BULLETIN
OMC 2003-01

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

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

DATE: **April 4, 2003**

RE: **Hospital Terminations: Notice Requirements and Calculation of the Start of the Four-Month Statutory Extension Period**

The Department of Health and Senior Services ("Department") is issuing this bulletin to remind Health Maintenance Organizations ("HMOs") of their regulatory obligations regarding termination of a hospital contract, and to clarify the Department's position regarding the issues of: prior notice to the Department and the Department of Banking and Insurance ("DOBI") of a termination; notice to members and other health care providers of a termination and its effects; and, calculation of the statutory four-month extension period when the date of termination is in dispute. Also, the Department is clarifying what the Department means when it refers to "terminations."

Termination

When the Department uses the terms "terminate" or "termination" in reference to contractual relationships, the Department does so using the terms' commonly understood meanings; that is, to bring something to an end. The Department uses the terms globally to include all methods that may be employed to accomplish the goal of terminating a contract, including "cancellation," "expiration" and "nonrenewal." The Department uses the terms to include all actions or omissions, active or passive, that result in a contractual relationship coming to an end. HMOs should not assume that the use of the term is somehow exclusive to, or exclusionary of, one or more methods resulting in a contractual relationship ending.

Requirement to Provide Notice of a Termination to the Department and DOBI

Termination of a hospital contract, through whatever means, represents a substantial change that requires 30-days' prior notice to the Department and DOBI in accordance with N.J.A.C. 8:38-2.7(a). Some HMOs have argued that they do not need to provide 30-days prior notice pursuant to N.J.A.C. 8:38-2.7(a) because that rule only applies to nonrenewals, and not other types of terminations. The argument is unfounded. N.J.A.C. 8:38-2.7(a) provides an illustration of events that constitute substantial changes requiring prior reporting, and specifically mentions nonrenewals of

hospital contracts at N.J.A.C. 8:38-2.7(a)3. However, the language of N.J.A.C. 8:38-2.7(a) is clear that the listed circumstances are not exhaustive. The practical outcome of a termination of a contractual relationship with a hospital will be the same regardless of whether the termination results from a nonrenewal, expiration or cancellation of the contractual relationship for whatever reason(s). The obligation to report arises on the basis of the possible loss of the contractual relationship, and not on *why or how* the loss of the contractual relationship may occur.[1] The Department is not persuaded by arguments that only some hospital terminations are reportable.

Some HMOs have argued that they are unable to predict a contract termination date when they have entered into good faith negotiations with a hospital following notice of an intent to (actively or passively) allow the contract to terminate. The HMOs argue that they cannot meet the 30-day prior notice requirement practicably, and so should not be held accountable to it. The Department disagrees, and is not persuaded by such arguments. The date of scheduled termination is always predictable; it is the outcome of the negotiations that is unknown. HMOs should structure their activities accordingly.

It may be that an HMO and hospital agree to postpone a scheduled termination date. If they do so at least 30-days prior to the date of the scheduled termination, the postponement is evidenced in writing, and is unequivocal in its terms, then the HMO may be within its rights to forestall providing notice of the originally-scheduled termination to the Department and DOBI.[2] This could go on indefinitely, so long as there is at least a 30-day window between each scheduled termination date that allows the HMO an opportunity to meet its regulatory requirements. However, the Department's experience is that this is not typically the case. It is always in the HMO's best interest to provide notice of the scheduled termination when the HMO first receives (or issues) the notice of termination.[3]

For purposes of determining whether an HMO has met its 30-day prior notice requirement pursuant to N.J.A.C. 8:38-2.7(a), the Department will not take into consideration: whether the parties entered into negotiations following the notice of

[1] If, based on the information most recently available to the Department, it appears that the loss of the hospital may result in network access issues for the HMO's membership, the Department will request that the HMO submit a network analysis using the assumption that the contractual relationship factually terminates and no new contract is effected prior to the end of the statutory four month extension period.

[2] The Department will penalize an HMO that obtains a postponement only after the scheduled termination date has passed. The Department typically will penalize an HMO that obtains a postponement less than 30 days prior to the scheduled date of termination being postponed. Either situation is evidence that the HMO failed to provide timely notice of the scheduled termination.

[3] The Department is also aware that not all notices of termination are factually valid. However, unless this issue is raised by the HMO to the hospital (and brought to the attention of the Department), the Department will take the position that the HMO has accepted the notice of termination notwithstanding its imperfections, and will not consider the validity of the notice when determining what date was appropriate for agency notice by the HMO.

termination; whether the negotiations are pursued in good faith; whether the parties agree that negotiations result in the termination date being explicitly delayed until some other specified date (except as the explicit postponement meets the standards specified in the preceding paragraph); or, whether the parties agree that the negotiations result in the termination date being implicitly delayed until both parties agree that negotiations are fruitless.

Furthermore, the Department will not release an HMO from its 30-day prior notice obligation with respect to contractual relationships that have not been reduced to writing, notwithstanding that the hospital failed to provide the HMO with at least 30-days prior notice of the intent to terminate the contractual relationship. The Department will not take into consideration whether the HMO believes that a hospital has violated an unwritten term of a contractual relationship, merely whether the HMO provided the appropriate notice to the Department and DOBI. However, it should be noted that, because hospitals and HMOs are both aware that the Department is entitled to at least 30-days prior notice of a termination pursuant to N.J.A.C. 8:38-2.7(a),[4] the Department believes that both the HMO and the hospital have an obligation to structure and treat their contractual relationship(s) accordingly. Thus, while the Department will not consider whether a notice to effect an immediate termination is valid, the Department will impose obligations on both the HMO and the hospital to assure that HMO members are provided with at least a full four month period during which the contractual relationship between the HMO and hospital will be extended, and the terms of the contractual relationship remain in force and effect on both parties, in accordance with N.J.S.A. 26:2J-11.1, and will do so by administrative order against both the hospital and the HMO, if necessary.

Requirement to Provide Written Notice of Termination and Statutory Four Month Extension Period to Members and Health Care Providers

HMOs are required to provide members and health care providers notice of a termination of a contractual relationship with a hospital, as well as notice of the statutory extension period during which the members and health care providers may continue to access services at the hospital in accordance with the terms of the now-terminated contract. The notice needs to be sent to members residing in the county where the terminating hospital is located, and members residing in contiguous counties. This requirement is set forth at N.J.S.A. 26:2J-11.1, and is further described at N.J.A.C. 8:38-3.5(e).

[4] Multiple hospitals have amply evidenced their knowledge of HMO obligations to provide prior notice of terminations to the Department, as has the New Jersey Hospital Association ("NJHA"). In addition, at the request of NJHA, Department representatives have made presentations to the NJHA and its membership regarding various rights and responsibilities of HMOs and hospitals with respect to terminations.

The HMO's regulatory obligation to provide notice to members and health care providers does not arise until actual termination of the contract is effective. Pursuant to N.J.A.C. 8:38-3.5(e), HMOs are to provide notice to members and health care providers within 15 business days following the date of termination of the contract. It is not necessary under statute or regulation for HMOs to provide prior notice of a scheduled termination to members or health care providers, because, of course, the scheduled date of termination may change multiple times in the course of negotiations, and factually may never occur.[5] Sending notice to members of a termination before the termination is effective tends to create anxiety for members and health care providers that may be unwarranted, and often results in multiple notices having to be sent to amend information that is no longer accurate, which may only confuse matters for members and health care providers.

Although the Department does not require HMOs to submit the member and health care provider notices to the Department for approval in normal course, the Department strongly encourages HMOs to submit their notices for Department review at some point prior to the scheduled date of termination to assure that the notices are appropriate. If the Department becomes aware that an HMO has issued a notice that does not provide all of the required information, or that is worded in such a nature as to be misleading regarding the members' rights to continue to access the terminated hospital, the Department will require the HMO to issue an amended notice.

Written notices to members need to provide the following information:

- The date the statutory four-month extension period begins;
- The date the statutory four-month extension period ends;[6]
- The other hospitals located in the county where the terminated hospital is located, and hospitals located in contiguous counties;
- A statement that the member can continue to access services at the terminated hospital for the duration of the extension period;
- A statement as to what members are to do regarding accessing hospital services once the extension period has ended;
- A statement as to who at the HMO members should contact in the event that the member needs more information, and instructions on how to make contact.

It is not necessary for written notices regarding a hospital termination to address the issue of physician termination, unless there are physicians in the HMO network

[5]Most of the time, a notice from one party to the other evidencing an intent to terminate the contractual relationship moves into a negotiation stage, and most negotiations are fruitful, resulting in renewed, amended or new contracts, without any need for notice of termination to be sent to members.

[6] Obviously, if the contract is being extended beyond the statutorily-required four month period, the date the extension actually ends should be stated instead.

whose participation is co-terminous with the hospital's participation. It should be noted that, in general, the Department does not assume that any physician's participation terminates as of the same date that a hospital terminates. Rather, for those physicians whose participation is contingent on having admitting privileges at a network hospital, and who have admitting privileges only at the terminated hospital, the Department assumes that the physicians continue in the HMO's network as a matter of course until the end of the extension period for the terminated hospital. During that period, the physician may obtain privileges at another hospital, or make other acceptable arrangements under the terms of the provider contract for admissions at another hospital within the HMO's network, and thus, may not be terminated solely on the basis of admitting privileges. If not, and termination of the physician's contract becomes effective, then the HMO would send out notice to members utilizing the physician(s) now terminated, with appropriate information regarding continuity of care and transition of care to other practitioners.

Nothwithstanding the Department's general position, the Department recognizes that some HMOs may have provisions for co-termination of hospitals and physicians, or other reasons why they believe it to be necessary or appropriate to provide information about potential physician terminations within the notice to members regarding hospital terminations. In such a scenario, HMOs must assure that the information provided is accurate regarding the transitioning of care and continuity of care, and the duration thereof, consistent with the time frames set forth at N.J.S.A. 26:2S-9.1.

Written notices to other health care providers regarding the hospital termination must include the following information:

- The date the statutory four-month extension period begins;
- The date the statutory four-month (or later) extension period ends;
- The other hospitals located in the county where the terminated hospital is located, and hospitals located in contiguous counties;
- A statement that the health care provider can continue to refer members to the terminated hospital for the duration of the extension period;
- A statement about how to refer members for hospital-based services once the extension period has ended;
- A statement as to who at the HMO health care providers should contact in the event that the health care provider needs more information about providing services to members, and instructions for making contact;
- A statement regarding the impact that the hospital termination may have upon health care providers that have privileges only at the terminated hospital, including information regarding transitioning of member care to other participating health care providers, and continuity of care obligations, consistent with the requirements of N.J.S.A. 26:2S-9.1, in the event that the health care provider is terminated;

- A statement explaining how health care providers that only have admitting privileges at the terminated hospital may avoid an adverse impact from the hospital's termination.
- A statement as to who at the HMO a health care provider should contact regarding the possible adverse impact on the health care provider's participation status, and instructions for making contact.

The Department does not prohibit HMOs from including in the notices to members or health care providers language that encourages them to start seeking hospital-based services through hospitals other than the terminated hospital before the extension period comes to a close. However, in no event may the language be such that members or health care providers would reasonably conclude that they will be considered to have accessed out-of-network hospital services when they use the terminated hospital prior to the end of the extension period.

Calculation of the Beginning of the Statutory Four-Month Extension Period when the Parties are not in Agreement about the Termination Date

The Department recognizes that sometimes there are disagreements as to whether and/or when the contractual relationship actually terminated. When there is disagreement as to whether a contract has terminated, with one party arguing that it has, the Department will assume that the contract has terminated. In doing so, the Department's intent is not to take the side of one party over the other. Rather, the Department's goal is to assure that members' rights pursuant to N.J.S.A. 26:2J-11.1 are preserved, and to minimize confusion for the members, who often receive conflicting information about whether they may access services at the hospital at issue. By the time the issue reaches the Department, the agitation level of one of the party's usually is at such a pitch that the working relationship is no longer tenable, and any meeting of the minds that may have existed at one time has disappeared.[7] However, the Department takes this position solely for purposes of implementing the provisions of N.J.S.A. 26:2J-11.1. The parties are free to seek a judicial determination and remedies available through that forum on the matter.

With respect to the question of when the contract terminated, the Department will take no position in a dispute. Rather, when it is apparent that the hospital and HMO can not reach a mutually agreed-upon date of termination, the Department will make a determination of when the statutory four-month extension period begins for purposes of assuring that the rights of members are not abrogated. In doing so, the Department

[7] Experience suggests that, in these situations, typically, there was a notice of termination, followed by negotiations, with at least one agreement, often verbal, to postpone the scheduled termination date. The subsequent scheduled date of termination passes with negotiations continuing. One party usually assumes that the termination date has been postponed indefinitely while negotiations are on-going, while the other party believes that the negotiations are occurring while the statutory extension period is running, but tends not to voice this position until it perceives the statutory extension period coming to an close.

often will specify in an Order the date from which the HMO must honor the four-month extension period, and this date will usually be no earlier than the date of the Order. Depending upon the specific circumstances, the date may run from the date the notices of the termination are first mailed to members and health care providers.[8] It should be noted that the Department will not impose more than a four-month extension period from whatever date is specified in the Order; however, if an HMO contracts to provide Medicaid managed care, the HMO may have to provide a longer extension period pursuant to its contract with the Department of Human Services. HMOs in those situations should not assume that satisfaction of the Department's standards means that they have also satisfied the requirements of the Department of Human Services' contract. [9]

Of course, the HMO and hospital can continue to debate the question of the actual date of termination of the contract in a judicial setting, as well as what damages, if any, may be appropriate, so long as members are not put into the middle of the disagreement, and are otherwise treated consistently with the provisions of the statute and rules. The Department's Orders are not intended to prejudice this process.

Enforcement Action

The Department usually issues Orders regarding hospital terminations against HMOs, requiring the HMOs to assure that their members are kept whole while accessing a terminated hospital during a required extension period. The Department does not usually address the matter of how the HMO will assure that the members are kept whole (that is, treated as though they are accessing services in-network), and believes that the HMO typically has one or more avenues of recourse in the event that the hospital refuses to accept the contracted fees, and the HMO believes this action is inappropriate. However, the Department has the authority to issue Orders against hospitals to require that they comply with the statutory extension period as well. In general, the Department will not do so strictly for purposes of assuring that the hospital and HMO continue with a certain compensation arrangement. The Department will issue an Order, however, if it receives information that a hospital is billing or balance billing members for covered services while an extension period is being observed, or when a hospital is reportedly hindering or refusing to allow an HMO's members to

[8] This scenario usually only arises when it is very likely that the HMO will not be in a position to send out notices for an extended period of time following the date of the Order. This has occurred when an HMO contracted to provide Medicaid managed care, and faced significant hurdles in obtaining approval of its notices to its Medicaid members.

[9] Likewise, HMOs that are acting in compliance with the Department of Human Services' contract requirements should not assume that they have necessarily met their regulatory requirements. For example, the Department of Human Services has no standard in their contract with respect to the provision of notices to health care providers regarding hospital terminations, but all HMOs must still provide notice of hospital terminations to other health care providers because there is a regulatory requirement to do so.

access services, including seeking precertification, while an extension period is in effect. Information of this nature should be brought to the Department's attention.