BULLETIN
OMC 2000-001

TO: **All Health Maintenance Organizations Doing Business in New Jersey and all New Jersey Hospitals**

FROM: **Marilyn Dahl, Acting Senior Assistant Commissioner, New Jersey State Department of Health and Senior Services**

DATE: **June 1, 2000**

RE: **Compliance with N.J.S.A. 26:2J-11.1 (Continuity of Care)**

It has come to the attention of the Department of Health and Senior Services (Department) that not all parties subject to the provisions of N.J.S.A. 26:2J-11.1 are aware that they are subject to compliance with the provisions of the statute. In addition, it has come to the Department's attention that not all parties which are aware of the application of N.J.S.A. 26:2J-11.1 are complying with the terms of the statute properly. Finally, the Department understands that not all parties subject to the statute are fully aware of the Department's interpretation of the statute. The Department intends to clarify its position with respect to N.J.S.A. 26:2J-11.1 through this bulletin.

N.J.S.A. 26:2J-11.1 states the following:

> "If a health maintenance organization authorized to operate in this State…and a general hospital…with which the health maintenance organization has a contract to provide services to its enrollees, are unable to agree on the terms of a new contract upon the expiration of the current contract, the hospital and the health maintenance organization shall continue to abide by the terms of the most current contract for a period of four months from a severance date mutually agreed upon by both parties. In that event, the health maintenance organization shall promptly notify the health care providers with which it has contracted to provide services and provide notification within the four-month extension period to those of its enrollees who reside in the county in which the hospital is located or in an adjacent county in writing as to the extension of the terms of the most current contract, and shall in the notice to its enrollees advise them of the options available to them with respect to their health care coverage."

The Department interprets the statute as follows:

1. N.J.S.A. 26:2J-11.1 applies equally to the hospital and the health maintenance organization (HMO) in establishing an obligation to abide by the terms of the statute.

The Department does not take the position that the statute applies solely to HMOs. Rather, the Department understands N.J.S.A. 26:2J-11.1 to apply to both parties to the contract at issue, and to be enforceable against both the HMO and the hospital(s) involved.

2. N.J.S.A. 26:2J-11.1 applies regardless of the reason that the contract is terminated, or the timing of the termination.

The Department does not believe that the basis for, or timing of, the termination is determinative of when the obligation to comply with the statute arises. In other words, the Department does not believe that it matters whether the contract is cancelled mid-term, or non-renewed, nor whether the termination is with or without cause. Rather, the fact that HMO enrollees will no longer have access to a hospital, and consequently, may no longer have continuing access to certain other health care practitioners, creates the obligation set forth under the statute.

3. N.J.S.A. 26:2J-11.1 applies regardless of which party to the contract initiates the termination.

The Department does not believe that the party initiating the termination is determinative of when the obligation to comply with the statute arises. In other words, whether it is the HMO that seeks to terminate the contract, or the hospital that seeks to terminate the contract, the statute applies, and applies equally to both parties.

4. N.J.S.A. 26:2J-11.1 applies to all products that the HMO underwrites, including Medicare, Medicaid and POS contracts.

The Department does not believe that the application of the statute is limited to only certain products underwritten by the HMO. In addition, the Department does not agree that the HMO and hospital may limit the applicability of the statute by language in the provider agreement. The Department notes that compliance with the terms of the statute does not mitigate any other notice requirements or obligations that may exist for an HMO with respect to its Medicare and/or Medicaid enrollees, or the health care providers providing services to those enrollees.

5. N.J.S.A. 26:2J-11.1 applies when the contract may not technically terminate, but the contract is substantially modified to eliminate the access of a class of an HMO's enrollees to one or more hospitals in the HMO's network, whether such modification occurs at the request of the HMO or the hospital(s).

As stated previously, the Department believes that the determinative factor as to whether the obligations under the statute apply is predicated on whether HMO enrollees will no longer have access to a hospital, and consequently, may no longer have continuing access to certain other health care practitioners. In addition, the Department believes that the obligations of, and consumer protections offered by, the statute arise even when only one segment of an HMO's enrollees (for instance, Medicare or Medicaid enrollees) lose access to a hospital as a network facility because the HMO and hospital have agreed that the hospital will no longer be a participating facility for that segment of enrollees. The Department believes that this assures that all enrollees are afforded the protections intended by the statute.

6. N.J.S.A. 26:2J-11.1 requires that access to the hospital during the four-month extension period is access as usual, and is not limited to enrollees engaged in a continuing course of treatment.

The Department does not believe that the statute limits in any way the services that an enrollee may obtain from a hospital that continues to be in the HMO network by virtue of the

four-month extension period. The terms of the contract that have been extended are applicable throughout the duration of the extension period.

7. N.J.S.A. 26:2J-11.1 requires that the date of termination, and thus, the beginning date of the four-month extension period, cannot be earlier than the date of actual termination of the contract.

The Department does not believe that the extension period can be determined to have begun until the date that the contract has actually been terminated (or, in the case of a purported modification in which a segment of HMO enrollees lose access to a hospital, the date of the modification). Notice of an intent to terminate a contract is not the equivalent of an actual termination, except in those rare instances in which the contract between the HMO and hospital dictate that the date of notice of termination, and the effective date of termination may be one and the same. The extension period and a prior notice of termination period shall not run concurrently.

8. N.J.S.A. 26:2J-11.1 permits the four-month extension period to be extended beyond four months if mutually agreed upon by both parties.

The parties to the contract may, at their option, elect to have the extension period exceed four months for whatever reason, if both agree to the option, without incurring any additional obligations under N.J.S.A. 26:2J-11.1. However, the Department believes that all of the terms of the prior contract must be abided by for the full duration of the extension period agreed upon, even when the extension period exceeds the required four months.

9. N.J.S.A. 26:2J-11.1 requires that all terms of the current contract are to be continued during the four-month extension period, including compensation and hold harmless provisions.

The Department believes that the statute plainly states that the parties will abide by all of the terms of the contract during the extension period.

10. If an HMO enrollee is admitted to a hospital prior to the end of the extension period, the HMO remains obligated for the costs for the covered services incurred by that enrollee until the enrollee is discharged from the hospital, the enrollee's coverage terminates, or the enrollee's coverage limits under the health benefits plan are reached, whichever occurs first, but only to the extent of the rate agreed upon by the hospital and the HMO in the contract under which the extension occurred.

To the extent that an enrollee is admitted to a network hospital, and is unable to be discharged from that hospital prior to the date that the hospital ceases to be a network facility for that enrollee, but the enrollee continues to be covered under the HMO's health benefits plan, and has benefits available under that plan, the HMO shall not determine that its liability for the admission has ended with respect to that enrollee. Likewise, the hospital may not bill or balance bill the enrollee for charges in excess of what the HMO agreed to pay for that enrollee pursuant to the contract under which the enrollee was admitted, except as copayments (deductibles, or coinsurance) may apply. (Situations in which the enrollee's health benefits plan terminates and is replaced with another health benefits plan issued by a different HMO or other carrier are subject to N.J.A.C. 11:2-13.)

11. The Department believes that the statute is enforceable against both HMOs and hospitals.

The Department may assess a penalty against either party in violation of N.J.S.A. 26:2J-11.1 in an amount of no less than $250 per day per violation, and no more than $10,000 per day per violation, in accordance with N.J.S.A. 26:2J-24.

It may be noted that the statute does not indicate a timeframe for providing notice to other health care providers and enrollees. However, rules at N.J.A.C. 8:38-3.5 do. Specifically, HMOs are required to provide notice of the termination and four-month extension period within the first 15 business days of the four-month extension period to both health care providers and enrollees. Such notice is required to advise both health care providers and enrollees of the health care options available *during the extension period as well as after the extension period*, the date the extension period will end, the consequences of the ending of the extension period, and the process that the enrollee and health care provider must follow to ensure that coverage under the HMO contract is maintained in full.

Questions regarding this bulletin may be submitted to Elisabeth Salberg, Director of the Office of Managed Care (phone: 609-633-0660), or Maura Johnston, Director of Health Care Financing Systems (phone: 609-984-7639).