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INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Managed Care Plans

Provider Networks

Adopted Amendments: N.J.A.C. 11:4-37.4; 11:22-4.2, 4.3, 4.4, and 4.5; 11:24-15.2; 11:24A-4.15; 11:24B-5.2; and 11:24C-1.3

Adopted New Rules: N.J.A.C. 11:24C-4

Adopted Repeals: N.J.A.C. 11:24B-5.8, 5.9, and 5.10

Proposed: February 21, 2012 at 44 N.J.R. 376(a).

Adopted: February 20, 2013 by Kenneth E. Kobylowski, Commissioner, Department of Banking and Insurance.

Filed: February 20, 2013 as R.2013 d.048, **with substantial and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 26:2S-1 et seq., and 17B:30-1 et seq.

Effective Date: March 18, 2013.

Operative Date: January 1, 2014.

Expiration Dates: September 28, 2018, N.J.A.C. 11:4;

September 21, 2018, N.J.A.C. 11:22;

February 15, 2015, N.J.A.C. 11:24;

March 1, 2018, N.J.A.C. 11:24A;

July 8, 2016, N.J.A.C. 11:24B;

May 20, 2016, N.J.A.C. 11:24C.

Summary of Public Comments and Agency Responses:

The Department received comments from the New Jersey Association of Health Plans; Horizon Blue Cross Blue Shield of New Jersey; Aetna; Cigna; the New Jersey Association of Mental Health and Addiction Agencies, Inc.; the New Jersey Psychological Association; the New Jersey Medical Group Management Association; JFK Health System; Raritan Bay Medical Center; the New Jersey Hospital Association; the Medical Society of New Jersey; and the New Jersey Academy of Family Physicians.

1. COMMENT: Some commenters expressed support for the Department's stated goal of "protecting consumers while promoting the growth, financial stability and efficiency of the insurance industry." One commenter commended the Department for taking steps to increase consumer transparency and relieve providers and health plans of regulatory burdens in negotiating mutually beneficial contractual arrangements. One commenter recognized that the Department regulates only carriers, and hoped that State regulators for providers and facilities can similarly propose rules improving transparency around provider and facility charges, network status, and referrals to non-network providers.

RESPONSE: The Department thanks the commenters for their comments.

2. COMMENT: One commenter stated that certain requirements contained within the rule proposal will result in increased costs and burdens for carriers to maintain large provider networks, thereby harming consumers who benefit from access to substantial provider networks.

RESPONSE: As was noted in the notice of proposal, while it is acknowledged that carriers may incur some costs to comply with the new and amended rules, it is the Department’s belief that having clear, enforceable rules prescribing the standards applicable to provider

agreements will improve long-term network stability and therefore benefit consumers and other participants in the market.

3. COMMENT: Some commenters expressed appreciation for the Department's efforts to address certain concerns regarding managed care networks, but also stated that the proposal contains certain provisions regarding network contracts that will further erode providers' ability to negotiate a contract that affords them the opportunity to provide affordable, quality care while maintaining financial viability. The commenters stated that the proposal as written would provide health insurance plans with even more discretion in the day-to-day management of contractual responsibilities with healthcare providers.

Several commenters stated their concerns with elements of this proposal (discussed more specifically in the following comments) that are so disadvantageous to the provider community that they will further harm providers who already have little leverage in negotiating contract terms. Additionally, providers will not have the benefit of certain provisions that were proposed by the Department in its original proposal, but are not contained in this proposal, including the following: (1) language defining the Commissioner's regulatory oversight of carriers' provider networks including credentialing, provider agreements and fee schedules, as well as language that would have allowed the Commissioner to receive information from any source including that deemed proprietary and confidential by a carrier and information concerning a carrier's compliance; (2) a definition of core terms that was subsequently used in a provision within the original proposal that would have required a statement that all agreements constitute the final, complete, and exclusive statement of the core terms. The original version further provided, among other amendments, that no agreement shall incorporate by reference other documents that contain, revise, or qualify core terms, including, but not limited to, provider manuals. This

language in the original proposal would have aided in addressing concerns regarding material and non-material changes; (3) a requirement that all agreements contain a summary disclosure form and the items to be included in said form. This provision would have established a checklist of many of the standards in the proposal and also would have provided a quick reference guide for carrier-specific information such as pre-authorization processes. Given that all carriers develop their own individual processes, this would have been beneficial to providers in adhering with same; and (4) the prohibition on mandatory binding arbitration for contract breaches. The original proposal allowed the right to elect binding arbitration on a case-by-case basis.

RESPONSE: The Department thanks the commenters for their expressions of appreciation. The Department agrees that several provisions of the prior proposed rule (see 41 N.J.R. 2426(a)) are not included in the subject rulemaking, but fails to see how the protections that are included could be disadvantageous. The Administrative Procedure Act includes notice and hearing provisions to ensure that affected stakeholders have the ability to be heard prior to the promulgation of regulations. During that process, many stakeholders pointed out that proposed provisions were overly prescriptive of required changes to existing business processes, threatening a net drain on resources and adding to costs in an environment where the cost of insurance is growing increasingly out of reach. The recast proposal therefore is more performance-based and focuses on desired ends, and less prescriptive of required means to reach those ends. The rules constrain, rather than increase, plan discretion in the management of provider relations, but those constraints are narrowly focused on sharp practices that the Department believes act to the net detriment of providers, consumers, and the marketplace. The

regulatory process is a dynamic rather than static process, and the Department will continue to monitor market conduct and refine rules as necessary and appropriate.

The following will address the specific points made above:

1) The Commissioner's regulatory oversight of carriers' provider networks and ability to receive information concerning a carrier's compliance is established by statute; the absence of language in the proposed rules should not be read to have any diminishing impact on that statutory authority. The Commissioner continues to have authority over carriers' provider networks and the ability to review books and records as necessary to verify a carrier's compliance with laws and regulations.

2) At any one point in time, provider contracts govern the amount and circumstances for reimbursement of facility, professional care, and supply delivery for many thousands of services and supplies for many thousands of diagnostic codes in multiple settings under many different circumstances. During the life of a contract, new technologies, practice patterns, and standards of excellence emerge, and some old technologies, practice patterns, and standards become discredited or fall into disuse. All of these factors affect the compensation payable under a provider network contract. To require that all elements affecting reimbursement under all of these circumstances be fixed with certainty at the inception of a contract by reference only to the four corners of the contract, and that those elements be changeable only with individualized negotiations with each member of the impacted community, would establish an impossible standard. The proposed rules are instead aimed at the material result rather than overly-prescriptive processes: negotiated terms may not be changed without negotiation regardless of where they are documented, and material changes may not be made in non-negotiated terms

without a right of termination before their application. The focus is on economic impact rather than rigidity of documentation.

3) The subject rules require plain language disclosure of the major provisions of the contract, but are not directive in how that is accomplished. Carriers enter into contracts with many providers in many different states, and overly-prescriptive state-specific rules run the risk of adding to cost that is not commensurate with the value added. Again, the rules utilize performance–based standards, rather than mandating the actions carriers must take to meet those standards.

4) The Department understands that some parties would prefer not to agree to arbitrate disputes, but do not have the bargaining power to negotiate such provisions out of contracts. On the other hand, other parties to contracts may find advance provision for dispute handling mutually beneficial. An across-the-board prohibition on parties including a provision in a contract should only be made based upon a determination that such a provision is always unjust, and the Department does not believe that standard has been met here.

4. COMMENT: The Health Claims Authorization, Processing and Payment Act (HCAPPA) establishes a permissive independent external arbitration process operated by the State which includes disputes over payments including billing and coding edits or interpretations. A contractual requirement to participate in mandatory binding arbitration could be inconsistent with the HCAPPA right to pursue a remedy outside of arbitration. One commenter requested that a prohibition on mandatory binding arbitration be incorporated into the adopted rule. The commenter stated that this serves as an example of why the Department should exercise its approval authority over agreements between carriers and providers. A review would reveal the inconsistency created by HCAPPA. The commenter stated that many physicians in New Jersey

have benefited from protections gained from class-action lawsuits against major health insurers and the availability of that legal recourse is an important one.

RESPONSE: The comment is beyond the scope of the proposal and revising the rules to include a prohibition on mandatory binding arbitration clauses in provider agreements would be a substantial change that cannot be made upon adoption. See N.J.A.C. 1:30-6.3. The Department concurs that the HCAPPA establishes a permissive external arbitration process. Whether that provision in the HCAPPA would preclude the inclusion of a mandatory binding arbitration clause in a provider agreement is an issue better addressed in the context of a specific case, rather than in the abstract, and is an issue that it may be more appropriate for a court to address based on principles of contract law.

5. COMMENT: One commenter applauded some of the Department's proposed provisions, but stated that they do not go far enough in providing to consumers and providers the protections mentioned in the Summary. The commenter pointed out that the Summary indicates that it is the Department's responsibility to protect these classes from economic harm or inadequate access to care. The commenter's concerns include the following: (1) the ability to provide for a binding arbitration mechanism concerning contractual disputes; (2) the inclusion of a contract form and summary disclosure form or term sheet which is offered to the provider by the managed care plan that includes all compensation terms, treatment policies, protocols, quality assurance activities, and utilization management systems related to the managed care plan and the health care provider's participation in the managed care plan. Also, if applicable, the health care provider submits, and the carrier accepts, the universal physician application for participation in the plan under the proposed rules for use of the Council for Affordable Quality

Healthcare (CAQH) credentialing forms; (3) providing enrollees of managed care plans with a standard electronic identification card which details eligibility, access, benefits, and co-insurances; and (4) a standard rule setting and arbitration for provider ranking and rating systems that impact network delivery systems and consumer choice. The commenter mentioned proposed pending legislation (A2391, A2392, S1222, and S1467) that addresses these concerns and provides greater direction on what many in the field of medical practice management would like to see accomplished in addition to the rules proposed by the Department.

RESPONSE: The Department thanks the commenter for its expression of support for the instant proposal. The suggestions for additional rules to address the specific concerns noted by the commenter are beyond the scope of the proposal. The Department will monitor the progress of the pending legislation mentioned in the comment and market conditions after the effective date of this adoption and will consider additional rulemaking if it concludes that a need exists for further regulatory action. As is set forth in a Response to a Comment below, N.J.A.C. 11:24-3.9 and 11:24A-4.7 continue to be applicable to reviews of the universal physician application (see Appendix Exhibit 1 of N.J.A.C. 11:24C) submitted by providers seeking to be credentialed by HMOs and/or the carriers referenced in N.J.A.C. 11:24A-4.7 and defined in N.J.A.C. 11:24A-1.2.

6. COMMENT: One commenter stated its concern that many current provider networks are actually "phantom networks" that list many providers who are not participating, and in many cases, have not been participating for many years. The commenter stated that it is a common complaint among providers that, despite numerous attempts to be removed from the public list of providers, it is virtually impossible, even when the provider is given official notice by the carrier that he or she is no longer participating in the network. Likewise, many patients have made the

same claim – that when they contact providers on the list from their insurance company, no one appears to be currently participating or they are not currently accepting new patients, despite still being listed as a current provider in the network. This greatly discourages patients from finding the care they need and serves as a disincentive and barrier to connecting patients with quality services. The commenter commended the Department for addressing this pervasive issue and developing regulations that provide for adequate networks that promote patient access to care.

RESPONSE: The Department thanks the commenter.

7. COMMENT: Some of the comments addressed the proposed credentialing standards regulations at N.J.A.C. 11:24C-1.3. One commenter expressed its concern in meeting the requirement at proposed N.J.A.C. 11:24C-1.3(a) that provider credentialing be completed within 90 days for providers that may require further investigation due to adverse actions. The commenter suggested including the following language to accommodate these circumstances: "If a provider requires further investigation due to license sanctions, malpractice history, or other adverse actions, the credentialing process may exceed 90 days."

RESPONSE: The Department believes 90 days is adequate time to fully vet candidates, including researching adverse actions.

8. COMMENT: One commenter expressed its appreciation for the Department's efforts to streamline the process for providers to become approved members of managed care networks, thereby expediting the process for providers to become known to consumers and, as a result, be able to begin providing their vital services sooner. The commenter was pleased that the Department incorporated the requirement that the carrier's credentialing committee complete their review within 90 days of receipt of a complete credentialing application, but stated that two significant problems working with carriers on credentialing have always been the ability to agree

on the actual date of receipt of the application by carriers and an agreement as to when the 90-day time line to complete the review is triggered. The commenter stated that this proposal does not resolve these issues for providers.

The commenter stated that the proposal provides no notification requirement by the carrier to the applicant upon its receipt of the information from CAQH. The proposal at N.J.A.C. 11:24C-1.3(a)1 allows carriers to wait up to 45 days from the time they receive the information from CAQH to notify the physician as to whether the application is complete or advise of its deficiencies; during this period, the physician still does not know if the carrier is in receipt of the CAQH information and lacks a contact number for inquiries to the carrier's credentialing staff. The commenter requested that carriers be required to send a notice to the applicant within 72 hours of receipt of the information from CAQH, which shall include contact information for the carrier's credentialing staff and all disclosures contained in this provision as proposed.

The commenter further expressed concern for the potential abuse by carriers of the proposed 45-day time period in terms of delays in the credentialing process. The commenter stated that the physician's application may be complete when the carrier receives the CAQH information, but this proposal authorizes the carrier to do nothing for 45 days. Conversely, if the carrier receives an incomplete application and the physician is not notified for 45 days, the physician has just lost that time to work on resolving the deficiencies in the application. The commenter requested that the 45-day period be shortened to 30 days.

RESPONSE: The Department understands that a plan can access a provider’s application through CAQH once the provider authorizes the plan on the authorization tab of their application. Providers wishing to fix the “receipt” date can provide positive notice to the plan that a completed application has been authorized by that provider for that carrier and request that

the carrier notify the provider when it accesses the application on the CAQH System. The Department disagrees that a carrier can "do nothing" for the first 45 days, as carriers are required to determine whether or not the application package is complete and communicate the determination and provide contact information for its credentialing staff to the provider in that timeframe. The time period was selected as a reasonable compromise considering the provider's interest in knowing the status of the application and the administrative burden on the carrier.

9. COMMENT: A few commenters stated that they do not support the proposed requirement at N.J.A.C. 11:24C-1.3(a) that a carrier provide notice within 45 days that the credentialing application is complete because it is costly and unnecessary. According to the commenters, a notice of incompleteness is appropriate and should be sufficient. One commenter stated that providers are able to contact a carrier by phone to determine the status of their credentialing application.

RESPONSE: The Department disagrees. Providers have an interest in knowing the status of their applications one way or another. Carriers in receipt of complete applications can save the expense of sending notices of completeness by, whenever possible, finalizing the credentialing process within 45 days and so notifying providers.

10. COMMENT: One commenter stated that the proposal includes a requirement at N.J.A.C. 11:24C-1.3(a)1 that the carrier specify a due date for the submission of missing information on a physician's application, but it does not appear that there are any further requirements for the carrier to notify the physician as to the completeness of the application that was previously deficient, or a time period for carriers' continued review for completeness. The commenter stated that this information is essential to physicians so they know when the 90-day time period is triggered. The commenter requested that in such cases, carriers should be required

to notify the applicant within 30 days of their receipt of the missing information when the application is complete, so the applicant is on notice as to when the committee's 90-day substantive review period begins.

RESPONSE: The Department disagrees. Applicants also have an interest in and responsibility for seeing that applications are complete prior to submission and subsequent to receipt of a notice of deficiency, so elaborate rules regarding follow-up on still-missing information should be unnecessary. Providers who believe that carriers are providing ambiguous information about missing documentation to delay the process are urged to file a complaint with the Department.

11. COMMENT: One commenter stated that the proposed requirements at N.J.A.C. 11:24C-1.3(a)2 that a carrier respond to all inquiries within five business days, and that carriers maintain a credentialing department e-mail address, are unnecessary. According to the commenter, carriers have telephone numbers staffed with customer service representatives available to assist with credentialing–related activities. Requiring a credentialing department e-mail address is duplicative and unnecessary. The commenter recommended that the Department require carriers to maintain an e-mail address or phone number to answer provider inquiries.

RESPONSE: The Department disagrees. Many providers have expressed frustration with their inability to communicate with carriers during the credentialing process, and the lack of accountability in carriers' failures to follow through on verbal commitments. While the Department encourages carriers to make telephonic access available, and believes that if effectively used it will preclude the need for electronic communication, providers who prefer to create an electronic record of outreach should have that option.

12. COMMENT: Some commenters expressed their support for the implicit encouragement in the proposal for physicians to use the CAQH uniform data collection (UDC) system by providing shortened timeframes for carrier review, and further support allowing carriers to make its use mandatory. One commenter stated that CAQH simplifies the credentialing process by replacing multiple plan-specific processes with a single UDC system, which is cost effective not only for carriers, but also providers. Providers would no longer need to complete multiple applications, thereby reducing duplicative paperwork and administrative costs. Providers would also have the ability to access, manage, and revise their information at their convenience and maintain control of the data, authorizing only the health plans of their choice to access the data. This would also allow carriers to ensure the accuracy of their online provider directories, which this proposed rule further seeks to enhance. The commenter recommended that recodified N.J.A.C. 11:24C-1.3(e) be revised to allow carriers to require the use of CAQH.

RESPONSE: The Department thanks the commenter for their comments. The suggestion to amend N.J.A.C. 11:24C-1.3(e) to authorize carriers to mandate the use of the CAQH process would be a substantive change that cannot be made upon adoption. See N.J.A.C. 1:30-6.3. Going forward, the Department will monitor the extent to which the respective credentialing application procedures referenced in the rule are utilized and, should the data indicate that the use of the non-CAQH procedure has declined to a significant extent, will consider amending the rule as suggested by the commenter.

13. COMMENT: One commenter stated that it is pleased that the majority of carriers in the state are utilizing CAQH for credentialing purposes. However, the exclusion of N.J.A.C. 11:24-3.9 (HMO networks) and 11:24A-4.7 (Health Care Quality Act rules regarding provider

application for participation in networks) from this proposal allows for different standards for the credentialing process and increases the administrative burdens on physicians managing these different standards. These rules require carriers within 60 days following receipt of the application to notify the provider that the application is incomplete, and also contain the 90-day committee review period. If these rules remain unchanged, physicians will continue to have notification and communication problems with the carriers when credentialing is not handled through CAQH. The commenter requested that the Department amend N.J.A.C. 11:24-3.9 and 11:24A-4.7 to reflect the same credentialing standards as is proposed in N.J.A.C. 11:24C-1.3.

RESPONSE: The Department agrees that the use of CAQH for credentialing purposes increases efficiencies for both the provider and the carrier. The rules at N.J.A.C. 11:24-3.9 and 11:24A-4.7 apply without regard to the use of CAQH, and both subchapters require the completion of the review of a complete application within 90 days of its receipt. New subsection (b) of N.J.A.C. 11:24C-1.3 clarifies that the timing requirements in N.J.A.C. 11:24-3.9 and 11:24A-4.7 continue to apply to non-CAQH credentialing applications. The Department believes carriers and providers alike have an obligation to use efficient processes; providers who would like to ensure uniform processing within the timeframes set forth in the amended rules can use CAQH for all credentialing. No change is being made.

14. COMMENT: Some commenters addressed proposed N.J.A.C. 11:24C-4.1(b), which states that the proposed subchapter does not apply to those contracts entered into between a carrier and Medicaid to provide Medicaid Only coverage or NJ FamilyCare coverage. Two commenters stated that the recent carve-in of many new populations and services into Medicaid managed care necessitates action by the Department to hold Medicaid carriers to the same standards as commercial payers. The commenters further stated that the exclusion of

Medicaid/NJ FamilyCare is particularly confusing in light of a recent rule adoption at N.J.A.C. 10:74-1.4 that emphasized the responsibility for issuing Medicaid MCO licenses rests squarely with the Department. One commenter questioned whether this exclusion is meant only to exclude the underlying carrier/State contracts. The commenter stated that since over 90 percent of the Medicaid patients in New Jersey are covered by managed Medicaid plans administered by four of the major insurers in New Jersey, and this rule is aimed at fairness in contracts and network relations, it is requesting that the Department clarify that the proposal is applicable to these programs or explain the rationale for not including certain Medicaid programs.

RESPONSE: The comments go beyond the scope of the proposal. If a service is being delivered with respect to a Medicaid-only or FamilyCare enrollee pursuant to a contract between the carrier and the State, N.J.A.C. 11:24C-4, pursuant to N.J.A.C. 11:24C-4.1(b), does not apply to that service. Because Medicaid-only and FamilyCare coverage plans are financed and contracted for differently than commercial health plans, and because only limited data is available on how the recent changes to Medicaid managed care noted in the Comment have affected the program, the Department withheld judgment on how, or to what extent, such plans should be impacted by these rules. Accordingly, the Department chose to exempt such plans from the application of these rules at this time. However, the Department may consider expanding the application of the rule in a future rulemaking if it determines that such expansion would be appropriate.

15. COMMENT: Two commenters recommended that the Department clarify that the proposed definition of "health benefits plan" at N.J.A.C. 11:24C-4.2 excludes any Medicare product, including Medicare Advantage, as well as any other Federal plan such as the Federal Employees Program (FEP).

RESPONSE: The proposed definition of “health benefits plan” is limited to those plans over which the Department has regulatory jurisdiction and, accordingly, does not include Medicare, Medicare Advantage, or other plans or programs regulated by the Federal government.

16. COMMENT: Two commenters recommended that the Department exclude certain coding changes and certain edits from the proposed definition of "adverse change" at N.J.A.C. 11:24C-4.2, specifically coding changes and edits that align with the Centers for Medicare and Medicaid Services (CMS) guidelines, industry standards, or national benchmarks.

RESPONSE: No change has been made to the definition of “adverse change.” The Department notes that carriers are not uniform in their adoption of CMS guidelines, and industry standards and national benchmarks are subject to interpretation. Timing of implementation also varies. The Department intends that providers be notified if payments to them or their administrative costs will be materially impacted by a change adopted by a carrier.

17. COMMENT: Two commenters expressed their support for the Department's proposed elimination of prior approval requirements for agreements between providers and carriers at N.J.A.C. 11:24C-4.3(a).

RESPONSE: The Department thanks the commenters for the comment.

18. COMMENT: Four commenters requested that the Department preserve the requirement for its prior approval of participating provider and carrier agreements, and that it exercise the right to disapprove when an agreement is not in compliance with applicable laws and regulations. One commenter stated that it appreciated that it may be burdensome to review every agreement, but the commenter believes that it is important for the Department to review at least the form of agreement for each product or plan. In addition, the commenter requested that the Department sample physician agreements from a variety of practice models, including solo

and small practices. According to the commenter, this would give the Department a birds-eye view of carrier compliance and, perhaps, some insight into the terms that are negotiable. The commenter believes that N.J.S.A. 17B:27A-54 and other related statutes require this and that it is this review and approval power that enables the Department to discipline carriers and check any attempt to modify agreements, that is not permitted by the terms of the agreement itself. The commenter further cited the Department's Bulletin 07-13, dated June 19, 2007, to all insurers concerning "side agreements." The commenter stated that it does not believe that strengthened rules governing provider contracts, alone, are sufficient protection for the Department to release this means of oversight.

Three commenters stated that in one provision of the proposed rules, the Department appears to be condoning the carrier's practice of making unilateral contract changes, while in another it appears the Department is also removing itself from any oversight when the plans choose to do so. The commenters pointed out that recently, the New Jersey Hospital Association needed assistance from the Department concerning at least three contract amendments that were thrust onto hospital providers unilaterally. In two of those instances, the carrier had not sought the Department's approval before attempting to implement the changes. The commenters stated that if carriers cannot follow the existing regulatory requirements, providers cannot be confident that without the Department's role as gatekeeper the carriers will not continue to misrepresent what can and cannot be included in a network agreement. The commenters specifically urged the Department to eliminate the suggested changes in the proposal at N.J.A.C. 11:24A-4.15(f), 11:24B-5.2(a), and 11:24C-4.3(a) that would repeal the Department's prior approval of contracts and amendments. The commenters further requested clarification as to what mechanism providers will employ when instances of non-compliance with either statutes or rules occur.

Additionally, the commenters requested guidance on whether it is the Department's intent that there will no longer be oversight and, if the Department intends to maintain its role in overseeing network agreements, specific details as to how and under what circumstances the provider and payer communities can make use of the Department's expertise.

RESPONSE: The Department appreciates the concerns of the commenters and will closely monitor the market impact of the change. Elimination of the prior approval requirement in no way represents a withdrawal from oversight over the contracting practices of the carriers, and is not being made to reduce any burden on the Department. Rather, it represents a shift toward the promulgation of performance-based standards through the transparent process of notice and comment. The Department has received complaints from providers and carriers that the filing and pre-approval requirements have had a chilling effect on the ability of the parties to quickly effect contractual changes both parties find beneficial. The rule change is intended to replace that regulatory impediment to commerce with effective rules that prescribe minimum standards for contracting. It in no way removes the Department from its role as regulator of the insurance community, and the utilization of contracts that do not comply with laws and regulations will continue to subject the issuer to potential regulatory penalties. Providers who believe that carriers have in any way violated insurance laws or regulations, including, but not limited to, minimum standards for provider contracts, are encouraged to continue to contact the Department, and corrective actions will be taken as appropriate. Carriers who are uncertain as to how the rules apply to a specific circumstance are encouraged to reach out to the Department for consultation. The Department will monitor the impact of the change on the marketplace, and may revisit the rule if it appears to be adversely affecting the industry or resulting in inappropriate practices.

Regarding the comment that N.J.S.A. 17B:27A-54 requires the Department to review and approve all provider agreements, that statute specifically relates to selective contracting arrangements and the Department's selective contracting arrangements rules at N.J.A.C. 11:4-37.4 as amended by this adoption continue to require the Commissioner's prior approval of these arrangements.

19. COMMENT: Three commenters addressed proposed N.J.A.C. 11:24C-4.3(b), which requires a carrier to make available its complete fee schedule to a provider contemplating participatiing in the carrier's network. One commenter stated that this proposed requirement clearly exceeds the disclosure requirement already established by statute at N.J.S.A. 26:2S-9.2, which requires the disclosure of only the top 20 evaluation and management codes and the top 20 services billed by the specialty of the provider upon request. Another commenter requested that the proposed rule be changed to mirror the statute. According to the commenters, providing a complete fee schedule would not be useful to a provider, as the complete fee schedule includes codes that the provider would never bill and would include over 10,000 codes. Moreover, this would impose an overly burdensome and unnecessary requirement on carriers that would offer little to no benefit for providers.

One commenter requested that the Department clarify that as part of any requirement for disclosure of a carrier's fee schedule, there must be a corresponding requirement that the provider keep the information confidential. The commenter further requested that the disclosure requirement should be limited to providers who have completed an application and exclude any specialty or geographic area for which the carrier does not need or wish to have additional network providers.

RESPONSE: The definition of "provider agreement" at N.J.A.C. 11:24C-2 includes any fee schedule that is part of the agreement, and "fee schedule" is defined therein as the complete fee schedule applicable to and part of an existing or contemplated provider agreement. In addition, N.J.S.A. 26:2S-9.2.b requires a carrier to reimburse a participating healthcare provider "in accordance with the fee schedule provided to the healthcare provider pursuant to the contract." Thus, this statute and the proposed rule refer to the fee schedule as a term of the provider agreement. The fee schedule is the contract provision that specifies the amount of compensation the provider will be paid and agrees to accept as consideration for performing the services the provider agrees to deliver under the terms of the agreement. Depending on the nature of the provider's practice, those services typically correspond to 100 or more CPT codes with distinct fee amounts for each code. The commenters' assertion that, based upon the text of N.J.S.A. 26:2S-9.2.a, carriers need only provide a fee schedule consisting solely of the fees for the "top 40" codes a provider of a certain type is likely to bill when the provider is contemplating contracting to join a network defies logic and is contrary to long-standing principles of contract law. Rather, the Department construes N.J.S.A. 26:2S-9.2.a as establishing the minimum requirement that carriers must meet when requested to provide a fee schedule to a provider with whom the carrier negotiates, but does not constrain the Department from requiring carriers to merely make available on their websites or through other electronic means the complete fee schedule applicable to providers of different types who do not negotiate compensation terms specific to them. This construction is supported by the full text of N.J.S.A. 26:2S-9.2.b, which provides that: "The carrier shall reimburse the healthcare provider in accordance with the fee schedule provided to the healthcare provider pursuant to the contract. The carrier may revise the fee schedule upon providing the health care provider with written notice of the change and, upon

request, a copy of the revised fee schedule." Since fee schedules almost always include many more than the "top 40" codes most frequently billed by providers in various types of specialties and subspecialties, it is evident from the text of subsection b that the Legislature contemplated that carriers would provide to healthcare providers the complete fee schedule applicable to their specialty or subspecialty in accordance with which the carriers are to reimburse providers "pursuant to the contract." Otherwise, subsection b would be of no effect with respect to codes on the fee schedule for which a provider is to be reimbursed by the carrier, or which are changed in a revised fee schedule, other than the "top 40" codes.

As proposed, N.J.A.C. 11:24C-4.3(b) addresses provider agreements for which fees are not individually negotiated and requires carriers to make available to the provider parties to such agreements all complete fee schedules that are or are to be included in such agreements. The Department believes that if providers who are unable to negotiate compensation terms unique to them are asked to commit to accept a level of reimbursement for providing a given service, that level should be available to such providers without regard to the frequency with which the service is performed. The Department appreciates that the cost of production and mailing can be high, and the rules therefore allow the requirement to be met by providing web access or electronic delivery. Responses to specific requests for fee schedules can of course be tailored to the scope of the request. Carriers routinely maintain fee schedules in electronic media for the purpose of claims adjudication. It is unclear why the commenter believes that providers would request something the commenter believes is of little or no value to them.

Nowhere in N.J.S.A. 26:2S-9.1 et seq. is the term "fee schedule" defined. As was noted above, N.J.S.A. 26:2S-9.2.a provides that a carrier that negotiates with a provider to become a participating provider shall, upon request, furnish to such a provider a written fee schedule, or in

an electronic format if agreed upon by both parties, showing the fees for the 20 most common evaluation and management codes and the 20 most common office-based or hospital-based in network services for the provider's specialty or subspecialty to be provided pursuant to the proposed or existing contract. The subsection goes on to address the circumstance where a carrier negotiates a fee schedule that is specific to a provider and, in that case, requires the carrier to provide only the applicable fee schedule for that provider. Thus, the statutory requirement that, upon request, carriers identify and provide the "top 40" fees by specialty or subspecialty only applies where the carrier and the provider do not negotiate a fee schedule that is specific to the particular provider. A carrier's doing so involves performing the function of identifying the "top 40" codes billed by a certain type of provider, which is distinct from providing or making available electronically the complete fee schedule applicable to a particular type of provider with whom the carrier has not individually negotiated the terms of the fees to be paid to the provider.

In addition, making the complete fee schedule, which is essentially the provider compensation provision of the contract, available to such providers furthers the goal of the proposal to facilitate providers joining networks and their remaining in networks after initially agreeing to participate. By doing so the strength of networks is enhanced and the cost savings realized by consumers receiving healthcare from network providers is increased. Requiring providers to decide whether to join or remain in a network without knowing the complete compensation terms of the network agreement places providers in a troublesome position and has a chilling effect on the maintenance of well-populated networks.

The Department does not believe the rule needs to include a confidentiality requirement, as pursuant to N.J.S.A. 26:2S-9.2 fee schedules are designated as proprietary and confidential.

20. COMMENT: One commenter applauded the Department's inclusion of the requirement that complete fee schedules be included in the agreement(s) made available to network providers and prospective network providers in its proposal. The commenter stated that many physicians have complained that they are "buying a pig in a poke" when they are asked to negotiate and sign a network agreement without the fee schedule. That one could be asked to sign a contract without knowing the payment terms defies logic, and proves that non-negotiated fee schedules are even worse than contracts of adhesion in that the provider is expected to commit without even knowing the payment terms. The commenter added that the fact that physicians have entered into contracts without knowing the payment terms tends to prove the dominant power of the carriers in these agreements. The commenter further requested that the language at proposed N.J.A.C. 11:24C-4.3(b)1 be revised to address a provider's contemplated participation in multiple health benefits plans offered by a carrier, each with different fee schedules. The commenter requested that the language in this provision be made internally consistent by adding the language in bold: "applicable to that provider for each plan in which the provider participates **or plans to participate**."

RESPONSE: The Department thanks the commenter for the expression of support and agrees that the language of N.J.A.C. 11:24C-4.3(b)1 should be made internally consistent by adding the language “or plans to participate” at the end of the subsection. Accordingly, this change is being made upon adoption. This amendment can be made upon adoption because it merely serves to clarify the intent of the Department in proposing this paragraph as set forth in the Summary in the notice of proposal, which referred to carriers making available to providers and prospective providers “all fee schedules that are or are to be included in their agreement.” (See 44 N.J.R. 377.)

21. COMMENT: One commenter expressed its appreciation for the Department's inclusion of N.J.A.C. 11:24C-4.3(b)2 in its proposal, but suggested some amplification on the amount of information carriers need to make available on line so as to provide an understanding of the specific commercial or proprietary edits used by the carrier. The commenter stated that it reviewed schedules of commercial edits that are virtually meaningless and serve as little more than notice that the carrier will deviate from the conventional coding guidelines. The commenter suggested that carriers be required to explain how the edit deviates from the National Correct Coding Initiative, American Medical Association (AMA) coding guidance, and/or the CMS Manual and payment policies. According to the commenter, reference to any one of these guidelines would give providers some benchmark on which to evaluate the impact of the edit and, consequently, the adverse impact.

RESPONSE: The Department appreciates the concern that the descriptions of edits provided by carriers may not be meaningful. The requirement in the rule that the description be detailed enough to provide an understanding of all carrier-specific edits is intended to prevent summary descriptions. The Department will monitor this, and suggests that any examples of meaningless or inadequate edit descriptions be brought to its attention by providers.

22. COMMENT: One commenter expressed support for the proposed prohibition at N.J.A.C. 11:24C-4.3(c)2 on most favored nation clauses. The commenter believes that consumers are best served by a competitive health insurance marketplace that offers varied choices of health plans permitting carriers to win business based upon quality and service. The commenter stated that most favored nation clauses are inherently anti-competitive and destructive to the marketplace. These contract clauses impose artificial constraints on the market

and serve neither consumers nor providers fairly by inhibiting the ability of providers to freely contract with insurance plans at competitive rates.

RESPONSE: The Department thanks the commenter for the comment.

23. COMMENT: Some comments concerned proposed N.J.A.C. 11:24C-4.3(c)1ii, which requires the agreement to disclose, in plain language, the specifics of the applicability of the agreement to any other products offered by the carrier with different compensation terms. The commenters urged the Department to clarify, with explicit language, that the provider agreement must include the specific products in which the provider agrees to participate. The commenters stated that this is necessary because a carrier may specify a family of plans, then add a specific product for which the provider has no interest in participating. One commenter noted that at least one carrier has taken the position that a participating provider for one product may be considered a participating provider for other products and that the carrier has paid network fees tied to products in which the physician does not participate. According to the commenter, this has been effectuated through the carrier's manual. The commenter added that it is clear from this proposal that the Department believes that each plan and corresponding fee schedule should be disclosed and agreed to. This is also a compelling reason to prohibit "incorporation by reference" clauses. One commenter stated that one of the original purposes of the working group meetings with the Department prior to its 2009 proposal of these rules was to ensure that there was transparency in the contracting process; the Department was in agreement that the contract was the contract. One commenter urged that proposed N.J.A.C. 11:24C-4.3(c)1ii be changed to include the language in bold: "**The specific products in which the provider agrees to participate;** and if the agreement applies to **multiple** products with different compensation or other terms, the specifics applicable to each." One commenter requested that the language found

in the Department's original proposal addressing "incorporation by reference documents" at proposed N.J.A.C. 11:24C-4.3(c)5, 41 N.J.R. 2433, be included in this proposal.

RESPONSE: The Department believes that the requested change is not necessary. The rule as proposed requires that if the agreement applies to products with different compensation or other terms, the agreement disclose in plain language the specifics applicable to each. If a provider has no interest in participating in a particular product, it would presumably be because the product has different compensation or other terms, so specifying those terms would appear to be of more value to a prospective provider than listing product names. As discussed above, the focus of the rules is on the material terms of participation and their transparency, rather than the specific document in which specifics may be found.

24. COMMENT: Several commenters stated that the Department's 2009 proposed rules addressing provider networks required the carrier to provide a summary disclosure form of the carrier's preauthorization process, but the current proposal at N.J.A.C. 11:24C-4.3(c)1v only requires the agreement to include "the provider's obligation to participate in preauthorization programs." The commenters agreed that the obligation should be stated if it is applicable, but averred that the 2009 proposal's requirement of a summary disclosure form of the preauthorization process is key to transparency and certainty. The preauthorization process certainly includes the clinical criteria on which these decisions are made. Changes in the clinical criteria for preauthorization, including those which are contracted out to third-parties that subsequently make treatment decisions, is one of the most significant problems faced by physicians. A persistent issue is whether the clinical criteria are truly that of the carrier or only the work-product of the sub-contracted party. Requiring more transparency, meaningful

disclosure, and responsiveness on this issue will reduce a tremendous amount of paperwork and burden that is now shouldered by physicians.

RESPONSE: The Department agrees that the basis of utilization management decisions on preauthorization requests should be transparent and clearly accessible. The Department does not, however, believe a summary disclosure form of a preauthorization process in a contract would effect the result desired by the commenters. HCAPPA requires all payers to provide information concerning utilization management and the processing and payment of claims in a clear and conspicuous manner through an Internet website, including the source of all commercially produced clinical criteria guidelines and a copy of all internally produced clinical criteria guidelines used by the payer or its agent to determine the medical necessity of health care services. This obligation extends to subcontractors the carrier may use. This, rather than the provider contract, should be the primary source of information on the clinical criteria that a carrier applies to utilization management determinations.

25. COMMENT: Several comments addressed proposed N.J.A.C. 11:24C-4.3(c)3 and 4 regarding unilateral and adverse changes to provider agreements. The commenters stated that they had serious concerns with these provisions. The commenters stated that, according to the proposal Summary, the proposal would allow unilateral changes to be made so long as providers are given "sufficient advance notice to permit termination in advance of the effective date" of any "adverse change" or "adverse amendment." The commenters asserted that this language would give regulatory authority to a practice that health plans currently engage in regularly and make that practice even more daunting by allowing adverse amendments to be made directly to the core terms of the contract itself. The commenters asserted that these changes are contrary to well settled contract law that a contract consists of an offer and an acceptance and that allowing

unilateral changes to contracts violates this fundamental principle. The commenters stated that the language in these provisions seems to create ambiguity surrounding what would be permitted to be amended unilaterally in a contract. Paragraph (c)3 seems to indicate that unilateral amendments are permissible so long as the provider is given sufficient notice. However, Paragraph (c)4 states that the payer or provider is prohibited from making unilateral amendments "if the terms of an agreement have been the subject of negotiation." To resolve such ambiguity, the commenters requested that the Department remove all language at N.J.A.C. 11:24C-4.3(c)3 and strongly urged the Department to prohibit the practice of permitting one side in a contractual arrangement to amend the terms of a contract unilaterally.

The commenters further stated that proposed N.J.A.C. 11:24C-4.3(c)3 poses serious problems for the provider community. According to the commenters, the process of contract termination is not something providers take lightly. The contractual relationship provides both the payer and the provider certain assurances in terms of volume, rates, and revenue. For hospitals in particular, termination is an arduous process that includes ensuring the appropriate State regulations are followed in extending the contract as required, ensuring that all physicians understand and support terminating a relationship with a particular carrier because they will no longer be able to refer plan members to that hospital, and acknowledging the potential to alienate the very community they serve (see, for example, N.J.A.C. 11:24-3.5 (HMO provider contract termination)). One commenter stated that significant numbers of providers dropping from networks would create new problems with network adequacy, and access to care would be compromised. For these reasons, it is no small undertaking for a provider to terminate an existing relationship. Therefore, offering termination as the only recourse to an adverse change or amendment is of no value to the provider, or to the patients it serves. Moreover, not only does

this undermine the sanctity of a contract, and in the best of cases provide payers with an upper hand, it could also be used as a foil by carriers to force termination. One commenter further recommended that when providers "opt out" or withdraw from contracts due to adverse changes or amendments, that patients currently in their care will remain covered by the carrier, under the prior contract terms, until reasonable accommodations can be made for safe and effective transfer of treatment.

The commenters requested that proposed N.J.A.C. 11:24C-4.3(c)3 be revised to state "Unless otherwise agreed to during negotiation of the contract, no adverse change or adverse amendment shall be made unilaterally to the administration of the contract." The commenters stated that this language would allow both the payer and provider to negotiate unilateral changes through the contract negotiation process. Alternatively, the Department could add language to the proposal that would establish a notification process for proposed amendments and would allow an existing contract to stay in effect in instances when there was failure to agree on the amendment. This would ensure that carriers have an opportunity to make policy changes that are truly nothing more than a change in policy. At the same time, it would protect providers against instances where a policy change is in actuality impacting the financial value of the contract entered into through negotiation. For this alternative, the commenters suggested that the Department include the following language at N.J.A.C. 11:24C-4.3(c)3: "The party proposing the change or amendment to the core term(s) shall provide the other party with at least 90 days' written notice of the change and specify in such notice the effective date of the change. The posting on a carrier's website of any revision to a core term in the provider agreement shall not, in the absence of some additional direct written or electronic notice of the change to the provider, constitute the supplying of advance notice as required by this rule. The party receiving notice of

the proposed change or amendment to the core term(s) shall, within 30 days of receipt of the notice of the proposed change, provide written or electronic notice of acceptance or rejection of the revision. A failure to provide such a response to a notice of a proposed change shall not be deemed acceptance. Should the parties fail to agree, the terms of the agreement as previously accepted by the parties shall remain in effect until the agreement expires or is terminated." The commenters believe that this language, which is based on the Department's original proposal that was never adopted, would prove invaluable should the Department determine that language allowing for unilateral contract changes at N.J.A.C. 11:24C-4.3(c)3 should be allowed to remain in the proposal upon adoption. The commenters stated that without a safeguard against changes that are material in nature, there is little or no value in negotiating contracts with health plans because they will be able to merely rescind any provision that is not beneficial to them. Further, the commenters stated that if the Department intends to afford providers relief from unilateral contract changes by proposing definitions that clearly identify what would be determined to be an adverse change or amendment, the definition in reality will be meaningless given that the proposal allows carriers to make adverse changes as long as there is notice.

Two commenters stated that while this proposed provision may afford some protection to those providers that have some measure of bargaining power already, it does nothing to level the playing field for the vast majority of primary care and other physician practices that are without meaningful bargaining power in New Jersey. The commenters requested that the Department prohibit all unilateral changes during the term of the contract unless there is mutual consent that is confirmed in writing. This prohibition was included in the Department's original proposal. One commenter suggested revising the provision as follows: "No changes shall be made unilaterally to the administration of an agreement that would result in an adverse change as

defined in this subchapter. For example, carriers may not unilaterally introduce Multiple Procedure Logic or changes to billing requirements that would result in a material reduction in reimbursement for services affected by the change."

Some commenters stated that if the proposed provision is not modified, this will result in a significant unintended consequence. It will create two vastly different classes of physician contracts. Those with some measure of market power who are able to individually negotiate an agreement and/or fees will be more likely to receive the benefit of their bargain. Those without any market power will have the right to terminate their contract, a hollow remedy which they do not wish to use. The commenters agree with the Department's stated intent to establish and maintain strong networks, but expressed concern that the termination right will not facilitate that mutual goal. The commenters believe that all physicians are entitled to the benefit of the bargain, the terms of the provider agreements, during the term of the agreement. Certainty of payment amount is appropriate. The uncertainty of payments is a primary reason that physicians are driven from networks.

RESPONSE: The proposed rule does not create a right of unilateral amendment. That right can only be created by contract between the parties. Absent a law or regulation to the contrary, parties to a contract are free to include any terms in contracts that are mutually acceptable to them. This includes methods by which the terms of the contract itself may be changed, such as by notice of one party to the other. Many of the same commenters who objected to the Department’s proposed restrictions on unilateral amendments also acknowledged they are commonplace. Therefore, the rules are not “authorizing,” “endorsing,” “blessing,” or “sanctioning” provisions for unilateral changes to contracts, but acknowledging their existence and limiting their application. The only effects of the rule are to ensure that the methods by

which the contract may be amended are disclosed in plain language in the agreement and ensure a right of exit before the imposition of an unacceptable unilateral change to an agreement that permits such changes. Some providers have complained to the Department that such provisions were being used to make changes so material that the contract would not have been accepted had they existed at inception, while other provisions prevented termination before their application. The Department believes that the terms to which parties agree to be bound at the inception of a contract should be available to those parties so the bargain can be clearly understood. This concept is the basis for N.J.A.C. 11:24C-4.3(b) with respect to fee schedules in contracts in which fees are not negotiated. Additionally, changes during the life of a contract materially affecting the bargain should include an "escape clause" such that no party is held to a contract that they would not have entered into had those terms existed at inception.

In recent class action settlement agreements between health plans and medical societies from several states, including the New Jersey Medical Society, insurers were required to provide participating physicians with 90 days' advance notice of material adverse changes. (See Section 7.6 of separate settlement Agreements with Aetna, CIGNA, HealthNet, Blue Cross and Blue Shield Association, among others.) The Department further notes that N.J.S.A. 26:2S-9.2 provides that a carrier may revise a fee schedule upon providing the health care provider with written notice of the change. Such notice requirements would not exist if it were true that contracts could not include clauses permitting change by notice in the first place.

The Department does not agree that offering termination as a recourse to an unacceptable adverse change or amendment is of no value to the provider. The bundle of rights and obligations under a contract at any point in time either is or is not acceptable to the parties. If it is, a contract continues; if it is not, the contract terminates, unless the contract by its terms bars

termination. The rule recognizes that a provider agreement may anticipate changes in a dynamic medical service delivery environment, but prohibits the imposition of ongoing contractual obligations in the face of an unacceptable change to one or more of its terms. The Department notes that currently there are no laws or rules that state that provider contracts may be terminated only for cause, so it is difficult to understand how a right of unilateral termination could be used as a "foil" by carriers to force termination.

One commenter correctly noted that carriers making changes that are not acceptable to providers create a risk that networks will become inadequate. Because carriers have an obligation to meet network adequacy standards, the burden is on them not to make such changes.

The Department appreciates the concerns of the commenters that many providers are at a disadvantage in negotiating contract terms with health plans, and that that disadvantage increases with the market share of the carrier. The Department further understands that different providers are differently situated in this regard – those controlling or dominating the delivery of a unique service within a geographic area may have an ability to negotiate specific terms that is not enjoyed by smaller practices in generalist fields. The Department does not agree that the subject rule creates these different classes of physician contracts, or that these market realities can be altered through this Department's rulemaking.

The Department also does not agree that there is any conflict between N.J.A.C. 11:24C-4.3(c)3 and 4. Paragraph (c)3 applies to all adverse changes to all contracts, and requires that contracts be terminable prior to application of the change. Paragraph (c)4 places a further constraint on that subset of contractual provisions that have been specifically negotiated between the parties, requiring that they not be changed unilaterally at all.

26. COMMENT: One commenter urged the Department to clarify that certain changes, including CMS and other third party coding edits that align with industry standards or national benchmarks, are not subject to proposed N.J.A.C. 11:24C-4.3(c)4 regarding unilateral changes to agreements that have been the subject of negotiation.

RESPONSE: No change has been made to the definition of adverse change. The Department notes that carriers are not uniform in their adoption of CMS guidelines, and industry standards and national benchmarks are subject to interpretation. Providers should be notified if payments will be materially impacted by a change adopted by a carrier regardless of whether the impact is as the result of actions by third parties or by the carrier itself.

27. COMMENT: Some commenters stated that the approach taken in proposed N.J.A.C. 11:24C-4.3(c)4, which prohibits unilateral changes that materially impact the business terms of the agreement, is appropriate and should remain in the proposal with a minor alteration in the definition of "material." Specifically, the commenters requested that the Department adopt a definition of the term "material impact" so that both the providers and payers are aware specifically what contractual terms could be subject to change mid-contract term. The commenters stated that it is well-documented that health plans take advantage of policy manuals to make amendments that are in fact material contract changes. For example, payers will regularly make changes to payment and claims processing policies, such as changing the guidelines they use to make utilization management determinations. While this may seem innocuous on the surface, for a provider it can have an overwhelmingly negative financial impact. The increased denials a provider will see from the change in guidelines will not only mean less compensation, but will also increase costs and administrative burdens as the provider expends increased resources in an attempt to appeal the denials. The commenters argued that

these changes, although couched as a policy change, are in reality "material" and therefore should be prohibited from implementation during the contract term unless the parties have an opportunity to negotiate the change in good faith in accordance with contract law.

RESPONSE: The Department agrees that the way a change is characterized or what document it appears in should not affect the ability of a plan to implement it, if it materially alters the deal between the parties. That is the reason the rule focuses on the material impact, either financially or administratively, of the change. Any action taken by a carrier that could reasonably be expected to have a material adverse impact on either the aggregate level of payment to a health care provider or the administrative expenses incurred by the provider in complying with the change, even if characterized as a payment or claims processing policy change, would trigger the notice and opt-out provisions of the rule. The Department does not believe it is necessary to provide a definition of "material impact" as requested by the commenters. The term "adverse change" is defined at N.J.A.C. 11:24C-4.2 as "any action taken by a carrier that could reasonably be expected to have a *material adverse impact* on either the aggregate level of payment to a health care provider or the administrative expenses incurred by the provider in complying with the change. . . ." Examples are included in the definition. (See Black's Law Dictionary, Fifth Ed.) Accordingly, the Department believes that the rules' definition of "adverse change," combined with common principles of contract law, make clear that the references to "material" impacts on the terms of negotiated provider agreements and material reductions in reimbursements in N.J.A.C. 11:24C-4.3(c)4 would mean any unilateral change that results in decreasing the aggregate level of payment to a health care provider or increasing the administrative expenses incurred by the provider in complying with the change.

28. COMMENT: Two commenters raised concerns about the proposed provision at N.J.A.C. 11:24C-4.3(c)5 regarding leased networks. One commenter stated that it approved of the disclosure requirement placed on carriers to divulge any third-party leased network, in the provider agreement, but stated that disclosure does not go far enough to level the playing field with carriers and their third-party discounters and re-pricers. According to the commenter, for this provision to have any teeth, providers must have the right to opt-out of or reject participation with any third-party that is identified, either at the time of the contract or subsequently when a new leased network is disclosed. Also, the addition of any newly identified leased network must be communicated in writing and mailed to the providers. It is simply not sufficient for a carrier to post new leased networks on its website and be able to create contractual obligations for physicians based on that posting. This undercuts the entire requirement that physicians be on notice of and agree to provide service in the leased networks.

The commenter further stated that the mere identification of a leased network and requiring that the leased network abide by all the terms of the underlying agreement is not satisfactory. The requirement to abide by "all terms" is contradictory since it is apparent that the proposal refers to discount and re-pricing arrangements. By definition, acceptance of a leased network will most certainly result in a discounted fee schedule. Therefore, the carrier must not only identify the leased network, but also disclose the discount arrangement, which must be set forth in writing and be part of the agreement. Unless the discount is disclosed, the rental network provisions entirely undercut the newly proposed provisions for provider agreements which specifically require disclosure of fee schedules.

RESPONSE: The provider’s contractual obligation is not created through a web posting. As specified in N.J.A.C. 11:24C-4.3(c)5i, if the carrier wishes to do so, the contract must state

the right of the carrier to lease its provider network. Providers may then decline to contract on the basis that the contract permits extension to third parties. The proposed regulation attempts to strike a balance between advancing transparency and protecting providers' rights while supporting the expansion of in-network treatment of consumers. The Department does not understand the comment regarding requiring disclosure of the fee schedule – fee schedules are required to be disclosed under N.J.A.C. 11:24C-4.3(b). This section applies when the carrier is making that previously disclosed fee schedule available to a third party.

The Department disagrees that the requirement imposed on carriers by N.J.A.C. 11:24C-4.3(c)5ii that all third party lessees of a carrier's network be contractually obligated to comply with all of the terms of its provider agreements is inconsistent with N.J.A.C. 11:24C-4.3(c)5v and vii, which refer, respectively, to " the discount" and "a provider's discounted rate." Rather, these references to "discount" refer to the discounted rate the provider agrees to accept from the carrier under the terms of the provider agreement.

In practice, these provisions would apply as follows: Carrier A enters into a contract with Provider including discounted payments and a right to grant third parties access to the contract. Carrier A subsequently agrees with Carrier B to lease its network, including Provider's contract. Patient insured by Carrier B goes to Provider. Carrier B pays according to the terms of Carrier A's contract with Provider, including discount, and notes on remittance advice to provider that Carrier A's contract is the source of the discount.

29. COMMENT: Four commenters addressed proposed N.J.A.C. 11:24C-4.3(d), which requires carriers to notify providers 90 days before implementing any adverse change or amendment to an agreement. One commenter stated that this provision would serve to protect providers and consumers because it would ensure that providers are not subject to any penalties

or limitations that would affect their ability to continue serving New Jersey residents or impact the viability of their organizations. One commenter stated that it is not clear who determines whether a change is adverse, or whether amendments or changes that are not considered "adverse" can be made in agreements without prior notice, hence making it critically important to have more explicit language in this provision. This would allow carriers a "loophole" to make amendments or changes they could claim are not "adverse" without notifying providers, and thus completely circumvent the spirit of this provision.

RESPONSE: The rule provides a definition of “adverse change,” including examples. Providers have recourse to the Department if carriers make changes that in fact materially adversely affect them without first meeting the requirements of the rule. The rule does not require carriers to provide advance notice of non-adverse changes, but the parties to provider contracts are free to include such a notification requirement in the contract.

30. COMMENT: Two commenters stated that proposed N.J.A.C. 11:24C-4.3(d) appears to allow providers to terminate the agreement at any point within the 90-day timeframe with little or no advance notice to the carrier or the consumer. Immediate termination by providers with no notice to the carrier would, however, adversely impact patients who benefit from notice and predictability in the network status of their physicians and other health care providers. One commenter suggested an alternative approach, which would require a period for negotiation, after notice of an adverse change, and if the negotiation does not result in an agreement, then require a 90-day notice by the provider before the effective date of the change.

RESPONSE: The commenters misunderstand the requirement. It does not permit terminations without notice. The substantive requirement in N.J.A.C. 11:24C-4.3(d) is that the carrier must provide at least 90 days advance notice of an adverse change. N.J.A.C. 11:24C-

4.3(c)3 requires that an agreement permitting the carrier to make a unilateral change must provide sufficient notice for termination by the provider to occur in advance of the effective date of the adverse change. Taken together, a contract may include a requirement for advance notice of termination by a provider, so long as the period in which the provider must provide notice of termination is short enough, and the carrier notice of material change long enough, that the provider can effectively exercise a right of termination after receiving the notice and before the change takes effect.

31. COMMENT: One commenter stated that the 30-day turnaround time for carriers to deliver agreements to participating providers at proposed N.J.A.C. 11:24C-4.3(f) seems excessive. The commenter recommended that this time frame be reduced to 10 days to help avoid any misunderstandings or other problems that may otherwise occur without more timely provision of this critical documentation.

RESPONSE: The Department notes that providers will have access to contracts prior to their execution and maintain copies of those until such time as fully-executed contracts are delivered. No change is being made.

32. COMMENT: One commenter addressed the proposed provider reimbursement provision at N.J.A.C. 11:24C-4.4. This provision requires that when participating providers are reimbursed on a basis other than fee-for-service, the agreement shall specify the "dollar amount **or** methodology used by the carrier to determine reimbursement, and identify the services included in and excluded from the alternate reimbursement methodology." The commenter stated that it is unclear why the Department is not requiring the carrier to disclose both the dollar amount and the methodology used to determine reimbursement. The commenter further stated that this provision should also require that the agreement include the actuarial basis for how the

capitation payment (or alternate reimbursement methodology) was developed. The commenter also noted that in the 2009 proposal the Department would have required the carriers to identify the "services included and excluded" from the alternate methodology, stating that this is essential as it provides physicians with a clear understanding of what services are actually included in the payment under the network agreement.

RESPONSE: Fees may be described as a fixed amount, such as $X for CPT code 12345, or by reference to some methodology, such as 105 percent of an amount based on Medicare's Resource-based Relative Value Scale. In the latter case, the actual dollar amount may change; for example, if Medicare's reimbursement is changed. It would therefore not be practical to specify the actual dollar amount, which could change over time. The Department does not see value in requiring a description of how fees were developed. It is the resulting amount that either is or is not acceptable, and which forms the basis of the contract.

33. COMMENT: Several commenters addressed proposed N.J.A.C. 11:24C-4.5, Content and availability of provider network directories. One commenter requested clarification of the Department's definition of "practice limitations" as that term is used at N.J.A.C. 11:24C-4.5(b). The commenter stated that its non-electronic directory currently contemplates practice limitations to mean patients age 12 and older.

RESPONSE: No change is being made. As proposed, the rules at N.J.A.C. 11:24C-4.2 include a definition of "practice limitation."

34. COMMENT: Three commenters addressed proposed N.J.A.C. 11:24C-4.5(c), which requires that directories contain a listing of the carrier's in-network hospital outpatient facilities by the types of services the facilities provide and, where applicable, advise members that not all outpatient service providers located at in-network hospitals are in-network providers. One

commenter stated that in the era of reform and transparency, specifically excluding hospitals from sections of directories whereby other free-standing entities are listed undermines the competitive nature of the business. The commenter stated that directories should be aggregated by the type of services provided to a carrier's membership, not by the type of facility providing the services.

Two commenters noted that this provision places the burden on the carrier to provide notice that certain providers in a facility may be out-of-network. The commenters stated that the statement may not provide consumers with a clear picture when they are accessing services at in-network facilities. One commenter stated that it should be the responsibility of the non-participating providers or the facility to provide notice directly to consumers regarding network affiliation. According to the commenter, this would be more effective than a general disclaimer from the carrier in a network directory. One commenter added that unless the Department, in conjunction with the Department of Health, addresses this issue with providers at the point of service, the statement will not address this problem. Also, in light of ongoing consumer concerns regarding non-participating providers at in-network facilities, it is also incumbent on providers to accurately and properly disclose the network status of all providers performing services at an in-network hospital or facility. The commenter requested that the Department work with the Department of Health to enhance consumer access to the network status of such providers.

RESPONSE: The Department notes that the norm in the production of provider directories is to segregate listings by type of provider rather than type of service, and the rule is consistent with the norm. The Department agrees that consumer awareness would be maximized if all interested parties identified the network status of the practitioners. As the commenter

points out, DOBI does not regulate providers. Health plan members use provider directories for the purpose of accessing network providers, so it is appropriate that the directory identify instances where, despite seeking care at a location listed in the network directory, the member may nevertheless be offered treatment by out-of-network practitioners.

35. COMMENT: Three commenters addressed proposed N.J.A.C. 11:24C-4.5(e), which requires carriers, upon request, to provide current printed directories to members and prospective members within five business days of the request. One commenter stated that the timeframe for response should be measured by the carrier's receipt of the request, not the date the request was sent or mailed to the carrier. The commenter further stated that some carriers have moved away from mass producing directories and would prefer to do individual printing based on specific requests; however, this takes more time to produce the directory and to fulfill the request. The commenter added that one carrier noted that once an order is placed, it is generally processed within 48 hours and then is released into the United States Postal mail stream, but that process may take up to 10 business days before receipt. Accordingly, the commenters requested that carriers have at least 10 business days to comply with these requests.

Two commenters recommended that the Department amend this provision to clarify that a carrier may allow for a customized response to a request for a printed provider directory, including only providers who practice in a specific specialty or in certain geographic areas. The commenters indicated that the full version of a printed directory will contain over 30,000 physicians, hospitals, and other health care providers and services. This would provide a plethora of information that would not be useful to consumers. The commenters stated that carriers should be permitted to limit the scope to providers within a certain radius from the requesting enrollee. Further, if it is clear from the request that it is for a specific provider type or

facility, the carrier should be permitted to limit fulfillment of the request to that provider or facility type.

RESPONSE: The Department agrees the time period for supplying a printed directory should be measured from the date of the carrier's receipt of the request to the date of mailing, which date is referenced in the rule as proposed, and is making that clarification upon adoption. The Department does not agree that it is reasonable to make requesters wait 10 business days, plus mailing time on both ends, to obtain a listing of their network providers.

Carriers are free to tailor the scope of the response to the scope of a request for a printed directory, but may not make assumptions about the scope of the request if a broad request for a network directory is received. Accordingly, no change is being made to the rule on this issue as requested by the commenters.

36. COMMENT: Three commenters addressed the proposed requirement at N.J.A.C. 11:24C-4.5(g) requiring carriers to maintain a history of their electronic directories for three years. One commenter stated that it preserves printed directories for 10 years, and that maintaining the electronic directory is duplicative and unnecessary. One commenter stated that it maintains a provider network of more than 30,000 providers, many of whom enter and exit the network periodically or make changes to their demographic information, including address and phone number changes. It would be overly burdensome and costly to require a carrier to maintain three years' worth of changes to the provider network. In essence, a carrier would be required to maintain thousands of versions of the provider directory over that time period, and the commenter indicated that it does not currently have the capabilities to do so. One commenter suggested that the Department consider a middle ground of quarterly snapshots of network directories.

RESPONSE: Carriers are required to maintain sufficient books and records to show compliance at any point in time, and this includes compliance with network adequacy requirements. The rule expressly does not require maintenance of the specific directory, but provides that this requirement may be met by a capability of reconstructing a directory as it existed on a given date. Carriers should currently be maintaining records of participating providers, together with effective dates and any termination dates. Consequently, reconstruction capability should not be overly burdensome.

37. COMMENT: Several commenters addressed proposed N.J.A.C. 11:24C-4.6, Standards for accuracy of provider directory information. One commenter commended the Department for addressing the issue of network directories. The commenter stated that accurate directories are essential for consumers to have current information to access providers participating in a particular network and necessary for physicians to make appropriate and accurate referrals for their patients. The commenter especially thanked the Department for incorporating one of its previous recommendations that carriers include in their process for updating network directories the most current information on providers received by CAQH.

The commenter went on to say that an additional concern is the ability of patients to have "true" access to care; simply ensuring accuracy does not provide patients with adequate access. The commenter recommended the Department consider an additional measure – if a patient can document that he or she is unable to make an appointment within a reasonable amount of time with an "in-network" specialist, who is within a reasonable distance and possesses the expertise to address their health concern, then the carrier must allow the patient to obtain services from an out-of-network provider who can provide the needed services and see the patient more promptly. This should be at no increased cost to the patient (that is, there is an agreement that the patient

only pay the cost of seeing an in-network provider and the carrier must cover the full fee of the out-of-network provider).

RESPONSE: The Department thanks the commenters for the comments. The comment regarding the ability to schedule a timely appointment with an in-network provider is outside the scope of the proposal. However, existing rules at N.J.A.C. 11:24-6.2 regarding network adequacy requirements, and N.J.A.C. 11:24-5.1, requiring HMOs to limit member cost-sharing to the in-network cost when referring members to out-of-network providers, including referrals due to inadequate network access, address the concerns noted in the comment.

As is the case with all DOBI rules, the Department will monitor carrier conduct for compliance with the rules. The Department also encourages anyone aware of an infraction to bring the matter to its attention.

38. COMMENT: Two commenters addressed proposed N.J.A.C. 11:24C-4.6(a), requiring carriers to implement a system for maintaining accurate and current information on all providers listed in a network directory. The commenters recommended that the Department include a requirement that providers submit an attestation as to the accuracy and validity of the data submitted to carriers. CAQH allows providers to ensure the accuracy and validity of their information, and, ultimately, it is incumbent upon them to provide accurate and complete information to carriers. The commenters requested that such an attestation of accurate data be made periodically to ensure that carriers have the most up-to-date information for the benefit of their members. The commenters stated that it would be burdensome and costly for carriers to request updated directory information periodically from providers. Instead, the commenters suggested that CAQH be used for physicians and health care professionals to update their attestations on a quarterly basis. If CAQH is not used or not mandated, one commenter stated

that the proposal imposes significant burdens and costs on the carrier in contacting the entire provider network for updates.

RESPONSE: The Department is unaware of problems with providers inaccurately self-identifying, and has no authority to regulate provider behavior. Based upon comments made on the prior proposal, the Department has greatly reduced the number of verifications of provider data that plans are required to make, both in number and interval, from those contained in the previous proposal. The rule strikes a balance between a reasonable administrative burden on carriers and the need for directory content accuracy. A provider directory is a plan's representation of the providers participating in its network, and the plan has a duty to ensure that its directory's content is accurate.

39. COMMENT: One commenter addressed proposed N.J.A.C. 11:24C-4.6(c), requiring carriers to update electronic directories within 20 days of the carrier's receipt of confirmation from a provider or the CAQH that its directory's current information on the provider is inaccurate or has changed. The commenter stated that the standard time frame for such updates is 30 days. The commenter stated that implementation of the proposed requirement would place unnecessary administrative and financial burdens on carriers when the current time frame for electronic updates sufficiently meets the goal of timely notification to consumers of changes in a carrier's provider network.

RESPONSE: The commenter did not identify the source of the purported standard or explain why it is an appropriate standard. The Department believes 20 days affords carriers sufficient time to make the necessary revisions to their electronic directories. No change is being made.

40. COMMENT: Four commenters addressed proposed N.J.A.C. 11:24C-4.6(d) requiring carriers to confirm the participation of any provider who has not submitted a claim for a period of 12 months or otherwise communicated with the carrier in a manner evidencing the provider's intention to continue to participate in the carrier's network and for whom no change in provider status has been reported by CAQH. One commenter urged the Department to shorten the time frame to four months as was proposed in the Department's original proposal. The commenter questioned whether a 12-month lapse in claims submissions is a robust enough standard to ensure that directories are accurate and up to date.

RESPONSE: The primary obligation for reporting changes in their status to carriers rests with providers. If a provider does so, the rule requires carriers to update electronic directories within 20 days. The 12-month status check applies only in those instances where a provider has failed to provide such notification, to submit a claim, or to have otherwise made contact with a carrier in a way that indicates its intention to continue as a participant in the network. The likelihood that a low-volume provider is nevertheless still participating in a network decreases with the amount of time that elapses with no claim activity or other contact having been made by the provider. The 12-month period strikes a balance between ensuring directories are fairly up-to-date and placing a reasonable administrative burden on insurers.

41. COMMENT: Two commenters requested clarification that the requirements of proposed N.J.A.C. 11:24C-4.6(d) apply to provider groups rather than individuals, as providers often submit claims under a group Taxpayer Identification Number (TIN). The commenters stated that in such situations, it would not be possible for a carrier to know if an individual provider has not submitted any claims since claims would continue to be submitted by other providers under the group TIN.

RESPONSE: The Department disagrees. The CMS 1500 claim form, the paper standard format for claims by providers (see N.J.A.C. 11:22-3.3(b)), captures identifying numbers for both the rendering and billing physicians. Carriers should not make representations that specific practitioners are available to render services as in-network providers without knowledge that they are in fact so available.

42. COMMENT: Three commenters indicated that meeting the requirements of N.J.A.C. 11:24C-4.6(d) would be onerous and expensive to carriers, and urged that this provision be removed. One commenter stated that, in effect, this provision requires carriers to measure participation every day of the year. If the provision must be retained, the commenter suggested that it be modified to require plans to check on a date or dates certain. Further, the commenter pointed out that network directory accuracy depends on proper communication between carriers and providers, and a provider must be responsive to a carrier's request checking a provider's participation status. The commenter stated that carriers cannot be solely responsible for accuracy.

RESPONSE: The Department disagrees that compliance would require measuring participation every day of the year. A carrier could, for example, review on a quarterly basis providers who have not communicated with the plan over the preceding nine months. The rule does not require absolute accuracy; rather, it requires that plans act on the information they do have. While the Department recognizes that accurate directories rely on effective communications between carriers and providers, carriers who affirmatively represent that their network consists of the providers in their directories have a duty to ensure that the information in their directories is accurate and not misleading.

43. COMMENT: One commenter stated that the negative impact on providers when networks are taken over by new entities or changed by mergers and acquisitions is only partly addressed by the Department's proposed rules. The commenter stated that it receives frequent complaints from member providers that they are never appropriately notified when one network is acquired by, or merged with, another network. Most become aware of this because practices or policies appear different, and when they contact the carrier they are informed about the change and told that they are bound to the policies under the "new" network because they signed a provider agreement with the network that was acquired, even though the terms are different. According to the commenter, providers are being held to terms they never agreed to and were never informed about as a result of a merger or acquisition. The commenter stated that this issue must be addressed explicitly in the Department's regulations. The commenter recommended that providers be notified in any instance of a merger or acquisition that would change the terms under which they currently operate, particularly when it involves differences in fee schedules, and that they be given the opportunity to withdraw from the network.

RESPONSE: Having the rules explicitly address the effects of a merger or acquisition of a carrier is beyond the scope of this proposal, but the Department fails to see how, in the absence of contract language that reflects the agreement of the provider to be bound by revised terms in the event of such a development, the mere occurrence of a merger or acquisition can justify the imposition of different contractual terms upon providers, and urges the commenter to furnish the Department with additional information to determine whether a separate rulemaking is warranted. If the compensation due to a provider under the terms of an agreement that does not contain such language but that permits unilateral changes was reduced due to a merger by or acquisition of a carrier, such a reduction would constitute an adverse change requiring the

provider to be afforded the opportunity to terminate the contract in accordance with N.J.A.C. 11:24C-4.3(c)3.

Federal Standards Statement

A Federal standards analysis is not required because the Department's adopted new rules, repeals, and amendments addressing provider network agreements entered into by health care providers and carriers are not subject to any Federal standards or requirements.

Full text of the adopted amendments and new rules follows (additions to proposal indicated in boldface with asterisks *__thus__*; deletions from proposal indicated in brackets with asterisks *[thus]*):

11:24C-4.1 Purpose and scope

(a) – (b) (No change from proposal.)

(c) On and after *[the operative date of its adoption]* ***January 1, 2014***, this subchapter shall apply to all newly entered agreements and all renewals of previously existing agreements.

11:24C-4.3 Provider agreements

(a) (No change from proposal.)

(b) For provider agreements for which fees are not individually negotiated, carriers shall make available to network providers and prospective network providers all complete fee schedule(s) that are or are to be included in their agreement. Fee schedules shall be supplied in writing unless the carrier makes the fees for included CPT or HCPCS codes available on their website or otherwise makes them available electronically to providers.

1. When a provider is contemplating participating in multiple health benefits plans offered by a carrier and such plans have different fee schedules, the carrier shall provide the complete proposed fee schedule(s) applicable to that provider for each plan in which the provider participates ***or plans to participate***.

(c) - (f) (No change from proposal.)

11:24C-4.5 Content and availability of provider network directories

(a) – (d) (No change from proposal.)

(e) Upon request, carriers shall provide their current printed directory to members and prospective members of the health benefits plans offered by the carrier. The requirement to supply printed directories upon request may be complied with by printing and mailing the most current version of the on-line directory applicable to a particular member's plan in lieu of periodic publication and stocking of hard copy directories. The carrier shall mail a copy of the printed directory to a member or prospective member within five business days of the request ***measured from the date of the carrier's receipt of the request***.

(f) – (h) (No change from proposal.)