing, or revocation of a license or certificate to do business. The Commissioner may request further information from the applicant or from the official state or Federal agency to determine compliance; and

23. Such other information as the Commissioner or the Commissioner of Banking and Insurance may require, on a case by case basis, from a specific applicant, to make the determinations required by N.J.S.A. 26:2J–4.

8:38–2.3 Issuance of a certificate of authority

(a) A certificate of authority to establish and operate an HMO to service commercial enrollees shall be issued upon approval of the Commissioner and the Commissioner of Banking and Insurance.

(b) A certificate of authority to establish and operate an HMO to service both Medicaid and commercial enrollees shall not be approved for purposes of serving Medicaid enrollees until such time that the Commissioner has received and considered the recommendation of the Department of Human Services, Division of Medical Assistance and Health Services on the applicant's compliance with the State and Federal requirements of a contract between the applicant and the Department of Human Services.

(c) Issuance of a certificate of authority shall be granted upon demonstration of compliance, to the satisfaction of the Commissioner of Health and Senior Services and Commissioner of Banking and Insurance, with these rules and the requirements in N.J.S.A. 26:2J–1 et seq.

(d) Prior to issuance of a certificate of authority, a preoperational audit shall be conducted by the Departments of Health and Senior Services, Banking and Insurance and/or Human Services to evaluate the HMO's ability to perform essential functions including, but not limited to, claims processing, utilization management and quality assurance protocols, adequacy of accounting and information systems, operational and financial controls, and network adequacy. The applicant shall bear all reasonable costs associated with conducting the preoperational audit, including, but not limited to, outside consultant and subcontractor fees.

Amended by R.1999 d.201, effective June 21, 1999.
See: 31 N.J.R. 610(a), 31 N.J.R. 1631(a).
Rewrote (d).

8:38–2.4 Comprehensive assessment reviews

(a) After issuance of a certificate of authority, the HMO shall undergo a comprehensive assessment review by the Department on a triennial basis.

(b) The comprehensive assessment review conducted by the Department may include an on-site review and shall be based upon the Department's review of the following:

1. A filing of information by the HMO of any substantial change to operations identified in N.J.A.C. 8:38–2.7 not previously filed with the Department. This filing shall not require the submission of any documents previously filed with the Department, if such documents have remained valid and unchanged since their original filing;

2. The results of the HMO's external quality audit, as required at N.J.A.C. 8:38–7.2;

3. A statement from the HMO attesting that it or any affiliate certified or licensed as an HMO or health insuror has been in substantial compliance with all applicable state and Federal rules and/or regulations for the last 12 months in any other state in which it has been approved to do business; and

4. All network adequacy, utilization management, continuous quality improvement, performance and outcome measurements or other data or information provided for in this chapter.

(c) The comprehensive assessment review required at (b) above shall be conducted by the Department in accordance with the following schedule:

1. For HMOs with a valid certificate of authority issued between January 1, 1973 and December 31, 1985, the first review shall be conducted in the year beginning January 1, 1997, no more than 180 days and no less than 90 days prior to the anniversary date of original issuance;

2. For HMOs with a valid certificate of authority issued between January 1, 1986 and December 31, 1994, the first review shall be conducted in the year beginning January 1, 1998, no more than 180 days and no less than 90 days prior to the anniversary date of original issuance;

3. For HMOs with a valid certificate of authority issued between January 1, 1995 and July 1, 1997, the first review shall be conducted in the year beginning January 1, 1999, no more than 180 days and no less than 90 days prior to the anniversary date of original issuance; and

4. For HMOs with a valid certificate of authority issued after July 1, 1997, reviews shall be conducted every third year, no more than 180 days and no less than 90 days prior to the anniversary date of issuance.

(d) An HMO that does not demonstrate compliance with the requirements of this chapter based on the Department's findings resulting from the comprehensive assessment review may be subject to enforcement actions pursuant to N.J.A.C. 8:38–2.14. Notice of violations shall be provided, pursuant to N.J.A.C. 8:38–2.13 to the HMO. The Department may also issue a narrative assessment of HMO performance based upon the comprehensive assessment review and require a corrective action plan from the HMO. This report shall become public information in the manner specified in N.J.A.C. 8:38–2.13(d).

8:38–2.5 Denial of a certificate of authority

Subject to the provisions of N.J.S.A. 26:2J–22, an application for a certificate of authority may be denied if the Commissioner or the Commissioner of Banking and Insurance finds noncompliance with these rules or any provision of N.J.S.A. 26:2J–1 et seq., or otherwise finds the HMO or other affiliated entity operating as an HMO or regulated health insurance business to be in violation of any other applicable New Jersey, other state or Federal law where these violations have resulted in an enforcement action, and the applicant owned, operated, or managed in whole or in part, HMO which was the subject of the action during the 12 month period preceding the filing of the application.

8:38–2.6 Amendment to an approved certificate of authority

(a) After issuance of a certificate of authority, any HMO which proposes to expand or reduce its service area, change the operational model of its health care delivery system, or initiate a contract with Medicaid and/or Medicare shall be subject to the approval of the Commissioner and the Commissioner of Banking and Insurance for an amendment to the HMO's certificate of authority. Actions that shall require an amendment include, but are not limited to:

1. A change in the operational model of the health care delivery system, including, but not limited to:

i. A group model converting to or adding an individual practice association (IPA); or

ii. An IPA model converting to or adding a group model, including establishment of the initial health center in any service area.

2. A change in the service area or sub-area, including adding or deleting a county or counties or sub-areas or a county (by zip code area); or

3. A change in the enrollment of the HMO to include Medicaid or Medicare recipients.

(b) For purposes of this section, the following words and terms shall have the following meanings:

"Group model" means the HMO organizational model in which the HMO contracts with health care providers to serve only its members in a health center(s) owned or leased by the HMO.

"Individual practice association (IPA) model" means the HMO organizational model in which the HMO contracts with health care providers to serve its enrollees in their private offices.

(c) The HMO shall apply to the Departments of Health and Senior Services and Banking and Insurance to amend the certificate of authority and shall submit complete supporting documentation at least 60 business days prior to the planned implementation of the change. If the HMO is expanding its enrollment to include Medicaid enrollees, the

HMO shall also submit a copy of the application to the Department of Human Services.

(d) In reviewing the proposed amendment to a certificate of authority, the Commissioner and Commissioner of Banking and Insurance shall determine whether the HMO has demonstrated compliance with all applicable rules of this chapter. The Commissioners shall also examine and evaluate the compliance record of the HMO for the period beginning 12 months prior to receipt of written notice, and may deny such application for a finding of non-compliance leading to an enforcement action pursuant to N.J.A.C. 8:38–2.13.

(e) If the amendment to the certificate of authority is for the purpose of expanding the HMO's enrollment to include Medicaid enrollees, the amendment shall not be approved until such time that the Commissioner has received and considered the recommendation of the Department of Human Services, Division of Medical Assistance and Health Services on the HMO's compliance with the State and Federal requirements of execution of a contract between the HMO and the Department of Human Services.

8:38–2.7 Notice of changes in HMO operations

(a) Following issuance of a certificate of authority, the HMO shall notify the Departments of Health and Senior Services and Banking and Insurance, in writing, of any substantial change to items identified at N.J.A.C. 8:38–2.2(c)1 through 23, when such change occurs. Upon receipt of a notice of change, the Department shall deem such change approved within 30 days unless the HMO is notified otherwise. Substantial changes include, but are not limited to:

1. Any change or reduction in the provider network that adversely impacts network adequacy requirements identified at N.J.A.C. 8:38–6;

2. The subcontracting of complaint and appeal, quality improvement, and/or utilization management functions to another entity;

3. The nonrenewal of a hospital provider's contract which shall be reported in accord with N.J.A.C. 8:38–3.5(b); and

4. The establishment of a new group health center in a county or service area that has previously received certificate of authority approval for initiation of group health center services in that area.

8:38–2.8 Approval of a point of service (POS) plan

In addition to the requirements set forth in N.J.A.C. 8:38–2.7, any HMO proposing to enter into an arrangement for the provision of out-of-network covered services to members shall also comply with the requirements delineated in N.J.A.C. 8:38–14.

8:38–2.9 Changes in ownership interests

(a) Certificates of authority shall not be assignable or transferable in whole or in part. Accordingly, the holder of record of any certificate of authority to operate in New Jersey shall, as a condition thereof, comply with all of the requirements of this section regarding changes in ownership interests. For the purposes of this subchapter, changes in ownership interests shall refer to changes in the ownership of the holder of record of any certificate of authority and/or changes in ownership of any individual, corporation or other entity which, through the ownership of voting securities, by contract or by any other means, has the authority to, or does in fact, direct or cause the direction of the management and/or the policies of the HMO which is the subject of the certificate of authority at issue.

(b) Any transaction or series of transactions requiring the filing of SEC forms 13g or 13d pursuant to the Securities and Exchange Act of 1934 or otherwise resulting in a change of five percent or more in ownership interests, shall be reported to the Commissioner in accordance with the provisions of N.J.A.C. 8:38–2.7 within 10 days of the occurrence thereof.

(c) Any proposed transaction or proposed series of transactions which would result in a change in ownership interests held by one party or entity or an affiliated group of parties or entities, of 10 percent or greater shall, in addition to the reporting requirement of (b) above, require the filing of an amendment to the certificate of authority in accordance with the provisions of N.J.A.C. 8:38–2.6.

(d) Any proposed transaction or proposed series of transactions which would result in a change in the controlling ownership of a holder of a certificate of authority, as that term is defined in (e) below, shall require the issuance of an amended certificate of authority in accordance with N.J.A.C. 8:38–2.6. Where the individual, corporation or other entity acquiring a controlling ownership interest in the holder of record of any certificate of authority to operate in New Jersey is itself the holder of a valid certificate of authority to operate in New Jersey, then the acquiring party may satisfy the requirements of this subsection by filing for and obtaining an amendment to its certificate of authority in accordance with (c) above.

(e) For the purposes of this subchapter, a controlling ownership interest shall exist in any individual, corporation or other entity which, through ownership of voting securities, by contract or by any other means, has the authority to or does in fact direct or cause the direction of the management and/or the policies of the HMO which is the subject of the certificate of authority at issue. A change in the controlling ownership interest shall be presumed to occur in, but shall not be limited to, any transaction involving the sale, exchange or other transfer of all or substantially all assets or equity interests.

(f) With respect to any change in ownership interest referenced in (c) above, the Commissioner or the Commissioner of Banking and Insurance may request from the holder of record of the certificate of authority at issue, any additional information which he or she determines to be necessary to verify the percentage of ownership interests affected. If upon the evaluation of any such additional information the Commissioner determines that the transaction does in fact involve a change in the controlling ownership interest as that term is defined in (e) above, then he or she shall direct the affected parties to comply with the terms of (d) above.

(g) With respect to any change in ownership requiring an amendment to the certificate of authority under (c) or (d) above, the Commissioner and the Commissioner of Banking and Insurance shall, in addition to all other applicable provisions of this chapter and N.J.S.A. 26:2J–1 et seq., take into consideration the following factors in reaching his or her decision to approve or deny the application:

1. After the change of ownership, the HMO would not be able to satisfy the requirements for the issuance of a certificate of authority;

2. The effect of the change in ownership would be to substantially lessen competition among HMOs in this State or tend to create a monopoly therein;

3. The financial condition of the acquiring party is such as might jeopardize the financial stability of the HMO, or adversely affect the provision of health care services to subscribers or members;

4. The proposed change in ownership is determined to be unfair and unreasonable to subscribers or members and/or is not in the public interest; or

5. The competence, experience and integrity of those persons who would control the operation of the HMO are such that it would not be in the interest of subscribers or members and of the public to permit those individuals to effect the merger or other acquisition of control. Evidence of such findings may include, but is not limited to, a criminal conviction or plea of guilty for a charge of fraud, embezzlement, misappropriation of property, or other related crime, or a civil judgment or administrative sanction for such causes, or a Federal or state action for revocation of a license, certificate of authority, or permit to operate or manage an HMO or other insurance business or a health care facility.

8:38–2.10 Surrender of a certificate of authority

(a) In the event that an HMO voluntarily ceases operation, it shall provide at least 90 business days advance notice to all members, employers, providers and the Departments of Health and Senior Services and Banking and Insurance. The notice shall identify the storage location of medical records, where applicable, and procedures for obtaining copies of such records.

(b) The HMO shall provide a plan at least 90 business days in advance of the surrender to the Department to assure continuity of coverage and medical care and assistance to members, as necessary, in accordance with N.J.A.C. 8:38–12.3.

8:38–2.11 Registered agent

Each HMO shall maintain an office in New Jersey and provide the Department with the name and address of its registered agent or else a power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his or her successors in office, and duly authorized designees, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served. The HMO shall assure in writing that it submits to New Jersey jurisdiction for all New Jersey laws and regulations and that it shall submit to inspections by Department of Health and Senior Services and/or Department of Banking and Insurance staff at any out of state site.

8:38–2.12 Examinations

(a) The Department and the Department of Banking and Insurance may conduct an examination of the HMO annually, but in no case less than once every three years, concerning quality of health care services and other affairs of the HMO, including providers with whom such organization has contracts, agreements, or other arrangements. This examination may include, but not be limited to, the review of documents, patient records, information required in N.J.A.C. 8:38–3.6, and conferences with providers and members. The HMO shall be assessed an annual fee of $1,000 or such amount authorized at N.J.S.A. 26:2J–18, as may be amended, to offset the expenses of examinations under this section. This fee shall be remitted with the annual report filed in accordance with the requirements at N.J.A.C. 8:38–3.7.

(b) The Department shall incorporate the annual examination process as described above into the comprehensive assessment review process.

(c) The Department may conduct special examinations at any time to ascertain whether the HMO is in compliance with this chapter and all applicable State and Federal statutes and regulations. A report of this examination shall be provided to the HMO within 30 business days of completion of the special examination. Any violations resulting from this examination shall be identified and responded to in accordance with N.J.A.C. 8:38–2.13.

8:38–2.13 Violations

(a) A violation may be cited by the Commissioner of Health and Senior Services and/or Banking and Insurance or their designees upon determination that the HMO does

not comply with the rules in this chapter and N.J.S.A. 26:2J–1 et seq.

(b) At the conclusion of an examination, or within 30 business days thereafter, the Department shall provide the HMO with a written summary of violations of this chapter and any factual findings used as a basis to determine that a violation has occurred.

(c) The Department or the Department of Banking and Insurance may require that the HMO submit a written plan of correction specifying how each violation that has been cited will be corrected along with the time frames for completion of each corrective action. A single plan of correction may address all events associated with a given violation. The plan of correction, where required, shall be submitted by the HMO within 20 business days of receipt of the notice of violations, or sooner, if the Commissioner determines that the violations jeopardize the safety of enrollees. The plan of correction shall be reviewed by the Department and shall be approved where the plan demonstrates to the satisfaction of the Department that compliance will be achieved within a reasonable time period. If the plan is not approved, the Departments of Health and Senior Services and Banking and Insurance may request that an amended plan of correction be submitted within five business days.

(d) The summary of violations and the written plan of correction shall not be released as public information until such time that the Department has received the plan of correction or, in the event no plan of correction is submitted, 20 business days of receipt of the summary of violations by the HMO, whichever is sooner. Unless otherwise documented, the Department will presume receipt of the summary of violations by the HMO by the third business day if sent by regular mail.

8:38–2.14 Enforcement remedies available

(a) The Commissioner of Health and Senior Services may impose the following enforcement remedies against an HMO for violations of regulations in this chapter or other statutory requirements:

1. A monetary penalty may be imposed for each violation in an amount determined by the Commissioner, which shall in such amounts as authorized by N.J.S.A. 26:2J–24, as may be amended from time to time. The Department shall provide the HMO with reasonable notice in writing of the intent to levy the penalty, and a reasonable time, as determined by the Commissioner, within which to correct the violation. Any such penalty may be recovered in a summary proceeding pursuant to the Penalty Enforcement Law (N.J.S.A. 2A:58 et seq.);

2. Suspension of a certificate of authority pursuant to N.J.S.A. 26:2J–19, which may include the suspension of marketing and enrollment;

3. Revocation of a certificate of authority pursuant to N.J.S.A. 26:2J–19;

4. An order to cease and desist pursuant to N.J.S.A. 26:2J–24;

5. Institution of a proceeding to obtain injunctive relief pursuant to N.J.S.A. 26:2J–24;

6. Other remedies for violations of statutes, as provided by State or federal law.

(b) The Commissioner shall serve notice to the HMO of any proposed enforcement remedy under this section, setting forth the specific violations, charges or reasons for the action. Such notice shall be served on the HMO or its registered agent in person or by certified mail.

(c) The assessment of civil monetary penalties, or revocation of a certificate of authority, shall become effective 30 days after the date of mailing or the date on which such notice was personally served on an HMO, unless the HMO files with the Department a written answer to the charges and gives written notice to the Department of its desire for a hearing, in accordance with N.J.A.C. 8:38–2.15. In such cases, the HMO may request an abeyance of the enforcement remedy until an administrative hearing has been concluded and a final decision is rendered by the Commissioner. The Commissioner may grant the abeyance where he or she determines that such action would not endanger the health, safety, and welfare of HMO members. Hearings shall be conducted in accordance with N.J.A.C. 8:38–2.15.

(d) Upon the imposition of an order to suspend marketing and enrollment, or following the suspension of a certificate of authority, the HMO shall not enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees.

(e) Upon the revocation of the certificate of authority, the HMO shall notify all members and providers and follow procedures in N.J.S.A. 26:2J–19d.

(f) The Commissioner or the Commissioner of Banking and Insurance may issue an order directing an HMO or a representative of an HMO to cease and desist from engaging in any act or practice in violation of the provisions of this chapter and N.J.S.A. 26:2J–1 et seq. Within 20 days after service of such an order, the HMO may request a hearing on the question of whether acts or practices in violation of this chapter and N.J.S.A. 26:2J–1 et seq. have occurred.

(g) The Commissioner may institute a proceeding to obtain injunctive relief, in accordance with New Jersey Court Rules, if the Commissioner elects not to issue a cease and desist order, or in the event of non-compliance with a cease and desist order pursuant to N.J.S.A. 26:2J–24(d).

8:38–2.15 Hearings

(a) Pursuant to N.J.S.A. 26:2J–22, if the Commissioner proposes to suspend, revoke, or deny a certificate of authority, or issues a cease and desist order, the Commissioner shall notify the HMO and the Commissioner of Banking and Insurance in writing, specifically stating the grounds for such denial, suspension, revocation, or order and fixing a time of at least 20 days thereafter for a hearing on the matter.

(b) If the Commissioner levies a civil penalty, the HMO has a right to request a hearing on the matter, which must be filed within 20 days of receipt of the notice.

(c) The hearing will be conducted through the Office of Administrative Law in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(d) After such hearing or upon failure of the HMO to request a hearing, the Commissioner shall make a final determination based on written findings and make such findings available to the HMO and the Commissioner of Banking and Insurance.

(e) The recommendations and findings of the Commissioner of Banking and Insurance shall be conclusive and binding upon the Commissioner in relation to suspension, revocation, or denial of a certificate of authority when the matter concerns the following:

1. Insurance business; and/or
2. Requirements in N.J.A.C. 8:38–11 through 15.

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:38–3.1 Compliance with laws and rules

(a) The HMO shall comply with the provisions of the New Jersey Health Maintenance Organizations Act, N.J.S.A. 26:2J–1 et seq.

(b) The HMO shall comply with applicable Federal, state, and local laws, rules and regulations.

8:38–3.2 Nondiscriminatory enrollment practices

(a) Except as provided in N.J.A.C. 8:38–3.4(a), an HMO shall not refuse to renew the coverage of a member covered under a contract for basic health care services, or alter the terms of, or cancel, an existing contract solely on the basis of the following:

1. The health of the member;
2. The age of the member;
3. The sex of the member;
4. The frequency of the member's use of the health care services of the HMO;
5. The filing of a complaint or appeal by the member as permitted by these rules; or
6. Other reasons prohibited by the Trade Practices Act, N.J.S.A. 17B–30–1 et seq., or the New Jersey Law Against Discrimination, N.J.S.A. 10:5–1.1 et seq.

(b) In accordance with N.J.S.A. 17B:48E–20, contracts of an HMO which provide coverage of a family member or dependents of a member shall also provide coverage to a newborn child of a member from the moment of birth until 31 days after the date of birth as if that child were enrolled, without additional premium for these 31 days. The coverage for newly-born children shall consist of coverage of at least injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(c) Contracts of an HMO which provide coverage of a member but do not provide coverage for a family member or dependent of the member shall nevertheless provide for coverage of newborn children of the member from the moment of birth until 31 days after the date of birth as if that child were enrolled, unless the contracts are such as provide no dependent coverage whatsoever for the member's class. The coverage for newly-born children shall consist of coverage of at least injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, provided application and payment of the required premium are submitted to the HMO to include coverage for a newly-born child within 31 days from the date of birth. The services under this section must be authorized by the HMO.

8:38–3.3 Open enrollment

(a) After an HMO has been in operation for 24 months, it shall have an annual open enrollment period for its group contracts for basic health care services of at least one month during which it accepts members up to the limits of its capacity, as determined by the HMO, in the order in which they apply for membership. Such requirement for annual open enrollment is not applicable to contracts executed pursuant to N.J.S.A. 17B:27A–18 and 19.

(b) Notwithstanding (a) above, HMOs providing or arranging for basic health care services on a group contract basis may limit the open enrollment to all members of the group or groups covered by such contracts.

(c) The HMO shall notify its subscribers in writing, both at the time of enrollment and through a notice in the promotional material which it distributes to prospective members, that, unless the member moves his or her place of residence outside of the HMO's designated service area, a person's choice of health benefits plan generally will determine his or her coverage until the next annual open enroll-

ment period, regardless of the continued availability of a particular health care provider who contracts with the HMO.

8:38–3.4 Member contract termination

(a) A member shall not have his or her membership in an HMO cancelled except for the following reasons:

1. Failure to pay the premiums and other applicable charges for such coverage, including copayment coinsurance and deductibles;

2. Failure to abide by the rules and/or policies and procedures of the HMO;

3. Fraud or material misrepresentation affecting coverage, including misuse of a member identification card; or

4. The group of which the individual is a member is not renewed in accordance with the HMO's underwriting guidelines or is cancelled for failure to pay premiums.

(b) Before a member's coverage can be terminated for (a)1 and 2 above, the member shall be given written notice of the violation and a reasonable opportunity to come into compliance. Following any decision to terminate a member's coverage, the HMO shall notify the member of his or right to appeal such decision as set forth in N.J.A.C. 8:38–3.6.

8:38–3.5 Provider contract termination

(a) The HMO shall establish a policy governing termination of providers. The policy shall include at least:

1. Notice to the provider of the termination in the time and manner specified in the provider's contract;

2. Methods by which the termination policy shall be made known to providers and members at the time of enrollment and on a periodic basis;

3. Written notification to each member within 30 business days prior to the termination or withdrawal from the HMO's provider network of a member's PCP and any other physician or provider from which the member is currently receiving a course of treatment. The 30–day prior notice to members may be waived in cases of immediate termination of a provider pursuant to contractual terms, where it is necessary for the protection of health, safety and welfare of members; and

4. Assurance of continued coverage of services at the contract price by a terminated provider for up to 120 calendar days in cases where it is medically necessary for the member to continue treatment with the terminated provider. In cases of the pregnancy of a member, medical necessity shall be deemed to have been demonstrated and coverage of services by the terminated provider shall continue to the postpartum evaluation of the member, up to six weeks after delivery. The policy shall clearly state that the determination as to the medical necessity of a member's continued treatment with a terminated provider shall be subject to the appeal procedures set forth at N.J.A.C. 8:38–8.5 through 8.7.

(b) In the event a hospital provider's contract is not renewed, the hospital and the HMO shall continue to abide by the terms of the most current contract for a period of four months from a severance date mutually agreed upon by both parties as required by N.J.S.A. 26:2J–11.1. In such an event, the HMO shall provide written notification within the first 15 business days of the four month extension to all health care providers with which it has contracted and members who reside in the county in which the hospital is located or in an adjacent county within the HMO's service area. The notice to members shall also advise them of available options with respect to their health care coverage.

8:38–3.6 Complaint and appeal system

(a) Every HMO shall establish and maintain a system to provide for the presentation and resolution of complaints brought by members or by providers acting on behalf of a member and with the member's consent, regarding any aspect of the HMO's health care services, including, but not limited to, complaints regarding quality of care, choice and accessibility of providers, and network adequacy. All such general complaint systems must, at a minimum, incorporate to the satisfaction of the Commissioner, the following components:

1. Written notification to all members and providers of the telephone numbers and business addresses of the HMO employees responsible for complaint resolution;

2. A system to record and document the status of all complaints, which shall be maintained for at least three years;

3. Availability of an HMO member services representative to assist members, as requested, with complaint procedures;

4. Establishment of a specified response time for complaints, not to exceed 30 days from receipt thereof by the HMO;

5. A process describing how complaints are processed and resolved;

6. Procedures for follow-up action including the methods to inform the complainant of resolution;

7. Procedures for notifying the continuous quality improvement program of all valid complaints related to quality of care; and

8. A mechanism for notifying members and providers in writing that they may contact the Departments of Health and Senior Services, Banking and Insurance or, in the case of Medicaid enrollees, Human Services, Division of Medical Assistance and Health Services, if dissatisfied with the resolution reached through the HMO's internal complaint system.

(b) Every HMO shall provide for the presentation to the HMO and resolution by the HMO of complaints brought by providers in accordance with N.J.A.C. 8:38–3.7(a)2, 7.1(a)9 and 7.1(f).

(c) In addition to the complaint process delineated above, every HMO shall establish and maintain a system for the presentation and resolution of appeals brought by members or by providers acting on behalf of a member and with the member's consent, with respect to the denial, termination or other limitation of covered health care services, hereinafter referred to as utilization management determinations. The appeals process for utilization management determinations shall comply with all of the provisions of N.J.A.C. 8:38–8.4 through 8.7.

(d) A description of the systems for filing complaints and for appealing utilization management determinations shall be included in the evidence of coverage and member handbook issued to members.

(e) No member or provider who exercises the right to file a complaint and/or appeal under this section shall be subject to disenrollment or otherwise penalized solely due to such complaint and/or appeal.

8:38–3.7 Submission of documents and data

(a) The HMO shall submit all membership, utilization, financial, and descriptive plan information to the Departments of Health and Senior Services and Banking and Insurance as requested. This shall include, but is not limited to:

1. A quarterly report on forms prescribed by the Department and specified at N.J.A.C. 8:38–11.6(d). This report shall be submitted within 45 days after the end of each quarter; and

2. An annual report, a current directory of providers, and a record of all member and provider complaints, inclusive of all malpractice actions, on forms prescribed by the Department, as specified at N.J.A.C. 8:38–11.6. These reports shall be submitted by March 1 of the following year. The record of member and provider complaints referred to above shall include at least the following:

i. The total number of complaints and utilization management appeals filed within the last year, categorized by cause and disposition;

ii. The average length of time for resolution of each complaint and utilization management appeal by cause or category; and

iii. The number, amount and disposition of malpractice claims settled or adjudicated during the year in which the HMO was a named party to the suit.

(b) The HMO shall submit a copy of its internal performance indicators to the Department of Health and Senior Services on an annual basis.

(c) The HMO shall submit continuous quality improvement information as required in N.J.A.C. 8:38–7 to the Department of Health and Senior Services, including, but not limited to:

1. A copy of the continuous quality improvement plan and all subsequent revisions to the plan on an annual basis;

2. A copy of the reports from the continuous quality improvement plan submitted to the Board of Directors on an annual basis;

3. A copy of the performance and outcome data as prescribed by the Department in N.J.A.C. 8:38–7; and

4. A copy of the member mailing list as requested by the Department, in accordance with N.J.A.C. 8:38–7.3(f).

SUBCHAPTER 4. MEDICAL DIRECTOR

8:38–4.1 Designation of a medical director

(a) The HMO shall designate a physician to serve as medical director.

(b) The medical director or his or her designee shall be designated to serve as the medical director for medical services provided to the HMO's New Jersey members. This physician shall be licensed to practice medicine in New Jersey and may also serve as the overall medical director of the HMO as required in (a) above.

8:38–4.2 Medical director's responsibilities

(a) The medical director shall be responsible for the direction, provision, and quality of medical services provided to members, including, but not limited to:

1. Defining responsibilities and inter-relationships of professional services;

2. Coordinating, supervising and overseeing the functioning of professional services;

3. Evaluating the medical aspects of provider contracts;

4. Overseeing the continuing in-service education of professional staff;

5. Providing clinical direction and leadership to the continuous quality improvement and utilization management programs;

6. Establishing policies and procedures covering all health care services provided to members; and

7. Establishing a committee that has the following responsibilities:

i. Establishing mechanisms for ensuring review of provider credentials;

ii. Delineating qualifications of participating providers;

iii. Reviewing credentials of physicians and other providers who do not meet the HMO's established credentialing standards; and

iv. Establishing a system for verification of provider's credentials, recertification, performance reviews and obtaining information about any disciplinary action against the provider available from the New Jersey Board of Medical Examiners or any other state licensing board applicable to the provider, or the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, P.L. 99–660 (42 U.S.C. § 1101 et seq.).

SUBCHAPTER 5. HEALTH CARE SERVICES

8:38–5.1 Provision of health care services

The HMO shall, at a minimum, provide or arrange for the provision to its members all basic comprehensive health care services and all other services enumerated in this subchapter and in N.J.S.A. 26:2J–1 et seq. as it may be amended from time to time.

8:38–5.2 Basic comprehensive health care services

(a) The HMO shall provide or arrange for the provision of the following basic comprehensive health services as medically necessary:

1. Periodic examinations and office visits to a primary care provider for routine and urgent care;

2. Diagnostic and disease detection studies, including laboratory and radiological services;

3. Prenatal care and obstetric care:

i. In accordance with P.L. 1995, c.138, obstetric care includes 48 hours of inpatient care following a vaginal delivery or a minimum of 96 hours of inpatient care following a caesarean section.

ii. Notwithstanding the provisions of (a)3i above, a member agreement that provides health care services for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours and 96 hours, respectively, of inpatient care unless such inpatient care is determined to be medically necessary by the attending physician or is requested by the mother.

4. Regular pediatric care including newborn care and immunizations;

5. Radiation therapy;

6. Consultations and specialists' services as requested by the primary care provider;

7. In accordance with N.J.S.A. 26:2J–4.3(4), out-of-hospital physical examinations, including related x-rays and diagnostic tests, to include, at a minimum, the following:

i. For members who are less than two years of age, up to six examinations during the first two years of life; for members who are minors of two years of age or older, one examination at age three, six, nine, 12, 15 and 18 years; and

ii. For members who are adults less than 40 years of age, one examination every five years; for members who are 40 or more years of age but less than 60 years of age, one examination every three years; and for members who are 60 years of age or older, one examination every two years;

8. Screening examinations prescribed at N.J.S.A. 26:2J–1 et seq., including:

i. Pap smears in accordance with N.J.S.A. 26:2J–4.12; and

ii. Mammograms in accordance with N.J.S.A. 26:2J–4.4;

9. Physical medicine and rehabilitation services including, but not limited to physical therapy;

10. Equipment and supplies for the treatment of diabetes in accordance with P.L. 1995, c.331;

11. Outpatient evaluative, crisis intervention and short term therapeutic mental health services;

12. Outpatient substance abuse care;

13. Medically necessary eye care services for detection and treatment of disease or injury to the eye and children's eye examinations conducted to determine the need for vision correction;

14. Inpatient hospital care, including semi-private room accommodations, 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;

15. Outpatient surgical care;

16. Inpatient psychiatric care;

17. Inpatient substance abuse care (a minimum of 30 days during any contract year) in a facility licensed to provide residential alcohol and drug abuse services;

18. Skilled nursing care (a minimum of 30 days during any contract year) in a licensed long term care facility;

19. Home health services (a minimum of 60 home care visits during any contract year); and

20. Hospice services from a Medicare certified hospice agency.

8:38–5.3 Emergency and urgent care services

(a) The HMO shall establish written policies and procedures governing the provision of emergency and urgent care which shall be distributed to each subscriber at the time of initial enrollment.

(b) Emergency and urgent care services shall include, but are not limited to:

1. Medical and psychiatric care, which shall be available 24 hours a day, seven days a week;

2. Coverage for trauma services at any designated Level I or II trauma center as medically necessary. Such coverage shall continue at least until, in the judgment of the attending physician, the member is medically stable, no longer requires critical care, and can be safely transferred to another facility. If the HMO requests transfer to a hospital participating in the HMO network, the transfer shall be effected in accordance with Federal regulations at 42 C.F.R. 489.20 and 489.24;

3. Coverage for out-of-service area medical care when medically necessary for urgent or emergency conditions where the member cannot reasonably access in-network services;

4. Prehospital care and hospital services regardless of location when medically necessary for injury or emergency illness; and

5. Upon a member's arrival in a hospital, coverage of a medical screening examination, as required under Federal law and as specified in N.J.A.C. 8:43G–12, as necessary to determine whether an emergency medical condition exists.

8:38–5.4 Supportive services

(a) The HMO shall provide or arrange for the provision of the following supportive services:

1. Ambulance or invalid coach services, as defined at N.J.A.C. 8:40, when authorized by the HMO for non-emergency medical transport;

2. Health education services and diabetes self-management education in accordance with P.L. 1995, c.331;

3. Nutritional education and counseling;

4. Medical social services; and

5. Preventive health services, including voluntary family planning services, and infertility services.

8:38–5.5 Health promotion programs

(a) In accordance with N.J.S.A. 26:2J–4.6, HMOs shall offer, directly or through written agreement, a health promotion program which includes, but is not limited to, the following tests and services:

1. Annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level for all persons 20 years of age and older;

2. A glaucoma eye test every five years for all persons 35 years of age or older;

3. An annual stool examination for presence of blood for all persons 40 years of age or older;

4. A left-sided colon examination of 35 to 60 centimeters every five years for all persons 45 years of age or older;

5. A pap smear every two years for all women 20 years of age or older;

6. An annual mammogram examination for all women 40 years of age or older as well as a baseline mammography for women who are at least 35 but less than 40 years of age;

7. Recommended immunizations for all adults; and

8. An annual consultation, for all persons 20 years of age or older, with a health care provider to discuss lifestyle behaviors that promote health and well-being, including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

(b) An HMO shall not be required to offer services to members delineated above for which the value exceeds:

1. $128.00 a year for each person between the ages of 20 to 39, inclusive;

2. $148.00 a year for each man age 40 and over and $241.00 a year for each woman age 40 and over, except that for persons 45 years of age or older, the value of a left-sided colon examination shall not be included in this amount; however, no HMO shall be required to provide services to members for a left-sided colon examination with a value in excess of $154.00.

(c) The Commissioner, in consultation with the Department of the Treasury, shall adjust the threshold amounts in (b) above annually in direct proportion to the increase or decrease in the consumer price index for all urban consumers in the New York City and Philadelphia areas as reported by the United States Department of Labor. The adjustment shall become effective on July 1 of the year in which it is reported.

8:38–5.6 Wilm's tumor

In accordance with N.J.S.A. 26:2J–4.1, the HMO shall provide health care services to any member for the treatment of Wilm's tumor, including, but not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful, notwithstanding that any such treatment may be deemed experimental or investigational.

8:38–5.7 Health care services for prescribed drugs

(a) HMOs which provide pharmacy services shall comply with the requirements set forth at N.J.S.A. 26:2J–4.7.

(b) In accordance with N.J.S.A. 26:2J–4.5, an HMO which provides health care services for prescribed drugs approved by the Federal Food and Drug Administration (FDA) shall also provide health care services for prescribed drugs which have not been approved by the FDA if it is recognized to be medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

1. The American Medical Association drug Evaluations;

2. The American Hospital Formulary Service Drug Information;

3. The United States Pharmacopeia Drug Information; or

4. A clinical study or review article in a major-peer reviewed professional journal.

(c) Notwithstanding the provisions of this section, coverage shall not be required for any experimental or investigational drug or any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Health care services provided pursuant to this section shall be determined and provided to the same extent as other services under the enrollee plan for drugs prescribed for treatments which have been approved by the FDA.

(d) Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug.

SUBCHAPTER 6. PROVIDER NETWORK

8:38–6.1 Health care service network

(a) Each HMO shall maintain primary, specialty, ancillary, and institutional services sufficient to meet the requirements in N.J.A.C. 8:38–5.

(b) Nothing contained in this subchapter shall preclude the New Jersey Department of Human Services, Division of Medical Assistance and Health Services from requiring higher standards for services to Medicaid recipients pursuant to a contract for services between the Division of Medical Assistance and Health Services and the HMO.

8:38–6.2 Primary, specialty and ancillary providers

(a) The HMO shall maintain an adequate network of primary care providers, specialists, and other ancillary health care personnel to serve the enrolled population at all times. For certificate of authority applications to initiate operations within a service area, this adequacy shall be evaluated based on enrollment projections at the end of 12 months of operation. At a minimum, the network of providers shall include:

1. Medical and other professional staff, as follows:

i. There shall be a sufficient number of licensed primary care providers (PCPs) under contract with the HMO to provide basic comprehensive health care services;

ii. There shall be a sufficient number of licensed medical specialists available to HMO members to provide medically necessary specialty care. The HMO must have a policy assuring access to such specialists within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or approved sub-county service area;

(1) Cardiologist;

(2) Dermatologist;

(3) Endocrinologist;

(4) ENT;

(5) General surgeon;

(6) Neurologist;

(7) Obstetrician/gynecologist;

(8) Oncologist;

(9) Ophthalmologist;

(10) Orthopedist;

(11) Oral surgeon;

(12) Psychiatrist; and

(13) Urologist;

iii. For specialists not identified in (a)1ii above, the HMO shall have a policy assuring access to such specialists within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or approved sub-county service area;

iv. There shall be a sufficient number of other health professional staff including but not limited to licensed nurses and other professionals available to HMO members to provide basic health care services;

v. There shall be sufficient licensed optometrists associated with or available to the HMO to assure that, unless referral to an ophthalmologist is determined by the PCP to be medically required and outside the scope of practice of an optometrist, the member can choose to have vision care services provided by a licensed optometrist. The HMO shall have a policy assuring access to these providers, as set forth above in N.J.A.C. 6.2(a)1ii.

vi. If the HMO provides pharmacy services, prescription drugs, or a prescription drug plan, no registered pharmacy or pharmacist shall be denied the right to participate as a preferred provider pursuant to the terms of N.J.S.A. 26:2J–4.7.

(b) Physicians qualified to function as primary care providers include the following categories:

1. Licensed physicians who have successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association in family practice, internal medicine, general practice, obstetrics and gynecology or pediatrics;

2. Licensed physicians who do not meet the qualifications in (a) above, but have been evaluated by the committee required at N.J.A.C. 8:38–4.2(b) and found to demonstrate through training, education and experience, equivalent expertise in primary care;

3. At the discretion of the HMO, exceptions may be made for appropriate licensed medical specialists to be designated as primary care provider for specified individual members or patient groups who, due to health status or chronic illness, would benefit from medical care management by such a medical specialist.

(c) Health care professionals qualified as primary care providers include the following categories:

1. Nurse practitioners/clinical nurse specialists certified by the State Board of Nursing in accordance with N.J.S.A. 45:11–45 et seq. in advance practice categories comparable to family practice, internal medicine, general practice, obstetrics and gynecology or pediatrics; and in hospitals or other facilities;

2. Physician assistants licensed by the New Jersey Board of Medical Examiners; and

3. Certified nurse midwives registered by the New Jersey Board of Medical Examiners.

(d) Geographic access and availability standards for primary care providers (PCPs) shall be as follows:

1. There shall be at least two PCPs within 10 miles or 30 minutes average driving time or public transit (if available) whichever is less of 90 percent of the enrolled population.

2. The HMO shall demonstrate that the projected PCP network is sufficient to meet adult, pediatric and primary ob/gyn needs of the projected enrollment on the basis of the following assumptions:

i. Four primary care visits per year per member, averaging one hour per year per member; and

ii. Four patient visits per hour, per PCP;

3. In order to demonstrate PCP availability, an HMO shall verify that the PCP has committed to provide a specific number of hours for new patients that cumulatively add up to projected clinic hour needs of projected enrollment by county or service area.

4. The HMO shall demonstrate that the network of PCPs is sufficient to assure that the following criteria will be met:

i. Emergencies shall be triaged immediately through the PCP or by a hospital emergency room through medical screening or evaluation;

ii. Urgent care shall be provided within 24 hours of notification of the PCP or HMO;

iii. In both emergent and urgent care, PCPs shall be required to provide seven day, 24 hour access to triage services;

iv. Routine appointments shall be scheduled within two weeks; and

v. Routine physical exams shall be scheduled within four months.

8:38–6.3 Institutional services

(a) The HMO shall maintain contracts or other arrangements acceptable to the Department with institutional providers which have the capability to meet the medical needs of members and are geographically accessible. The network of providers shall include:

1. At least one licensed acute care hospital including at least licensed medical-surgical, pediatric, obstetrical, and critical care services in any county or service area no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of members within the county or service area;

2. Surgical facilities including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physicians surgical practices available in each county or service area no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of members within the county or service area;

3. Tertiary and specialized services as follows:

i. The HMO shall have a contract or otherwise agree to cover medically necessary trauma services at a reasonable cost with all Level I or II trauma centers designated by the New Jersey Department of Health and Senior Services pursuant to N.J.A.C. 8:33P. The member may not be balance billed for any covered trauma services provided by such designated trauma centers.

ii. The HMO must have a policy assuring access, as evidenced by contract or other agreement acceptable to the Department, to the following specialized services, as determined to be medically necessary. Such services will be available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of members within each county or approved sub-county area:

(1) At least one hospital providing regional perinatal services;

(2) A hospital offering tertiary pediatric services;

(3) In-patient psychiatric services for adults, adolescents and children;

(4) Residential substance abuse treatment center;

(5) Diagnostic cardiac catheterization services in a hospital;

(6) Specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio facial and congenital anomalies; and

(7) Comprehensive rehabilitation services.

iii. The HMO shall have a policy assuring access, as evidenced by contract or other agreement acceptable to the Department, to the following specialized services, as determined to be medically necessary. Such services will be available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of members within each county or approved sub-county area:

(1) A licensed long term care facility with Medicare-certified skilled nursing beds;

(2) Therapeutic radiation provider;

(3) Magnetic resonance imaging center;

(4) Diagnostic radiology provider, including x-ray, ultrasound, and CAT scan;

(5) Emergency mental health service, including a short term care facility for involuntary psychiatric admissions;

(6) Out-patient therapy providers for mental health and substance abuse conditions; and

(7) Licensed renal dialysis provider.

4. At least one home health agency licensed by the Department to serve each county where 1,000 or more members reside; and

5. At least one hospice program certified by Medicare in any county where 1,000 or more members reside.

(b) The HMO may request, and will be granted, relief from the time and mileage requirements in (a) above where it can document to the satisfaction of the Department that appropriate access to alternative sites is available. Such documentation shall address travel accommodations and travel times, financial hardship placed on families and other logistical details as requested by the Department of a specific HMO.

(c) In any county or approved sub-county service area in which 20 percent of an HMO's projected or actual membership must rely upon public transportation to access health care services, as documented by U.S. Census Data, the driving times in the criteria in (a) above shall be based upon average transit time using public transportation. The HMO shall demonstrate how it will meet this requirement in its application.

SUBCHAPTER 7. CONTINUOUS QUALITY IMPROVEMENT

8:38–7.1 Continuous quality improvement program

(a) The HMO shall have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to members. This program shall be under the direction of the medical director or his or her designee, who shall be a physician, and shall be based on a written plan which is reviewed at least annually and revised as necessary. The plan shall describe at least:

1. The scope and purpose of the program;

2. The organizational structure of quality improvement activities;

3. Duties and responsibilities of the medical director and/or designated physician responsible for continuous quality improvement activities;

4. Contractual arrangements, where appropriate, for delegation of quality improvement activities;

5. Confidentiality policies and procedures;

6. Specification of standards of care, criteria and procedures for the assessment of the quality of services provided and the adequacy and appropriateness of health care resources utilized;

7. A system of ongoing evaluation activities, including individual case reviews as well as pattern analysis;

8. A system of focused evaluation activities, particularly for frequently performed and/or highly specialized procedures;

9. A system of monitoring member satisfaction and network providers' response and feedback on HMO operations;

10. The procedures for conducting peer review activities which shall include providers within the same discipline and area of clinical practice; and

11. A system for evaluation of the effectiveness of the continuous quality improvement program.

(b) The board of directors of the HMO shall be kept apprised of continuous quality improvement activities and shall be provided at least annually with regular written reports from the program delineating quality improvements, performance measures used and their results, and demonstrated improvements in clinical and service quality.

(c) There shall be a multidisciplinary continuous quality improvement committee responsible for the implementation and operations of the program. The structure of the committee shall include representation from the medical, nursing and administrative staff, with substantial involvement of the medical director of the HMO.

(d) The program shall monitor the availability, accessibility, continuity and quality of care on an ongoing basis. Indicators of quality care for evaluating the health care services provided by all participating providers shall be identified and established and shall include at least:

1. A mechanism for monitoring patient appointments and triage procedures, discharge planning services, linkage between all modes and levels of care and appropriateness of specific diagnostic and therapeutic procedures, as selected by the continuous quality improvement program;

2. A mechanism for evaluating all providers of care. The findings from a health care facility's internal quality assurance program may be used to supplement, but shall not fully constitute, the HMO's assessment of patient care; and

3. A system to monitor provider and member access to utilization management services including at least waiting times to respond to phone requests for service authorization, member urgent care inquiries, and other services required in N.J.A.C. 8:38–8.3.

(e) The HMO shall follow up on findings from the program to assure that effective corrective actions have been taken, including at least policy revisions, procedural changes and implementation of educational activities for members and providers.

(f) Continuous quality improvement activities shall be coordinated with other performance monitoring activities including utilization management, risk management, and monitoring of member and provider complaints.

(g) The HMO shall maintain documentation of the quality improvement program in a confidential manner. This documentation shall be available to the Commissioner or his or her designee and shall include:

1. Minutes of quality improvement committee meetings; and

2. Records of evaluation activities, performance measures, quality indicators and corrective plans and their results or outcomes.

8:38–7.2 External quality audit

(a) Each HMO shall submit, as part of the comprehensive assessment review process, evidence of the most recent external quality audit that has been conducted within three years of the date of the comprehensive assessment review. Such audit shall be performed by an external quality review organization (EQRO) approved by the Department.

(b) The report shall describe in detail the HMO's conformance to performance standards established by the (EQRO), other national standard-setting bodies for HMOs, and/or the rules within this chapter. The report shall also describe in detail any corrective actions proposed and/or undertaken and approved by the (EQRO). The report shall be submitted to the Department within 60 days of its receipt in final form by the HMO.

(c) The HMO shall not be required to receive "accreditation" or "certification" or other such status granted by the (EQRO). If the HMO attains "accreditation" or "certification" or other such status granted by the (EQRO) within the 12 months prior to the Department's comprehensive assessment review, the HMO shall be exempted from examination by the Department in any area in which the Commissioner determines that the (EQRO's) review demonstrated specific compliance with standards substantially equivalent to those contained in this chapter.

(d) The Commissioner may grant an HMO a deferral of the above requirement for an external quality audit for a 12–month period if it is in the initial three years of start-up operations, and it demonstrates a financial or operational hardship.

8:38–7.3 Performance and outcome measures

(a) The Department shall develop a performance and outcome measurement system for monitoring the quality of care provided to HMO members. The data collected through this system may be used by the Department to:

1. Assist HMOs and their providers in quality improvement efforts;

2. Provide the Department with information on the performance of HMOs for regulatory oversight;

3. Support efforts to inform consumers about HMO performance;

4. Promote the standardization of data reporting by HMOs and providers; and

5. Any other purpose consistent with this chapter and N.J.S.A. 26:2J–1 et seq. .

(b) The performance and outcome measures shall include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction. To minimize costs to HMOs, providers, and the Department, performance measures shall incorporate, when possible, data routinely collected or available to the Department from other sources. Data for these performance measures may include, but not be limited to, the following:

1. Indicator data collected by HMOs from chart reviews and administrative data bases;

2. Member and patient satisfaction surveys;

3. Provider surveys;

4. Quarterly and annual reports submitted by HMOs to the Department as specified in N.J.A.C. 8:38–3.7;

5. Computerized health care encounter data; and

6. Data collected by the Department for administrative, epidemiological and other purposes, such as the State cancer registry, vital records, and hospital UB–92 records.

(c) HMOs shall submit such performance and outcome data as the Department may request from time to time.

(d) The Department shall make, when appropriate, statistically valid adjustments to account for demographic variations among HMOs. Each HMO shall have opportunity to comment on the compilation and interpretation of the data before its release to consumers.

(e) The Department shall conduct audits of each HMO's performance and outcome data including desk and on-site audits.

(f) The Department shall conduct or arrange for periodic member satisfaction surveys. The HMO shall provide the Department with the member mailing list, upon request, to be used to select samples of the HMO's membership for the surveys.

(g) The Department shall ensure the confidentiality of patient specific information.

(h) The Department shall take all necessary measures to reduce duplicative reporting of information to State agencies.

8:38–7.4 Healthcare Data Committee

(a) The Department shall establish a Healthcare Data Committee (HeDaC) to assist the Department in developing a performance measurement and assessment system for monitoring the quality of care provided to HMO members as described in N.J.A.C. 8:38–7.3.

(b) The HeDaC shall be comprised of no more than 12 and no less than 10 members who shall be appointed by, and serve at the pleasure of, the Commissioner. The members shall include providers, consumers and at least three HMO representatives. In addition to the above, representatives of the New Jersey State Health Benefits Commission and the Departments of Banking and Insurance and Human Services shall serve as additional ex-officio members. The HeDaC shall be chaired by the Commissioner or his or her designee. Additional experts may be invited to participate on an invitational ad hoc basis as needed.

(c) The HeDaC shall advise the Commissioner on the development of a uniform data reporting system to obtain reliable, standardized and comparable information from all HMOs. In the process of developing this system, the HeDaC shall address the following:

1. The relevance, validity and reliability of each measure selected to be an indicator of performance;

2. The protection of confidentiality of patient-specific information;

3. The cost and difficulty of data collection;

4. The measures to reduce duplicative reporting of information to state agencies; and

5. The public release of data in formats useful to purchasers and/or consumers.

SUBCHAPTER 8. UTILIZATION MANAGEMENT

8:38–8.1 Utilization management program

(a) The HMO shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care and services. The program shall be under the direction of the medical director or his or her designee, who shall be a physician, and shall be based on a written plan that is reviewed at least annually. The plan shall identify at least:

1. Scope of utilization management activities;

2. Procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;

3. Mechanisms to detect underutilization and overutilization;

4. Clinical review criteria and protocols used in decision-making;

5. Mechanisms to ensure consistent application of review criteria and uniform decisions;

6. Development of outcome and process measures for evaluating the utilization management program;

7. System for providers and members to appeal utilization management determinations in accordance with the procedures set forth at N.J.A.C. 8:38–8.4 through 8.7; and

8. A mechanism to evaluate member satisfaction with the complaint and appeals systems set forth at N.J.A.C. 8:38–3.6 and at 8:38–8.4 through 8.7. Such evaluation shall be coordinated with the performance monitoring activities conducted pursuant to the continuous quality improvement program set forth in N.J.A.C. 8:38–7.

(b) Utilization management determinations shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers within the network and based upon generally accepted medical standards. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to members and participating providers in the relevant practice areas.

8:38–8.2 Utilization management staff availability

(a) A registered professional nurse or physician shall be immediately available by phone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(b) For routine utilization-related inquiries, the HMO shall provide all members and providers with a toll free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis.

(c) All members must have immediate phone access seven days a week, 24 hours a day, to their primary care provider or his or her authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

8:38–8.3 Utilization management determinations

(a) The HMO shall have written policies and procedures that address responsibilities and qualifications of staff who render determinations to authorize admissions, services, procedures or extensions of stay.

(b) All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The determination shall be directly communicated by the physician to the provider or, if this is not possible, the provider shall be supplied with the physician's name, telephone number, and where he or she can be reached. The physician shall be available immediately in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the HMO's New Jersey members. Such determinations shall be made in accordance with clinical and medical necessity criteria developed pursuant to N.J.A.C. 8:38–8.1(b) and the evidence of coverage.

(c) All determinations shall be made on a timely basis, as required by the exigencies of the situation.

(d) An HMO shall not retroactively deny reimbursement for a covered service provided to a member by a provider who relied upon the written or oral authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

(e) A member or provider acting on behalf of a member shall receive upon request a written notice of any determination to deny coverage or authorization for services required in this subchapter or in the evidence of coverage, which shall be subject to appeal in accordance with N.J.A.C. 8:38–8.5, 8.6 and 8.7. The written notice of determination shall include an explanation of the appeal process.

8:38–8.4 Appeals of utilization management determinations.

(a) All HMO members, and any provider acting on behalf of a member with the member's consent, may appeal any utilization management determination resulting in a denial, termination, or other limitation of covered health care services in accordance with the provisions of N.J.A.C. 8:38–8.5 through 8.7. All members and providers shall be provided with a written explanation of the appeal process in the member handbook and upon the conclusion of each stage in the process as described in N.J.A.C. 8:38–8.5 through 8.7. The appeal process shall consist of an informal internal review by the HMO (stage 1 appeal), a formal internal review by the HMO (stage 2 appeal), and a formal external review (stage 3 appeal) by an independent utilization review organization (IURO).

(b) Nothing in the HMO's policies, procedures or provider agreement shall prohibit a member or provider (on behalf of a member) from discussing or exercising the right to an appeal available under N.J.A.C. 8:38–8.5 through 8.7.

8:38–8.5 Informal internal utilization management appeal process (Stage 1)

Each HMO shall establish and maintain an informal internal appeal process (stage 1 appeal) whereby any member, or any provider acting on behalf of a member, with the member's consent, who is dissatisfied with any HMO utilization management determination, shall have the opportunity to discuss and appeal that determination with the HMO medical director and/or the physician designee who rendered the determination. All such stage 1 appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed 72

hours in the case of appeals from determinations regarding urgent or emergency care and five business days in the case of all other appeals. If the appeal is not resolved to the satisfaction of the member at this level, the HMO shall provide the member and/or the provider with a written explanation of his or her right to proceed to a stage 2 appeal.

8:38–8.6 Formal internal utilization management appeal process (Stage 2)

(a) Each HMO shall establish and maintain a formal internal appeal process (stage 2 appeal) whereby any member or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of the stage 1 appeal, shall have the opportunity to pursue his or her appeal before a panel of physician and/or other health care professionals selected by the HMO who have not been involved in the utilization management determination at issue.

(b) The formal internal utilization management appeal panel shall have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties. In no event, however, shall the consulting practitioner or professional have been involved in the utilization management determination at issue. The consulting practitioner or professional shall participate in the panel's review of the case, if requested by the member and/or provider.

(c) All such stage 2 appeals shall be acknowledged by the HMO, in writing, to the member or provider filing the appeal within 10 business days of receipt.

(d) All such stage 2 appeals shall be concluded as soon as possible after receipt by the HMO in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care and, except as set forth in (e) below, 20 business days in the case of all other appeals.

(e) The HMO may extend the review for up to an additional 20 business days where it can demonstrate reasonable cause for the delay beyond its control and where it provides a written progress report and explanation for the delay to the satisfaction of the Department, with notice to the member and/or provider within the original 20 business day review period.

(f) If the stage 2 appeal is denied, the HMO shall provide the member and/or provider with written notification of the denial and the reasons therefor together with a written notification of his or her right to proceed to an external (stage 3) appeal. This notification shall include specific instructions as to how the member and/or provider may arrange for an external appeal and shall also include any forms required to initiate such an appeal.

(g) In the event that the HMO fails to comply with any of the deadlines for completion of the internal utilization management determination appeals set forth in N.J.A.C. 8:38–8.5 or 8.6, or in the event that the HMO for any reason expressly waives its rights to an internal review of any appeal, then the member and/or provider shall be relieved of his or her obligation to complete the HMO internal review process and may, at his or her option, proceed directly to the external appeals process set forth at N.J.A.C. 8:38–8.7.

8:38–8.7 External appeals process

(a) Any HMO member, and any provider acting on behalf of a member, with the member's consent, who is dissatisfied with the results of the internal appeal process set forth at N.J.A.C. 8:38–8.5 through 8.6 above, shall have the right to pursue his or her appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below (stage 3 appeal). Except as set forth in N.J.A.C. 8:38–8.6(g), the right to an external appeal under this section shall be contingent upon the member's full compliance with both stages of the HMO internal appeal process set forth at N.J.A.C. 8:38–8.5 and 8.6.

(b) To initiate an external appeal, a member and/or provider shall, within 30 business days from receipt of the written determination of the stage 2 internal appeal panel under N.J.A.C. 8:38–8.6(f), file a written request with the Department. The request shall be filed on the forms provided to the member in accordance with N.J.A.C. 8:38–8.6(f), and shall include both the fee specified in (c) below and a general release executed by the member for all medical records pertinent to the appeal. The request shall be mailed to the following address:

Office of Managed Care
Division of Health Care Systems Analysis
CN 360
Trenton, New Jersey 08625–0360

(c) The fee for filing an appeal shall be $25.00, payable by check or money order to the "New Jersey Department of Health and Senior Services". Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by the member through evidence of eligibility for either the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI, or New Jersey Unemployment Assistance.

(d) Upon receipt of the appeal, together with the executed release and the appropriate fee, the Department shall immediately assign the appeal to an IURO in accordance with N.J.A.C. 8:38–8.8, for review.

(e) Upon receipt of the request for appeal from the Department, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:

1. The individual was or is a member of the HMO;

2. The service which is the subject of the complaint or appeal reasonably appears to be a covered service under the benefits provided by contract to the member;

3. Except as set forth at N.J.A.C. 8:38–8.6(g), the member has fully complied with both the stage 1 and stage 2 appeals available pursuant to N.J.A.C. 8:38–8.5 and 8.6; and

4. The member has provided all information required by the IURO and Department to make the preliminary determination including the appeal form and a copy of any information provided by the HMO regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the HMO and any other relevant health care provider.

(f) Upon completion of the preliminary review, the IURO shall immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefor.

(g) Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the HMO's utilization management determination, the member was deprived of medically necessary covered services. In reaching this determination the IURO shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the HMO pursuant to N.J.A.C. 8:38–8.1(b).

(h) The full review referenced in (g) above shall initially be conducted by a registered professional nurse or a physician licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.

(i) The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event the IURO shall, prior to the conclusion of the preliminary review, provide written notice to the member and/or provider, to the Department, and to the HMO setting forth the status of its review and the specific reasons for the delay.

(j) If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend to the member and/or provider who filed the appeal, the HMO and the Department, the appropriate covered health care services the member should receive.

(k) Within 10 business days of the receipt of the determination of the IURO as set forth in (j) above, the HMO shall submit a written report to the IURO, the member and/or provider who filed the appeal, and the Department indicating whether it will accept and implement or reject the recommendations of the IURO. In the case of a rejection, the HMO shall specifically indicate in writing each and every basis for its rejection of the IURO's recommendation.

(*l*) Nothing in this section shall limit the authority of the Division of Medical Assistance and Health Services (DMAHS) or the Department of Human Services (DHS) to adopt in any contract to provide HMO services to Medicaid recipients, its own process for appeals of utilization management determinations. At the request of the Commissioner of Human Services, the Commissioner shall adopt, in accordance with N.J.S.A. 52:14B–1 et seq. and N.J.A.C. 1:30, any such appeals process proposed by DMAHS or DHS as the exclusive appeals process for all Medicaid HMO members, if he or she find that it meets or exceeds the standards set forth in this chapter.

8:38–8.8 General requirements for independent utilization review organizations

(a) The Department shall, from time to time, enter into contracts with as many independent utilization review organizations as it deems necessary to conduct the external appeals provided for under N.J.A.C. 8:38–8.7. The physician reviewers of the IUROs selected by the Department shall be experienced in managed care utilization review. The contracts shall set forth all terms which the Department deems necessary to ensure a member's right of appeal under N.J.A.C. 8:38–8.7 including, but not limited to, an assessment of separate costs to the HMO for the initial IURO review under N.J.A.C. 8:38–8.7(e) and the full review under N.J.A.C. 8:38–8.7(g).

(b) As a part of the contract process set forth in (a) above, all IUROs shall submit to the Department and shall maintain current, a list identifying all HMOs, health insurers, health care facilities and other health care providers with whom the IURO maintains any health related business arrangements. This list shall include a brief description of the nature of any such arrangement.

(c) Upon receipt of any request for an external appeal under N.J.A.C. 8:38–8.7(d) above, the Department shall assign that appeal to one of the approved IUROs on a random basis. The Commissioner reserves the right to deny any assignment to any IURO if, in his or her determination, such an assignment would result in a conflict of interest or would otherwise create an appearance of impropriety. In

reaching such a determination, the Commissioner shall take into consideration the list required of IUROs in (a) above.

SUBCHAPTER 9. MEMBER RIGHTS AND RESPONSIBILITIES

8:38–9.1 Policies and procedures

(a) The HMO shall establish and implement written policies and procedures regarding the rights of members and the implementation of these rights.

(b) The HMO shall provide each member with a current copy of a member's benefit handbook, including at least:

1. A complete statement of the member's rights;

2. A description of all complaint and grievance procedures, including the address and telephone numbers of the complaint offices of the HMO and of the Departments of Health and Senior Services and Banking and Insurance; and

3. A clear and complete summary of the evidence of coverage, including limitations, exclusions, and procedures for accessing out of network services, as required by N.J.S.A. 26:2J–8(b).

(c) The statement of the member's rights shall include at least the right:

1. To available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions. The statement shall include a reminder that the "911" emergency response system should be called whenever a member has a potentially life-threatening condition. This information shall also be provided on the membership identification cards;

2. To be treated with courtesy and consideration, and with respect for the member's dignity and need for privacy;

3. To be provided with information concerning the HMO's policies and procedures regarding products, services, providers, appeals procedures and other information about the organization and the care provided;

4. To choose a primary care provider within the limits of the covered benefits and availability and included as participating providers in the plan network;

5. To be afforded a choice of specialists among participating network providers following an authorized referral, subject to their availability to accept new patients;

6. To obtain a current directory of participating providers in the HMO network upon request, including addresses and telephone numbers, and a listing of providers who accept members who speak languages other than English;

7. To obtain assistance and referral to providers with experience in treatment of patients with chronic disabilities;

8. To receive from the member's physician(s) or provider, in terms that the member understands, an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, whether or not these are covered benefits. If the member is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the member's medical record;

9. To be free from balance billing by providers for medically necessary services that were authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract;

10. To formulate and have advance directives implemented;

11. To all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands;

12. To prompt notification, as required in this chapter, of termination or changes in benefits, services or provider network; and

13. To file a complaint or appeal with the HMO or the Departments of Health and Senior Services and Banking and Insurance and to receive an answer to those complaints within a reasonable period of time.

(d) The HMO shall establish and implement written policies and procedures regarding the responsibilities of members, such as financial responsibilities, including copayments and deductibles. A complete statement of these responsibilities shall be included in the member's benefit handbook.

SUBCHAPTER 10. MEDICAL RECORDS

8:38–10.1 Policies and procedures

(a) The HMO shall develop and implement a policy for the transfer of medical records of members whenever the following occur:

1. Change of physician or other provider;

2. Disenrollment of member from HMO; or

1. The explanation shall be certified to by the Chief Financial Officer of the HMO.

8:38–11.8 Rating

(a) Prior to issuing or amending any contracts for coverage, an HMO shall submit a certification, including an actuarial opinion certified by a member of the American Academy of Actuaries or an active fellow of the Society of Actuaries, for filing with the Commissioner of Banking and Insurance demonstrating that the rates to be used by the HMO are not excessive, inadequate or unfairly discriminatory (except as (a)1 below applies), specifying the rating methodology the HMO shall use.

1. Except as (a)2 below may apply, the Commissioner of Banking and Insurance shall find that a filing that uses one of the three following rating methodologies produces rates that are not unfairly discriminatory without further actuarial certification or demonstration:

i. Community rating that does not consider the age, gender, geography, occupation or health status of any specific member covered under a contract form when determining premiums of that specific member;

ii. Community rating by class that does not take into consideration the health status of any specific member covered under a contract form when determining premiums for that specific member; or

iii. Prospective experience rating by group that does not take into consideration the health status of a covered member of a specific (employment-based) group when determining premiums for that specific member, but which does segregate the group's health history and claims experience from other groups covered under the same contract form for purposes of establishing premiums for the group on a prospective basis.

2. Notwithstanding (a)1 above, every HMO shall comply with N.J.S.A. 17B:27A–2 et seq. and 17B:27A–17 et seq. when establishing rating methodologies for their individual and small employer group contracts.

8:38–11.9 Subrogation and third party claims

(a) An HMO group contract for covered services may contain subrogation provisions or provisions that require the return to the HMO by a member of benefits paid (or comparable dollar amounts for services provided) for illness or injury up to the amount a covered person receives from a third party through settlement, a satisfied judgment or other means, as compensation for the medical costs of such illness or injury, subject to the following:

1. Repayment by the member shall be required only where the amounts received from the third party through settlement, judgment of other means are specifically identified as amounts paid for health benefits which have been paid or provided by the HMO under the group contract under which the member is covered;

2. The repayment shall not exceed the amount of benefits paid (or comparable cost of services provided) by the HMO under the contract under which the member is covered for the particular illness or injury; and

3. The group contract shall allow the member to deduct from the repayment to the HMO the reasonable prorata expenses incurred in effecting the third party payment.

(b) Subrogation shall only be applicable when third party liability benefits may exist, subject to the restrictions set forth in (a) above and (c) below.

(c) No HMO contract shall include a provision for subrogation with respect to benefits that may exist under the personal injury protection provisions of any automobile insurance policy issued in New Jersey in accordance with N.J.S.A. 39:6A–4, 4.3 or 9.1.

SUBCHAPTER 12. REHABILITATION, CONSERVATION AND LIQUIDATION

8:38–12.1 Rehabilitation, conservation and liquidation generally

(a) An HMO shall cease new enrollment, except for addition of family members of current members, upon receipt of notice of the filing of a petition by the Commissioner of Banking and Insurance for an order authorizing rehabilitation of the HMO pursuant to N.J.S.A. 17B:32–31 et seq., Life and Health Insurers Rehabilitation and Liquidation Act, if enrollment has not ceased prior to that date, until such time as the petition may be denied.

(b) Participating health care providers, whether or not subject to a total or partial hold harmless provision of their participation contract with the HMO, and nonparticipating health care providers incurring expenses for rendering services to the HMO's members that are covered within the terms of the HMO's contract with the member shall have class 3 claims against the HMO as specified in N.J.S.A 17B:32–71 (which follow the class 3 claims of members or subscribers and their beneficiaries), and shall not bill or otherwise pursue any legal action against a member of an HMO against whom an order or rehabilitation of liquidation has been issued.

(c) Neither the reformation of member or provider contracts, restructuring of liabilities, or transfer of all or a portion of the HMO's business to another HMO that may occur in the course of the rehabilitation or liquidation of an HMO shall alter the applicability of (a) or (b) above unless the Commissioner of Banking and Insurance or a court of competent jurisdiction specifically orders that (a) or (b) or both be altered so as to facilitate the reformation, restructuring or transfer of business.

8:38–12.2 Alternate methodology for assuring continuation of services to HMO members

(a) The Commissioner of Banking and Insurance may order carriers and other HMOs to offer the members of an insolvent HMO an opportunity to become insured or to enroll with the carriers and other HMOs, during no less than a 30–day open enrollment period to be determined by the Commissioner of Banking and Insurance, except as (b) below may apply.

i. Submission of a description of a continuing education program by an HMO in accordance with (e)2 above shall in no way serve as a substitute for the submission and approval process set forth for the continuing education requirements of N.J.A.C. 11:17–3.4.

3. Submissions shall be made to the addresses set forth at N.J.A.C. 8:38–11.6(i) and (j) with respect to the Departments of Banking and Insurance and Human Services.

(f) Every HMO shall maintain records for each Medicaid marketing representative specifying the registration of the Medicaid marketing representative, certification of completion of all initial and continuing education programs, and a copy of the notice of termination of registration filed with the Department of Banking and Insurance, which records shall be available for inspection by the Departments of Health and Senior Services, Human Services and Banking and Insurance within a reasonable time following request.

1. HMOs shall maintain records of terminated Medicaid marketing representatives for no less than three years following the date of termination of their registration.

(g) The requirements set forth in this section are in addition to any standards and requirements which may be established by the Department of Human Services for the Medicaid program.

(h) The requirements set forth herein in this section in addition to the requirements of N.J.A.C. 11:17–2.9.

8:38–13.3 Advertising and marketing

Except to the extent that HMOs shall be specifically exempted by reference by a provision of an applicable statute or rule, HMOs, producers and Medicaid marketing representatives shall comply with statutes and rules regulating the marketing, advertising, solicitation and sale of health insurance, and enforcement thereof by the Commissioner of Banking and Insurance, including, but not limited to, N.J.A.C. 11:2–11 and 11:4–17.

8:38–13.4 Disclosure of provider compensation arrangements

(a) Every HMO shall make the following disclosure statement in all applications for enrollment and member handbooks:

DIFFERENT PROVIDERS IN OUR NETWORK HAVE AGREED TO BE PAID IN DIFFERENT WAYS BY US. YOUR PROVIDER MAY BE PAID EACH TIME S/HE TREATS YOU ("FEE-FOR-SERVICE"), OR MAY BE PAID A SET FEE EACH MONTH FOR EACH MEMBER WHETHER OR NOT THE MEMBER ACTUALLY RECEIVES SERVICES ("CAPITATION"), OR MAY RECEIVE A SALARY.

(The following statement shall be added if the HMO contracts directly or indirectly with providers to participate in financial incentive arrangements. For example, this includes financial incentive arrangements between an intermediate entity and a physician or physician group):

THESE PAYMENT METHODS MAY INCLUDE FINANCIAL INCENTIVE AGREEMENTS TO PAY SOME PROVIDERS MORE ("BONUSES") OR LESS ("WITHHOLDS") BASED ON MANY FACTORS: MEMBER SATISFACTION, QUALITY OF CARE, AND CONTROL OF COSTS AND USE OF SERVICES AMONG THEM.

In addition, each HMO shall make the following statement:

"IF YOU DESIRE ADDITIONAL INFORMATION ABOUT HOW OUR PRIMARY CARE PHYSICIANS OR ANY OTHER PROVIDERS IN OUR NETWORK ARE COMPENSATED, PLEASE CALL US (OR HMO NAME) AT [NUMBER] OR WRITE; [ADDRESS]."

(b) The HMO may propose alternate stylistic language for the statement in (a) above which may be utilized only with the prior written approval from both the Departments of Health and Senior Services and Banking and Insurance. Any modification must be written in plain language and cannot substantively alter the meaning and/or intent of the above section.

(c) All statements are required in (a) and (b) above shall be prominently displayed and printed in at least the same point and print as used for other material contained in the application and handbook other than captions or headings.

(d) HMOs shall be required to provide information in response to requests made pursuant to the disclosure requirement set forth in (a) above with respect to provider compensation by disclosing the method by which a specific provider is compensated. An HMO shall not be required to state the dollar amount of compensation or otherwise provide more specific information about the compensation arrangement it has with a specific provider.

(e) HMOs shall provide a copy of this disclosure statement to all members and prospective members upon March 15, 1997 and be allowed up to July 13, 1997 to bring their applications for enrollment and member handbooks into compliance and to begin distributing such revised member handbooks to current and new members.

Law Review and Journal Commentaries

Liability Implications of HMO Financial Incentive Arrangements. Brad X. Terry, 154 N.J.L.J. 952 (1998).

8:38–13.5 Trade and claims practices and coordination of benefits

(a) HMOs shall be subject to all of the provisions of the Trade Practice Act, N.J.S.A. 17B:30–1 et seq., any amendments thereto, and all rules promulgated thereunder, except to the extent that HMOs have been specifically excluded by

reference from a provision of the applicable statutes or rules.

(b) HMOs that elect to coordinate their benefits with those of other benefits or coverages available to members may do so subject to compliance with N.J.A.C. 11:4–28, Coordination of Benefits. HMOs that do not comply with N.J.A.C. 11:4–28 shall provide primary coverage to all members.

8:38–13.6 Penalties

Every producer or Medicaid marketing representative found to be in violation of this subchapter shall be subject to penalties and fines (per contract) in accordance with N.J.A.C. 11:17D, including suspension or revocation, in whole or in part, of his or her producer license or registration privilege pursuant to N.J.S.A. 17:22A–17.

SUBCHAPTER 14. INDEMNITY BENEFITS OFFERED BY A HEALTH MAINTENANCE ORGANIZATION

8:38–14.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the standards by which HMOs may offer and deliver a contract for a point of service product in New Jersey.

(b) This subchapter applies to all HMOs authorized to transact business in this State for the purposes of providing health care services in accordance with N.J.S.A. 26:2J–1 et seq.

8:38–14.2 (Reserved)

Repealed by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
Section was "Definitions".

8:38–14.3 General standards

(a) Except as set forth in (b) below, an HMO shall not enter into any arrangement for the provision of out-of-network covered services to any subscriber or member that is not in compliance with this subchapter.

(b) An HMO providing out-of-network covered services under an arrangement approved by the Department of Banking and Insurance on or before April 15, 1996 shall bring the arrangement and any contracts issued under that arrangement into compliance with this subchapter beginning on the first 12 month anniversary date of each of the subscriber contracts occurring on or after October 12, 1996.

(c) An HMO shall not offer or provide any POS contract to groups of 50 or more until the form of that contract, along with applicable evidence of coverage forms, has been filed and approved or deemed approved, by the Department and the Department of Banking and Insurance; an HMO shall not offer or provide a POS contract by rider, amendment or endorsement of any HMO contract.

1. If not disapproved within 60 days of the date of receipt by the Departments, the form shall be deemed filed, if not affirmatively approved prior thereto.

2. Disapproval of the form shall be in writing, and shall specify the reasons for the disapproval.

3. An HMO whose form has been disapproved shall have 60 days following the date of the initial disapproval within which to correct any deficiencies set forth in the notice of disapproval, and shall have 30 days following the date of notice of any subsequent disapproval within which to correct deficiencies. A resubmission of a form shall be deemed approved upon the expiration of 30 days following resubmission of the filing to the Department and the Department of Banking and Insurance unless the Departments approve or disapprove the resubmission within the 30 day period.

4. If an HMO does not respond to a notice of disapproval within the required time frame, the matter shall be considered closed by the Departments; if the HMO desires further consideration of its form, it shall submit the form anew to the Department and the Department of Banking and Insurance.

(d) Contemporaneous with the submission of the POS contract form, the HMO shall make an informational rate filing with the Department of Banking and Insurance meeting the requirements of this subchapter.

(e) Submission of forms and rates to the Department of Banking and Insurance shall be made to (and accompanied by the appropriate service fee, if any, specified at N.J.A.C. 11:1–32):

Managed Care Bureau
Life and Health Division
New Jersey Department of Banking and Insurance
PO Box 325
20 West State Street
Trenton, NJ 08625–0325

(f) The requirements of this subchapter shall be in addition to, and not in lieu of, more specific standards that may be established for compliance with the Individual Health Coverage Program, N.J.S.A. 17B:27A–2 et seq., and the Small Employer Health Benefits Program, N.J.S.A. 17B:27A–17 et seq., and rules promulgated pursuant thereto.

Amended by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
Substituted "Department of Banking and Insurance" for "Department of Insurance" throughout.

8:38–14.4 Out-of-network benefit restrictions under an HMO POS contract with a reinsurance-type or group master policy arrangement

(a) An HMO may offer a POS contract with or without a gatekeeper system for out-of-network covered services, except that any POS contract is offered without a gatekeeper system for out-of-network covered services shall meet the following:

1. The deductible for the out-of-network covered services shall be no less than $250.00 per person per benefit period, or $500.00 per family per benefit period, and the coinsurance requirement shall be no less than 20 percent for the next $5,000 of covered charges for covered services per individual per benefit period, and no less than 20 percent for the next $10,000 of covered charges for covered services per family per benefit period; or

2. The deductible and coinsurance requirements are otherwise designed so that, in combination, there is a substantial disincentive to accessing out-of-network covered services, as determined satisfactory to the Commissioner of Banking and Insurance, consistent with (a)1 above.

(b) Notwithstanding that an HMO elects to utilize a gatekeeper system for out-of-network covered services, the HMO shall provide that the deductible and coinsurance requirements for the access of out-of-network covered services are otherwise designed so that, in combination, there is a reasonable, disincentive to accessing such out-of-network covered services, as determined satisfactory to the Commissioner of Banking and Insurance.

(c) Notwithstanding (a) and (b) above, the actuarial value of the out-of-network covered services shall not vary by more than 30 percent from the actuarial value of the in-network covered services under any POS contract, as further specified at N.J.A.C. 11:4–37.3(b)6.

Amended by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
Substituted "Department of Banking and Insurance" for "Department of Insurance" throughout.

8:38–14.5 POS under a reinsurance-type contract arrangement

(a) The reinsurance-type contract shall cover the entire cost of the out-of-network covered services, and shall not provide for any deductible, coinsurance, copayment, or other type of mechanism by which any portion of the out-of-network covered services become self-funded by the HMO.

1. The HMO may elect not to include benefits for emergency and out-of-area care under the reinsurance-type contract.

2. If the HMO elects to include benefits for emergency and out-of-area care under the reinsurance-type contract, the HMO and the carrier or insurer may specify a deductible or other mechanism by which the HMO shall self-fund some portion of the emergency and/or out-of-area care benefits only.

(b) The reinsurance-type contract shall include a provision by which the carrier or insurer agrees to indemnify members directly, subject to the terms of the HMO's contract with its subscribers and contractholders, if the HMO is placed into conservation, rehabilitation or liquidation.

(c) The reinsurance-type contract shall be specific to the HMO's POS contract(s); stop loss or excess risk insurance, insolvency insurance, general letters of guaranty by parent or affiliate corporations and similar such forms of insurance and guarantees shall not be considered acceptable reinsurance-type contracts in compliance with this subchapter.

(d) An HMO shall not report the reinsurance-type contract as an offset to its reserves for out-of-network covered services unless the carrier or insurer from whom the reinsurance-type contract is purchased and the transaction meet the requirements of N.J.A.C. 11:2–28, Credit for reinsurance.

(e) The informational rate filing shall specify the premium and premium rating methodology for all services covered under the POS contract, including the cost to the HMO of purchasing the reinsurance-type contract to provide indemnity benefits for the out-of-network covered services.

(f) Every reinsurance-type contract shall be submitted on an informational basis to the Department of Health and Senior Services and the Department of Banking and Insurance prior to the date of marketing of any POS contract for which the reinsurance-type contract is being purchased.

Amended by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
Substituted "Department of Health and Senior Services" for "Department of Health" and "Department of Banking and Insurance" for "Department of Insurance".

8:38–14.6 POS under a group health contract master policy arrangement

(a) The master policy form, certificate form and any other form that becomes a part of the group health contract and rates, as applicable, shall be submitted by the carrier in duplicate in accordance with N.J.S.A. 17B:27–26 et seq., 17:48–1 et seq., 17:48A–1 et seq., or 17:48E–1 et seq., and N.J.A.C. 11:4–40, for filing to:

Health Bureau
Life and Health Division
New Jersey Department of Banking and Insurance
CN 325
20 West State Street
Trenton, NJ 08625–0325

(b) The master policy form shall comply with all applicable insurance laws in this State.

(c) The master policy form and certificate form shall clearly indicate that the contract shall be used in conjunction with an HMO service contract, wherein the group policyholder is an HMO and the insureds are a class of HMO subscribers and members.

(d) The master policy shall provide indemnity benefits for all of the out-of-network covered services, except that the HMO and carrier may elect not to insure the HMO's emergency and out-of-area care through the master policy.

(e) The POS contract and evidence of coverage shall specify all of the covered services under the POS contract, clearly indicating when services covered vary between the network and out-of-network covered services (for instance, due to differences between mandates between HMOs and carriers).

(f) The certificate to be delivered to HMO members and the evidence of coverage to be delivered to HMO members may be contained in a single document, in which instance, the document shall be submitted by the HMO to the Managed Care Bureau of the Department of Banking and Insurance, and the carrier shall include a statement in its form submission to the Health Bureau of the Department of Banking and Insurance that the certificate shall be combined with the evidence of coverage and shall be submitted by the HMO in accordance with this subchapter, which statement shall be certified to by a duly authorized officer of the carrier.

(g) The informational rate filing submitted by the HMO shall specify the premium and premium rating methodology for all services covered under the POS contract, including the cost to the HMO of purchasing the master policy to provide indemnity benefits for the out-of-network covered services.

Amended by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
In (f), amended Department names.

8:38–14.7 POS under a dual contract arrangement

(a) No HMO shall enter into a dual contracting arrangement until both the HMO contract forms and rates thereof and the indemnity policy forms and rates thereof, as applicable, have been submitted to the Department of Banking and Insurance for filing, each with unique identifying numbers for the dual contract arrangement product; neither riders, amendments nor endorsements of an HMO contract or an indemnity policy shall be filed for use as a dual contracting arrangement.

(b) An indemnity policy designed to provide benefits for out-of-network covered services in conjunction with an HMO's network-based arrangement shall be subject to the following:

1. The policy form shall specify that it shall be issued and delivered in conjunction with an HMO contract, and shall contain reciprocal language incorporating the other contract;

2. The policy form shall not be designed, nor shall it be offered, as a stand-alone policy;

3. The policy form shall require execution of the indemnity policy by the contractholder; and

4. The policy form, application, certificate and other documents that make up the contract, as well as the rating formula, shall be filed by the Department of Banking and Insurance as required by N.J.S.A. 17B:27–49, 17:48–1 et seq., 17:48A–1 et seq., or 17:48E–1 et seq. and N.J.A.C. 11:4–40, as appropriate for the carrier.

(c) An HMO contract designed to provide services on a network-based arrangement in conjunction with a carrier's indemnity policy shall be subject to the following:

1. The contract form shall specify that it shall be issued and delivered in conjunction with an indemnity policy, and shall contain reciprocal language incorporating the other contract;

2. The contract form shall not be designed nor offered as a stand-alone contract;

3. The contract form shall require execution of the HMO contract by the contractholder; and

4. The contract form, application, certificate and other documents that make upon the contract, as well as the rating formula, shall be submitted to the Department and the Department of Banking and Insurance for filing, and the forms shall not be used until so filed by the Department and Department of Banking and Insurance.

(d) The HMO informational rate filing shall specify, by formula, the portion of the dual contract arrangement's full premium that shall be charged by the HMO for the network-based covered services; any modifications thereof shall be on a prospective basis only.

(e) The carrier's rate filing, if a rate filing is required pursuant to statute, shall specify, by formula, the portion of the dual contract arrangement's full premium that shall be charged by the carrier for the out-of-network covered services.

(f) Descriptive material (evidences of coverage, certificates, booklets) required to be provided to enrollees shall specify how both the HMO provisions and the indemnity provisions apply to the services and expenses covered under the dual contract arrangement.

(g) The HMO shall submit a detailed description to the Department and the Department of Banking and Insurance specifying the responsibilities of the HMO and the carrier to one another, both administratively and financially, prior to implementation of any dual contracting arrangement. Arrangements established by an HMO and carrier to implement a dual contract that have the effect of violating the HMO or insurance laws of this State shall not be permitted.

Amended by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).

Substituted "Department of Banking and Insurance" for "Department of Insurance" throughout.

8:38–14.8 Network variations

(a) Neither HMOs nor carriers shall restrict utilization of any HMO's network or offer any alternative or substitute network of providers, whether or not the providers are or are not within an approved network of the HMO or carrier (for the purpose of offering rate differentials or for any other purpose) until the network restriction or alternative or substitute network is approved by the Department and the Department of Banking and Insurance as a stand-alone secondary network adequate for the purposes intended.

(b) HMOs shall submit requests for approval of secondary networks as a modification of the HMO's original certificate of authority, and shall clearly identify the purpose of every secondary network. An application for modification of a certificate of authority shall include the following:

1. A nonrefundable fee of $100.00;

2. A copy of every form of contract between the HMO and all providers to be included in the secondary network;

3. A copy of the form of the individual and group contract, if any, which is to be issued to employers, unions, trustees or other organizations pursuant to utilization of the secondary network;

4. A description of the proposed method of marketing and financing of the secondary network;

5. A description and map of the geographic area to be served by the secondary network identified by county or zip codes, if sub-areas of counties are to be proposed as boundaries of the service area;

6. Enrollment projections presented on a quarterly basis for the first three years of operation for each county or sub-area proposed as the service area, including a description of the demographic characteristics of the population by at least gender and age;

7. A list of all providers under the proposed secondary network by county, municipality and zip code, accompanied by maps of the service area identifying the location of these providers, with the list segregated by primary care providers, specialists, hospitals and ancillary providers, if any, including the name, address and hospital affiliation of every provider, as applicable; and

8. Such other information as the Commissioner or the Commissioner of Banking and Insurance may require to determine that a modification of the certificate of authority is appropriate.

(c) The Department and the Department of Banking and Insurance shall approve a modification of a certificate of authority based upon a proposed secondary network upon a submission of a complete application to amend the certificate of authority in accordance with (b) above, and a determination by the Department and the Department of Banking and Insurance that the secondary network is adequate to serve the purposes intended, as specified by the HMO, with respect to availability of services, product design (including integration with other networks established by the HMO, if integration will or may occur) and financial stability of the HMO. In making this determination, the criteria for adequacy which apply to establishment of any network by an HMO shall apply to establishment of a secondary network.

Amended by R.1997 d.68, effective February 18, 1997 (operative July 1, 1997).
See: 28 N.J.R. 2456(a), 28 N.J.R. 3118(b), 29 N.J.R. 625(a).
Substituted "Department of Banking and Insurance" for "Department of Insurance" throughout.

8:38–14.9 Penalties

An HMO determined to be acting in violation of this subchapter shall be subject to any and all penalties and fines available under law (assessed per contract), including revocation, in whole or in part, of its certificate of authority. Prior to any revocation of a certificate of authority, the HMO shall have an opportunity to request a hearing, in accordance with the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B–1 and 14 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

SUBCHAPTER 15. PROVIDER AGREEMENTS AND RISK TRANSFERENCE

8:38–15.1 Assumption of financial risk or risk-sharing

(a) No person shall assume financial risk, in whole or in part, for the cost or provision of, or arrangements for, one or more health services to others unless the person is:

1. An authorized payor as defined at N.J.A.C. 8:38–1.2;

2. A provider actually performing the health services (including providing supplies) within the scope of his or her license; or

3. An employer with respect to its own employees, and dependents of those employees.

(b) A secondary contract shall not be considered to have assumed financial risk for the delivery of health care services to residents of this State for which licensure as an authorized payor would otherwise be required if the secondary contractor enters into a contractual agreement with an authorized payor to provide the delivery of health care services to the individuals covered by the authorized payor which meets the requirements of N.J.A.C. 8:38–15.2 and 15.3

(c) Contracts with secondary contractors shall not contain provisions that cede some or all of the financial risk of the

authorized payor to the secondary contractors, whether through compensation formula, stop loss insurance requirements or other means, except in accordance with N.J.A.C. 8:38–15.2, and an HMO shall not reduce its reserves on the basis of a contractual agreement with any secondary contractors.

8:38–15.2 Minimum standards for provider agreements

(a) Both primary contractor and secondary contractor agreements shall be consistent with laws regarding confidentiality of information and with professional licensing standards and shall comply with the standards of (b) through (e) below.

(b) 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;

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

3. The method of reimbursement, including the method, events and timing of application of any penalties, bonuses or other types of compensation arrangements.

i. 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 HMO shall include in its contracts a right of each provider to receive a periodic accounting (no less frequently than annually) of the funds held.

ii. 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.

iii. 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;

4. The services and/or supplies to be provided by the provider and covered by the HMO;

5. A provision whereby the provider shall hold the member harmless for the cost of any service or supply covered by the HMO, whether or not the provider believes its compensation for the service or supply from the HMO (directly or through a secondary contractor) is made in accordance with the reimbursement provision of the provider agreement, or is otherwise inadequate.

i. Members shall not be held harmless for payment of required copayments, deductibles or coinsurance, if any.

ii. Providers shall not balance bill members who have obtained covered services or supplies through the HMO network mechanism.

iii. An HMO contractual agreement with a secondary contractor shall provide that the secondary contractor's contract with its network providers shall include a provision whereby the provider is required to hold the HMO's members harmless for the cost of any service or supply covered by the HMO, subject to (b)5i and ii above, whether or not the provider believes the compensation received is adequate;

6. That providers shall not discriminate in their treatment of HMO patients;

7. That providers shall comply with the HMO's quality assurance and utilization review programs;

8. That providers shall maintain licensure, certification and adequate malpractice coverage.

i. With respect to a physician and dentist malpractice insurance shall be at least $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

ii. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

iii. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year; and

9. That patient information shall be kept confidential, but that the HMO and the provider shall have a mutual right to a member's medical records, as well as timely and appropriate communication of patient information, so that both the providers and the HMO may perform their respective duties efficiently and effectively for the benefit of the member.

10. The process for an internal provider complaint and grievance procedure to be used by participating providers, pursuant to N.J.A.C. 8:38–3.6(b).

(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 HMO to assure 24 hour, seven-day a week emergency and urgent care coverage to members, and the procedures to assure proper utilization of such coverage consistent with the requirements of N.J.A.C. 8:38–5.2.

(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 HMO when such procedures are no longer appropriate;

2. The admission authorization procedures for members;

3. The procedures for notifying the HMO when members present at emergency rooms; and

4. The procedures for billing and payment, schedules, and 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) In addition to (b) through (e) above, the contract between an HMO and a secondary contractor shall specify that the HMO is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and a secondary contractor's contract(s) with health care providers shall provide that the HMO shall have privity of contract with the health care providers such that the HMO shall have standing to enforce the secondary contractor's contract(s) with the health care providers in the absence of enforcement by the secondary contractor.

(g) In lieu of (f) above, the HMO shall contract separately with each health care provider under contract with the secondary contractor, and such contracts shall be in accordance with (b) through (e) above.

Petition for Rulemaking.
See: 30 N.J.R. 1640(b).

8:38–15.3 Review and approval

(a) The form(s) of the provider agreement(s), and any amendments thereto, shall be submitted to the Departments of Health and Senior Services and Banking and Insurance, at the addresses specified at N.J.A.C. 8:38–11.6(i), for prior approval.

(b) Provider agreements in effect upon July 1, 1997 that are not in compliance with the requirements of this subchapter shall be brought into compliance by July 1, 1998, or the first date of renewal specified within the provider agreement occurring after July 1, 1997, whichever date is earlier.

8:38–15.4 Penalties

Every person acting as a secondary contractor in violation of this subchapter shall be subject to penalty and fine by the Department of Banking and Insurance under the insurance laws of this state as an unauthorized insurer in accordance with N.J.S.A. 17:51–1 et seq., or 17B:33–1 et seq., as may be appropriate.

SUBCHAPTER 16. CLAIMS PAYMENTS

Authority

N.J.S.A. 17B:30–1 et seq., 26:2J–5.1 and 26:2J–15.

Source and Effective Date

R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).

8:38–16.1 Prompt investigation and settlement of claims

(a) An HMO shall establish and maintain an auditable system for recording of all claims, clearly indicating the date on which a claim is received and the date(s) any action(s) on the claim occur, which shall also include an identifier of the office handling the claim on behalf of the HMO.

(b) An HMO shall pay clean claims promptly but no later than 60 calendar days after the date the HMO receives written or electronic notice of the claim.

1. If, for whatever reason, a claim is submitted electronically and in written form, the date of the earlier submission of the claim shall be the date of notice from which the HMO shall calculate the 60–day period.

2. Notwithstanding (b)1 above, if an HMO and a provider have agreed in writing to the submission of claims by a specific mode of transmission, the HMO shall calculate the 60–day period beginning on the date that the claim is received in the agreed-upon mode.

(c) An HMO shall provide written or electronic notice to the provider of a determination by the HMO that the claim is a contested claim promptly but no later than 45 calendar days following the date that the HMO receives written or electronic notice of the claim.

1. The written or electronic notice shall comply with N.J.A.C. 8:38–16.3.

(d) If an HMO determines that a part of a claim is a contested claim, the HMO shall provide written or electronic notice of that determination to the person submitting the claim promptly but no later than 45 calendar days following the date that the HMO receives written or electronic notice of the claim, and shall proceed to pay the portion of the claim determined by the HMO to be a clean claim promptly, but no later than 60 calendar days following the date that the HMO received written or electronic notice of the claim.

1. The written or electronic notice shall comply with N.J.A.C. 8:38–16.3.

(e) In no instance shall an HMO contest a claim or a portion of a claim because the claim fails to provide certain information if the information determined to be lacking has no factual impact upon the HMO's ability to adjudicate the claim.

(f) If an HMO determines that a claim provides sufficient information for the HMO to deny the claim, the HMO shall provide written or electronic notice of this determination to the person submitting the claim or member, if different from the person submitting the claim, promptly but in no instance later than 60 calendar days following the date that the HMO receives written or electronic notice of the claim, including the following information:

1. All of the reasons of which the HMO is aware for denial of the claim;

2. The date the service was rendered, the type of service rendered, the name of the provider who rendered the service and the name of the person to whom the service was rendered; and

3. The address of the office responsible for handling the claim, and a means by which the office may be contacted without toll charges exceeding the charges that otherwise apply for the provider or member to place a call in his or her area code.

8:38–16.2 Effective notices and payments

(a) Except as (a)1 below applies, written notice of a claim shall be effective upon the date that the claim is received at the address provided by the HMO to the providers or its members for receipt of claims of the type submitted.

1. If a provider and an HMO agree to administer claims by electronic transmission, then the HMO shall have constructive notice of the claim as of the date the claim is posted to the electronic transfer system.

(b) Payment from the HMO shall be effective as of the date that:

1. A draft or other valid instrument equivalent to payment is placed in the United States mail in a properly addressed, postage-paid envelope;

2. The date the HMO posts the item to an electronic transfer system; or

3. The date of delivery of the draft or other valid instrument equivalent to payment if (b)1 or 2 do not otherwise apply.

(c) Payment and notices distributed by an HMO's subcontractor, secondary contractor or primary contract or shall be effective when made in compliance with (b) above and (d) below, as appropriate.

(d) Notices from the HMO shall be effective as of the date that the notice is:

1. Placed in the United States mail in a properly addressed, postage-paid envelope;

2. Posted to an electronic system; or

3. Delivered, if (c)1 or 2 otherwise do not apply.

8:38–16.3 Contents of a notice of a contested claim

(a) The HMO shall specify in its notice of a contested claim at least the following information:

1. The name, address, telephone number and facsimile number of the HMO's office handling the claim or other designated claims representative knowledgeable about the claim with which the person submitting the claim, provider or member (as applicable) should communicate to resolve problems with the claim;

2. The date of the service, the type of service, the provider of the service, and the name of the person to whom the service was rendered to the extent that this information is known to the HMO;

3. The specific information needed by the HMO to make a determination that the claim is a clean claim; and

4. The date the claim was received.

(b) In addition to (a) above, the HMO shall include in a notice regarding a claim that the HMO has determined is in part a contested claim, a statement specifying those portions of the claim that are considered to be a clean claim, and the amounts payable with respect to the clean claim portion.

(c) Requests for information made by an HMO on a contested claim shall be reasonable and relevant to the determination of whether the claim is a clean claim or claim that will be denied.

(d) HMOs may use the form set forth as Exhibit 1 in the Appendix to this chapter, entitled "Notice of Contested Claim," incorporated herein by reference, to satisfy the requirements of (a) through (c) above.

8:38–16.4 Overdue payments

(a) HMOs shall add 10 percent simple interest per annum to all overdue payments made by the HMO to a provider or member, with the interest first accruing as of the date that the claim is overdue.

(b) Payment for a clean claim or portion of a claim determined clean shall be overdue if the HMO makes payment on the claim later than 60 calendar days following the date that the claim was received by the HMO.

(c) Payment for a contested claim, or contested portion of a claim that is subsequently perfected shall be overdue if the HMO makes payment on the claim later than 90 calendar days following the date that the HMO receives all of the information required to perfect the claim.

(d) Payment of a claim previously denied incorrectly shall be overdue if payment by the HMO is made more than 10 calendar days following the date that the previously denied claim is determined a clean claim, or a portion of the claim is determined a clean claim, unless specified otherwise by an order of the Commissioner or a court of competent jurisdiction regarding any challenge of the denial of the claim.

8:38–16.5 Use of intermediaries

An HMO's use of subcontractors, secondary contractors or primary contractors to perform one or more of the HMO's claims handling functions shall not in any way mitigate an HMO's responsibility to comply with all of the terms of this subchapter.

8:38–16.6 Contracts currently in effect

(a) A contractual arrangement in effect as of October 1, 1998 which is inconsistent with this subchapter (unless more favorable to participating providers) shall be read and interpreted to be in compliance with N.J.S.A. 26:2J–5.1 and this subchapter as of October 1, 1998, but shall be amended as expeditiously as possible by the HMO as is necessary for the contractual arrangement to become physically compliant.

(b) HMOs shall administer, or assure the administration of, all contractual arrangements for its network in order to be in compliance as of October 1, 1998, and any claims not settled as of October 1, 1998 shall be treated in accordance with this subchapter.

8:38–16.7 Penalties

HMOs that fail to comply with the terms of this subchapter shall be subject to penalty and fine of no less than $250.00 nor no more than $10,000 per day of violation, as set forth at N.J.S.A. 26:2J–24, and penalties and fines in accordance with N.J.S.A. 17B:30–1 et seq., in addition to any other remedies available under law.

APPENDIX

Exhibit 1

Notice of Contested Claim

The information below is with respect to a single patient (see Part B) identified on a claim filed by your office with us on ___/___/___. Those services marked with an asterisk (*) under the column "HMO Payment" are contested. The reasons for which the claim, or a portion of the claim, is contested and the information we need to make a final determination on the claim are set forth in Part D. Please contact the individual(s) identified in Part E if you have additional questions regarding this notice. If there are portions of a claim which we are not contesting, the "HMO Payment" column indicates the amount we are paying or will pay you for the services rendered, and the "Patient Copay" column indicates whether a copayment should have been collected by you from the patient. The information contained in Parts A, B and C are derived from the claim filed by your office.

Part A: Service information

	Procedure codes	Date of service	Provider	Billed amount	HMO Payment	Patient Copay
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Part B: Patient Information

Name: _____
Age: _____ Gender: M / F
SSN: _____
Address: _____
_____
Phone (Home): _____
Subscriber Name and SSN: _____

Part C: Provider Information

Name: _____
HMO ID: _____
Address: _____
_____
Phone: _____ FAX: _____

Patient Acct # (if any): _____

Part D: Reasons for contesting the claim, or portion of a claim, and additional information needed

Specific services, if listed, are listed by number in the order stated in Part A:

_____

_____

_____

_____

_____

_____

_____

_____

Additional pages are attached.

Part E: HMO and Contact Person Information

HMO Name: _____
Address: _____
_____
_____

Contact: _____
Title (as applicable): _____
Address: _____
_____
_____
Phone: _____ FAX: _____
E-mail: _____

New Rule, R.1998 d.458, effective September 8, 1998.
See: 30 N.J.R. 1546(a), 30 N.J.R. 3313(a).