IN THE MATTER OF HEALTH NET OF NEW JERSEY, INC., AND ITS UTILIZATION MANAGEMENT APPEALS PROGRAM	)))	ADMINISTRATIVE ORDER

THIS MATTER having been opened by the Department of Health and Senior Services (hereinafter, "DHSS") in accordance with the authority set forth at N.J.S.A. 26:1A-15, and N.J.S.A. 26:2J-1 et seq.;

WHEREAS, Health Net of New Jersey, Inc. (hereinafter, “Health Net”) is a health maintenance organization (hereinafter, “HMO”) issued a certificate of authority to operate in New Jersey;

WHEREAS, HMOs in New Jersey are required to comply with N.J.S.A. 26:2J-1 et seq. and N.J.A.C. 8:38, among other statutes and regulations;

WHEREAS, HMOs are required by N.J.A.C. 8:38-8.1 to have and maintain a utilization management (hereinafter, “UM”) program to monitor access to and appropriate utilization of health care and services;

WHEREAS, an HMO’s UM program shall, pursuant to N.J.A.C. 8:38-8.1(a)7 include a system for providers and members to appeal UM determinations in accordance with the procedures set forth at N.J.A.C. 8:38-8.4 through 8.7;

WHEREAS, N.J.A.C. 8:38-8.4 states that all HMO members, and any provider acting on behalf of a member with the member’s consent, may appeal any UM determination resulting in a denial, termination, or other limitation of covered health care services in accordance with the provisions of N.J.A.C. 8:38-8.5 through 8.7, and that nothing in the HMO’s policies, procedures or provider agreement shall prohibit a member or provider acting with the member’s consent from exercising the right to an appeal;

WHEREAS, N.J.A.C. 8:38-8.5 states that an HMO shall have an informal internal appeal process (hereinafter, "Stage 1"), which shall be concluded as soon as possible in accordance with the medical exigencies of the case, but within no more than 72 hours if the matter is in regard to urgent or emergency care, and within five business days in all other instances;

WHEREAS, N.J.A.C. 8:38-8.5 specifies that the 72-hour time period applies to all situations in which the member is confined as an inpatient;

WHEREAS, N.J.A.C. 8:38-8.6 states that an HMO shall have a formal internal appeal process (hereinafter, "Stage 2"), which shall be concluded as soon as possible in accordance with the medical exigencies of the case following receipt of the appeal by the HMO, but within no more than 72 hours if the matter is in regard to urgent or emergency care, and within 20 business days in all other instances;

WHEREAS, N.J.A.C. 8:38-8.6 specifies that the 72-hour time period applies to all situations in which the member is confined as an inpatient;

WHEREAS, N.J.A.C. 8:38-8.6 specifies that an HMO shall acknowledge receipt of an appeal within 10 business days after receipt of the appeal;

WHEREAS, N.J.A.C. 8:38-8.6 specifies that an HMO may extend a review regarding non-urgent or emergency care matters for an additional 20 business days if, prior to the end of the original 20 business day period, the HMO:

1. Demonstrates to the satisfaction of DHSS that there is reasonable cause for the delay beyond the HMO's control;

2. The HMO provides DHSS with a written progress report on the matter when the request for an extension is made; and

3. The HMO provides notice to the member and/or provider of the need and request for an extension;

WHEREAS, N.J.A.C. 8:38-8.6(g), states that when an HMO fails to comply with the time frames for completion of a Stage 1 or Stage 2 appeal, the member or provider acting on the member's behalf with the member's consent, may elect to proceed directly to the New Jersey Independent Health Care Appeals Program (IHCAP), rather than waiting for the HMO to complete Stage 1 and/or Stage 2[1];

WHEREAS, DHSS was presented with a request by St. Joseph's Regional Medical Center (hereinafter, "St. Joseph's") to go to the IHCAP without exhausting Stage 1 or Stage 2 of Health Net's appeal process with respect to five cases (hereinafter referred to as "1-B," "1-CB," "1-CG," "1-N," and "1-P") that had been appealed by St. Joseph's on behalf of the Health Net members, with the members' consents, setting forth the following information:

1. St. Joseph's sent a letter to Health Net dated July 27, 2002, asserting a Stage 1 appeal on behalf of 1-B, and Health Net's written decision on the appeal was dated September 13, 2002, more than five business days following initiation of the appeal There is no indication that Health Net notified St. Joseph's of Health Net's decision verbally on any earlier date;

2. St. Joseph's sent a letter to Health Net dated August 13, 2002, asserting a Stage 1 appeal on behalf of 1-CB, and as of January 22, 2003 (when DHSS notified St. Joseph's that it could proceed to file the five appeals with the IHCAP), no final determination from Health Net had been rendered verbally or in writing;[2]

[1] In addition, an HMO may waive its rights to an internal review of any appeal, and allow the member or provider to go directly to the IHCAP. Such a waiver must be made expressly.

[2] Health Net indicated in a letter dated December 10, 2002 that it originally processed this appeal as a provider appeal – to which the time frames of N.J.A.C. 8:38-8 do not apply – but had recently opened it as a Stage 2 appeal, and marked as an urgent case. Subsequent conversation with Health Net indicated that Health Net was still awaiting medical records from the hospital on this case, and had last contacted St. Joseph's about the medical records on

3. St. Joseph's sent a letter to Health Net dated August 13, 2002, asserting a Stage 1 appeal on behalf of 1-CG, and Health Net's written decision on the appeal was dated November 11, 2002, more than five business days following initiation of the appeal. There is no indication that Health Net notified St. Joseph's of Health Net's decision on any earlier date;

4. St. Joseph's sent a letter to Health Net dated July 12, 2002, asserting a Stage 1 appeal on behalf of 1-N, and Health Net's written decision on the appeal was dated October 24, 2002, more than five business days following initiation of the appeal. There is no indication that Health Net notified St. Joseph's of Health Net's decision on any earlier date; and

5. St. Joseph's sent a letter to Health Net dated August 1, 2002, asserting a Stage 1 appeal on behalf of 1-P, and Health Net's written decision on the appeal was dated November 1, 2002, more than five business days following initiation of the appeal. There is no indication that Health Net notified St. Joseph's of Health Net's decision on any earlier date;

WHEREAS, DHSS did not at any point in time receive a request from Health Net to extend its Stage 2 review time an additional 20 days with respect to the appeal regarding member 1-CB;[3]

WHEREAS, DHSS investigated St. Joseph's assertions, and obtained a written letter from Health Net, dated December 10, 2002, stating, among other things, that Health Net was having problems processing UM appeals timely, and was taking corrective measures to solve the problem, including: the hiring of additional appeals staff; instituting mandatory overtime until

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January 10, 2003. The August 13, 2002 letter from St. Joseph's indicated that at least some medical records had been included with the submission of the appeal.

[3] For purposes of this Order, DHSS does consider the appeal of 1-CB to be a Stage 2 appeal, based on the statements made by Health Net in its December 10, 2002 letter to DHSS.

more staff was hired and trained; hiring of temporary clerical staff; and, researching the root causes of the appeals in an effort to decrease volume;

WHEREAS, DHSS was presented with a complaint from a Health Net member (hereinafter referred to as "2-S") with respect to the timeliness and other matters involved with the handling of the member's appeal by Health Net, setting forth the following information:

1. The member submitted to Health Net on October 2, 2002 what was intended to be a Stage 2 appeal.

2. Health Net did not acknowledge receipt of the member's appeal.

3. As of the date of the member's letter to DHSS (November 11, 2002), Health Net had not rendered a decision on the appeal.

WHEREAS, an investigation of the complaint of 2-S indicated that a Stage 2 appeal had been filed by Hackensack Medical Center ("Hackensack") on behalf of the member with the member's consent,[4] with Health Net acknowledging the following information in writing submitted to DHSS by fax on December 9, 2002:

1. Health Net received a request for a Stage 2 appeal on behalf of 2-S on September 20, 2002;

2. Health Net rendered its decision on the appeal on December 9, 2002;

3. Health Net knew it was having problems processing UM appeals timely, and was taking corrective measures, including: the hiring of additional appeals staff; instituting mandatory overtime until more staff was hired and trained; hiring of temporary clerical staff; and, researching the root causes of the appeals in an effort to decrease volume;

[4] It is not clear why both the member and the hospital filed an appeal, or whether Health Net elected to combine the appeals. It may be that the hospital was appealing only hospital-related services, and the member was appealing issues related to non-hospital services. Regardless, Health Net has not acknowledged the receipt of any appeal directly from the member, only from the hospital.

WHEREAS, DHSS did not at any point in time receive a request from Health Net to extend its Stage 2 review time an additional 20 days with respect to the appeal regarding member 2-S;

WHEREAS, DHSS was presented with a complaint from a Health Net member (hereinafter referred to as "3-L") with respect to the timeliness involved with the handling of the member's appeal by Health Net;

WHEREAS, DHSS investigated the complaint, and obtained the following information in a letter from Health Net, dated July 12, 2002:

1. Health Net had received a Stage 1 appeal from member 3-L on February 6, 2002, regarding a denial of authorization for an in-network exception, which was rendered by Health Net on January 10, 2002 to the involved physician's office;

2. Health Net did not render its decision on the Stage 1 appeal until March 6, 2002;

3. Member 3-L did not seek a Stage 2 appeal;

WHEREAS, DHSS reviewed the IHCAP files from 2002 involving Health Net, and determined that Health Net failed to meet the required time frames for processing the Stage 1 appeal in six of its 19 IHCAP files (referred to herein to: "4-D," "4-F," "4-HA," "4-HO," "4-P" and "4-U"), and also failed to meet the required time frames for processing the Stage 2 appeal for seven of its 19 IHCAP files (referred to herein as: "5-A," "5-B," "5-C," "5-D," "5-J," "5-O," and "5-U");

WHEREAS, DHSS has no record of Health Net having made a request to extend the Stage 2 review with respect to the seven IHCAP files for which the time frames were exceeded;

WHEREAS, DHSS believes some of these appeals were processed through Paidos Health

Management Services (hereinafter, "Paidos"), which apparently has an arrangement to perform certain UM functions for Health Net;

WHEREAS, N.J.A.C. 8:38-1.1 states that the provisions of the HMO rules apply to HMO subcontractors that may perform one or more of the obligations or services of the HMO;

WHEREAS, Health Net has not submitted its contract with Paidos to DHSS or the Department of Banking and Insurance (hereinafter, "DOBI")[5] for review notwithstanding five separate requests for the contract made by DHSS, and four requests made by DOBI;

WHEREAS, the extent of the services and compensation arrangement established under the agreement between Paidos and Health Net has not been reviewed and/or approved in accordance with N.J.A.C. 8:38-15, and Paidos did not submit an application to be licensed or certified as an Organized Delivery System consistent with N.J.S.A. 17:48H-1 et seq.;[6]

WHEREAS, it appears that there is a pattern in Health Net's handling of UM appeals in an untimely manner;

WHEREAS, Health Net has acknowledged there was a delay in response to appeals, and was instituting measures to correct its systemic problems going forward; and

WHEREAS, it appears that Health Net is using a contract that has not been approved by DHSS in the handling of some of its UM appeals;

[5] DHSS has a letter of intent signed by Paidos and Physicians Health Services.

[6] Paidos could have submitted a preliminary application in accordance with jointly-issued Bulletin 2000-17 or jointly-issued Bulletin 2001-02, and if risk-assuming, should have submitted an application with DOBI pursuant to N.J.A.C. 11:22-4 either to be licensed, or to receive an exemption from licensure because its risk is *de minimis*.

NOW, THEREFORE, IT IS ORDERED on this 1st day of April, 2003, that:

1. Health Net shall pay a fine totaling $77,070 for failing to handle appeals in a timely manner, and for using the services of Paidos without an approved contract, the components of the total fine being broken down as follows:

a. With respect to the 20 UM cases, $34,570;[7]

b. With respect to the Paidos contract, $42,500.[8]

2. Health Net shall submit payment of the penalties by check or money order made payable to the State Treasurer of New Jersey in a single sum no later than the date on which this paragraph becomes effective, as specified in Paragraph 15 of this Order. Health Net shall submit the check or money order to the Director of the Office of Managed Care, P.O. Box 360, Trenton, NJ 08625-0360.

3. Health Net shall submit a Plan of Correction within 20 days from the date of this Order setting forth with specificity how it has or will revise its operations to assure compliance

[7] DHSS added the total number of days between the time the appeals were dated as submitted (or acknowledged as received), and the date of the letter from Health Net setting forth a determination on the appeal, or the date that DHSS advised the appellant that they could submit the appeal to the IHCAP. DHSS subtracted 5 days from each Stage 1 appeal, and subtracted 20 days from each Stage 2 appeal in recognition of the time periods Health Net had available by regulation to make a determination on the respective appeals. Thus, the number of days for each case is as follows: (1). 1-B = 49; (2). 1-CB = 90; (3). 1-CG = 57; (4). 1-N = 67; (5). 1-P = 58; (6). 2-S = 63; (7). 3-L = 23; (8). 4-D = 76; (9). 4-F = 11; (10). 4-HA = 27; (11). 4-HO = 10; (12). 4-P = 45; (13). 4-U = 4; (14). 5-A = 166; (15). 5-B = 134; (16). 5-C = 38; (17). 5-D = 33; (18). 5-J = 43; (19). 5-O = 18; (20). 5-U = 25. The total number of days is 1037. DHSS then divided that sum by 30 to derive an approximation of the number of months of violation by Health Net of the timeframes for processing appeals either at the Stage 1 or Stage 2 level, or both, thus: 1037 ÷ 30 = 34.57. DHSS multiplied the number of months by $1,000 to obtain the fine being assessed, thus: 34.57 x $1,000 = $34,570. With respect to 1-CB, DHSS chose January 22, 2003 as the end date for the calculation, that being the date that DHSS notified St. Joseph's that the appeal could be pursued through the IHCAP, rather than waiting for a determination from Health Net. With respect to 2-S, DHSS based the calculation on Health Net's December 9, 2002 letter, indicating receipt of the appeal on September 20, 2002.

[8] DHSS is assessing the maximum fine amount of $10,000, but on a per year basis, for each year (1999, 2000, 2001 and 2002, and 2003 prorated for three months) that Health Net appears to have had and acted upon a service management relationship with Paidos, but did not obtain approval from DHSS of the relationship, or otherwise attempt to bring its subcontractor into compliance with laws regarding subcontracts and organized delivery systems.

with the requirements of N.J.A.C. 8:38-8, except as Bulletin 2002-01 applies to Health Net's business.[9]

a. The Plan of Correction shall specify short-term actions to assure that current appeals are processed appropriately, and long-term actions to assure systemic problems in the appeals process are remedied, and do not recur.

b. The Plan of Correction shall include the dates when corrective actions are to be completed, and goals accomplished.

c. In no event shall any date be more than 30 days later than the date of submission of the Plan of Correction.

d. To the extent that Health Net believes that actions it has taken recently on its own initiative have achieved some or all of the goals for a short-term and/or long-term solution to its systemic problems, Health Net shall provide empirical information supporting its belief when it submits its Plan of Correction.

4. Within 20 days following the date of this Order, Health Net shall submit a list of all of the Stage 1 appeals it received or processed as of January 1, 2002 through the date of this Order, inclusive, and shall provide the following information for each:

a. The date the appeal was initiated;

b. Whether or not the appeal was for urgent or emergency care, as specified at N.J.A.C. 8:38-8.5;

c. The date Health Net made a determination on the appeal;

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[9] Carriers with group health plans must comply with the requirements of 29 C.F.R. 2560.503-1 regarding appeals processing to the extent that the federal law supercedes state law on the issue. Bulletin 2002-01 allows carriers to alter certain of their UM appeals practices across their lines of business for ease of administration. For instance, the appeal reviewer at Stage 1 must be different from the person who made the initial denial of the service for group health plans under federal law, superceding New Jersey's law that says the reviewers must be the same. Bulletin

d. The date Health Net communicated its determination to the provider and/or member;

e. The date Health Net memorialized the determination and sent it to the provider and/or member, if different from the date the determination was communicated to the provider and/or member.

5. Within 20 days following the date of this Order, Health Net shall submit a list of all Stage 2 appeals received or processed as of January 1, 2002 through the date of this Order, inclusive, and shall provide the following information for each:

a. The date the appeal was received by Health Net;

b. Whether the appeal was for urgent or emergency care, as specified at N.J.A.C. 8:38-8.6;

c. The date Health Net sent acknowledgment of receipt of the appeal;

d. The date Health Net requested an extension in making a determination on the appeal, if any;

e. The date DHSS approved or disapproved the extension, if any was requested;

f. The date Health Net made a determination on the appeal;

h. The date Health Net communicated its determination to the provider and/or member;

i. The date Health Net memorialized the determination and sent it to the provider and/or member, if different from the date the determination was communicated to the provider and/or member.

2002-01 allows carriers to use a different reviewer at Stage 1 for all of their New Jersey business, but the reviewers must otherwise meet the standards required by New Jersey regulations.

6. Within 20 days following the date of this Order, Health Net shall submit to the Office of Managed Care for review and approval the waiver letters specified in Paragraphs 7 and 8 below.

7. Within 5 business days after written approval is sent by the Office of Managed Care, Health Net shall send the approved Stage 1 waiver letter to all parties that made or have made a Stage 1 appeal in which Health Net's communication regarding its determination on the appeal exceeded or has exceeded the regulatory time frames established for the type of appeal (that is, expedited or not expedited), providing the following information:

a. That the parties may pursue an appeal through the IHCAP, and DHSS shall accept the appeal as timely if it is postmarked within the later of:

(1) 60 days from the date of Health Net's written determination on the Stage 1 appeal; or

(2) 60 days following the date of the waiver letter.

b. Instructions about how to request an appeal through the IHCAP, including:

(1) the cost;

(2) a statement that the waiver letter must be included with the request for an appeal through the IHCAP; and

(3) a statement that all written correspondence the party has from Health Net regarding the denial, limitation or termination of the service at issue must be included with the request for an appeal through the IHCAP.

8. Within 5 business days after written approval is sent by the Office of Managed Care, Health Net shall send the approved Stage 2 waiver letter to all parties having made a Stage 2 appeal for which Health Net has failed to render a written determination on the appeal within the

regulatory time frames established for the type of appeal (that is, expedited or not expedited), and for which, with respect to appeals that do not need to be expedited, Health Net has not sought an extension from DHSS, or sought an extension that was denied. Health Net shall set forth the following information in the Stage 2 waiver letter:

a. That the parties may pursue an appeal through the IHCAP without obtaining a final Stage 2 determination from Health Net, but must file a request for an IHCAP appeal within 60 days following the date of the waiver letter, as evidenced by postmark of the IHCAP request.

b. Instructions about how to request an appeal through the IHCAP, including:

(1) the cost;

(2) a statement that a copy of the Stage 2 waiver letter must be submitted with the request for an appeal through the IHCAP; and

(3) a statement that a copy of the Stage 1 Health Net written determination must be submitted with the request for an appeal through the IHCAP.

9. Health Net shall continue to issue Stage 1 and Stage 2 waiver letters when its reviews have exceeded the regulatory time frames until Health Net has fully implemented the corrective actions set forth in a Plan of Correction approved by DHSS. Health Net shall provide prior written notice to DHSS of when Health Net will discontinue issuing Stage 1 and Stage 2 waiver letters pursuant to the terms of this Order, with a written explanation satisfactory to DHSS of why Health Net believes it appropriate to discontinue issuing the waiver letters.

10. Within 20 days following the date of this Order, Health Net shall submit three copies of its contract with Paidos to the Office of Managed Care.

11. Nothing in this Order shall be interpreted to prejudice the interests of Health Net or Paidos in any legal action, and nothing in this Order shall be interpreted to prejudice the interests

of health care providers or members in any legal action that has been or may be brought against Health Net or Paidos.

12. Nothing in this Order shall be construed to preclude DHSS from taking enforcement action against Health Net for related matters not set forth herein.

13. Obligations under this Order are imposed pursuant to the police powers of the State of New Jersey for the enforcement of law and the protection of public health, safety, and welfare and are not intended to constitute a debt or debts subject to limitation or discharge in a bankruptcy proceeding.

14. All numbered paragraphs of this Order, other than Paragraphs 1 and 2 shall be effective as of the date of this Order.

15. Paragraphs 1 and 2 shall not become effective until 30 days following the date of this Order, in accordance with N.J.A.C. 8:38-2.14(c), unless Health Net files with DHSS, prior to the end of the 30-day period, a written request for a hearing, and a written request to Stay the Order with respect to Paragraphs 1 and 2 until an administrative hearing has been concluded and a final decision is rendered by the Commissioner of DHSS. A request for a hearing shall be accompanied by a written response to the violations set forth in this Order.

16. If Health Net wishes to request an administrative hearing, Health Net shall submit its request in writing no later than 30 days following the date of this Order to Debra Johnson, Office of Legal and Regulatory Affairs, P.O. Box 360, Trenton, NJ 08625-0360, or by fax at (609) 292-5333.

Questions regarding this Order should be submitted to Marilyn Dahl, Senior Assistant Commissioner (609-984-3939), or Sylvia Allen-Ware (609-633-0660), Director of the Office of Managed Care.

MARILYN DAHL
Senior Assistant Commissioner
Health Planning and Regulation
New Jersey Department of Health and Senior Services

/s/ Marilyn Dahl