

INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH

Organized Delivery Systems

Proposed Readoption with Amendments: N.J.A.C. 11:24B

Proposed Repeals: N.J.A.C. 11:24B-2.5 and 11:24B Appendix Exhibits 3 through 8

Proposed Repeals and New Rules: N.J.A.C. 11:24B-2.8 and 2.9

Authorized By: Steven M. Goldman, Commissioner, Department of Banking and Insurance

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 17:48H-1 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2008-380

Submit written comments by January 16, 2009 to:

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The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) proposes to readopt N.J.A.C. 11:24B, which is scheduled to expire on February 17, 2009, in accordance with N.J.S.A. 52:14B-5.1b. In accordance with N.J.S.A. 52:14B-5.1c, the submission of this notice of proposal to the Office of Administrative Law extends the expiration date 180 days, to August 16, 2009.

N.J.S.A. 17:48H-1 et seq. (the Act), enacted on January 18, 2000, provides for the certification or licensing of an “organized delivery system” (ODS). An ODS, among other things, is an entity that has the capacity to contract with insurers, health maintenance organizations and medical, hospital and health service corporations (collectively referred to as carriers), to provide or arrange for the provision of health care services to individuals covered under one or more of a carrier’s health benefits plans delivered in New Jersey. The Act requires that an ODS either become certified by the Department of Health and Senior Services (DHSS) or licensed by the Department of Banking and Insurance (Department). An ODS must become licensed if it assumes risks. If it does not assume risks, the ODS must be certified. DHSS promulgated rules to implement the Act effective February 17, 2004. In 2005, the Office of Managed Care in DHSS was transferred to the Department. Accordingly, the regulatory oversight of certified ODSs now resides with the Department. The rules, originally codified at N.J.A.C. 8:38B, have been recodified at N.J.A.C. 11:24B.

Rules concerning the following subjects are codified in this chapter, listed by subchapter.

1. General provisions, which include the scope, definitions, timeframes for compliance, suspension or revocation of a certification, penalties for violations of the chapter, and confidentiality of information submitted.
2. Certification and review of applications.
3. Functional obligations of an ODS, which include carrier and ODS obligations to comply with certain standards, limitations on delegations of duties by carriers, application of statutes and rules to certified and licensed ODSs, and other aspects of a certified ODS’s operations.
4. Management agreements with carriers.

5. Provider agreements.

The Department has reviewed these rules and has determined them to be reasonable, necessary and proper for the purpose for which they were originally promulgated. The Department believes that the original purpose for each rule, as set forth in the rules itself, continues to exist. Moreover, the Department continues to believe that the rules proposed for readoption are necessary to provide guidance and a regulatory framework to implement the Act. The Department also has determined to amend certain rules in the chapter and to repeal others, to eliminate requirements no longer deemed necessary, to streamline the oversight process, to reflect the regulation of licensed ODSs as set forth in N.J.A.C. 11:22-4, and to make technical changes as a matter of form. A summary of the proposed amendments and repeals follows.

In N.J.A.C. 11:24B-1.2, the reference to “DHSS” in the definition of “participating provider” is proposed to be changed to read “Department” to reference the Department of Banking and Insurance, which now has all of the oversight and regulatory authority over certified ODSs.

N.J.A.C. 11:24B-1.3(b), which provides transitional compliance timeframes for certified ODS filings and contracts in effect on February 17, 2004 (the effective date of the chapter), is proposed to be deleted as it is no longer necessary. Similarly, N.J.A.C. 11:24B-1.3(a) is proposed to be amended to delete reference to N.J.A.C. 11:24B-1.3(b), and to delete the reference to February 17, 2004. Similar references in N.J.A.C. 11:24B-2.3(a)9i, 11i and 13i are proposed to be deleted for the same reason. Also, the reference to N.J.A.C. 11:24B-1.3 in N.J.A.C. 11:24B-2.2(b) is proposed to be deleted.

N.J.A.C. 11:24B-1.6(c) and (d) are proposed to be deleted. These subsections, and Exhibit 1 in the Appendix referenced therein, provide detailed calculations for determining

penalties. Upon review, the Department has determined that this is unnecessary and inconsistent with other rules providing for penalties applicable to all other regulated entities by the Department. N.J.S.A. 17:48H-10 provides for penalties of not less than \$250.00 nor more than \$10,000 for violations of the Act by a certified ODS. This is reflected in N.J.A.C. 11:24B-1.6(a). The Department believes that the current rule unnecessarily limits the discretion of the Department in determining the amount of an actual penalty it may seek to impose in an individual case. Moreover, the proposed amendment promotes consistency with the rules and procedures utilized by the Department for the imposition of penalties on all other regulated entities.

N.J.A.C. 11:24B-1.8(b) is proposed to be amended to delete the documents listed as being public under the Open Public Records Act, N.J.S.A. 47:1A-1 et seq. (OPRA). The documents listed may contain proprietary and trade secret information that would not be deemed public records under OPRA. Information that is not otherwise confidential under OPRA or any other legal authority would be public.

N.J.A.C. 11:24B-1.9(a) is proposed to be amended to revise the wording so as to apply to ODSs, rather than carriers, as a matter of form, since these rules generally apply to ODSs. In addition, the rule is proposed to be amended to apply to contracts made “directly or indirectly” between the carrier and the ODS. The Department has seen instances where a carrier contracts with one entity, which is not required to be certified as an ODS, and that entity contracts with an ODS. The Department believes that an ODS involved in such an arrangement should still be reviewed by the Department to ensure that policyholders/claimants are still afforded the protections otherwise provided by the Act, including the protections under the Health Care Quality Act, N.J.S.A. 26:2S- 1 et seq.

N.J.A.C. 11:24B-1.9(b), which provides that nothing in the rules shall relieve a carrier from compliance with any law or rule, except as stated in the rules, is proposed to be deleted as the Department believes it is redundant and unnecessary.

N.J.A.C. 11:24B-2.2(c)2 is proposed to be amended to delete the requirement that in filing an application for certification, the information required by N.J.A.C. 11:24B-2.4 must follow that required by N.J.A.C. 11:24B-2.3, as unnecessary. Also, the heading of the rule is proposed to delete reference to “initial” certification as the Department intends to delete the requirement for renewal of certification, as set forth below.

N.J.A.C. 11:24B-2.3(a)1 through 4 and 7 are proposed to be amended to delete references to forms set forth in Exhibits 3 through 7 in the Appendix, which are proposed to be repealed, and to provide that the forms may be found on the Department’s website. This conforms these rules with other rules by which forms are provided on the Department’s website, to enable the Department to more readily make changes to required forms. At N.J.A.C. 11:24B-2.3(a)7, a summary of the information required in the Biographical Affidavit is added.

N.J.A.C. 11:24B-2.3(a)8vii and viii, which provide that a business plan shall contain a description of any reinsurance or stop loss arrangements and a plan in case of insolvency of the ODS for continuation of its services, are proposed to be deleted. These subparagraphs relate to a licensed ODS and are not necessary as part of an application to be a certified ODS.

N.J.A.C. 11:24B-2.4(c)3 is proposed to delete the reference to Exhibit 8 in the Appendix, which is proposed to be repealed, and provide a summary of the tables’ context and that the tables can be found on the Department’s website, for the reasons set forth previously.

N.J.A.C. 11:24B-2.4(e) through (k) are proposed to be amended to delete the reference to N.J.A.C. 11:24B-2.4(c)1 as the Department has determined that it is unnecessary. N.J.A.C.

11:24B-2.4(c)1 provides that as part of an application for certification as an ODS, the applicant shall provide a list setting forth the name of providers under contract with the ODS by county, municipality and zip code, accompanied by maps of service areas. Since an ODS is already required to provide this information under N.J.A.C. 11:24B-2.4(c)1, requiring the information under N.J.A.C. 11:24B-2.4(e) through (k) would be superfluous and redundant.

N.J.A.C. 11:24B-2.4(f) through (k) are proposed to be amended to delete the phrase “on behalf of a carrier, whether for one or more types of health services, and whether for a network the ODS manages or across a broader range of a carrier’s business,” as the Department, upon review, believes it is not necessary as it is redundant and addressed in other rules in the chapter. This phrase may appear to limit the application of the rule. However, the phrase encompasses all ODSs, and thus its inclusion is confusing in addition to being redundant. In addition, the Department is proposing to amend N.J.A.C. 11:24B-2.4(e) to delete the phrase “on behalf of a carrier, whether with respect only to the ODS’ contracted providers or other providers that may be contracted with the carrier directly or through another ODS” for this same reason.

N.J.A.C. 11:24B-2.5 is proposed to be repealed and the section reserved. This rule relates to requirements for licensed ODSs, which requirements are addressed in N.J.A.C. 11:22-4.

N.J.A.C. 11:24B-2.8, which provides the requirements for a renewal of an ODS certification every three years, is proposed to be repealed and replaced with a process for the automatic renewal of a certification every three years. The Department believes that it would be more appropriate to provide that renewal of a certification will occur automatically every three years unless the Department has found that the ODS does not satisfy the requirements of the Act, or fails to file a completed annual report detailing its operations. This is consistent with

regulation of licensed ODSs and insurers. The Department believes that it is a more appropriate and efficient use of Department resources to have a report of an ODS's operations due March 1 of each year, rather than requiring certified ODSs to essentially repeat the application process once every three years. The information proposed to be required as part of the annual report includes operational data related to utilization management, complaints, and continuous quality improvement. The form of the report will be posted on the Department's website. In addition, the proposed amendment provides that the Department may examine the affairs and method of operation of a certified ODS at any time to ensure compliance with the Act and these rules.

N.J.A.C. 11:24B-2.9, which provides detailed fees for various filings, is proposed to be repealed and a new rule is proposed to provide a flat, one-time fee of \$2,500 for review of an application for certification.

N.J.A.C. 11:24B-2.10(a)2, (b) and (e) are proposed to be deleted as unnecessary. N.J.A.C. 11:24B-2.10(a)2 relates to information filed in an application for renewal of certification, which applications are proposed to be deleted as discussed above. N.J.A.C. 11:24B-2.10(b) provides that the Department may request additional information from an ODS after an application is found or deemed complete. This is superfluous since, pursuant to proposed N.J.A.C. 11:24B-2.8(d), the Department may request additional information from an ODS as deemed necessary by the Commissioner to determine compliance with N.J.S.A. 17:48H-1 et seq. or the subchapter. N.J.A.C. 11:24B-2.10(e) provides that a certified ODS may only perform those functions for which it is certified. This is already set forth in the certification issued to the ODS. N.J.A.C. 11:24B-2.10(e)1 provides that a certified ODS may contract with more than one carrier, so long as the carrier complies with specified statutes and rules. This

provision is also redundant in that being certified allows an ODS to contract with multiple carriers. Carriers are subject to the statutes and rules referenced in paragraph (e)1 by their terms.

N.J.A.C. 11:24B-2.10(g) is proposed to be deleted and the requirements therein are proposed to be incorporated in N.J.A.C. 11:24B-2.10(f) by adding a reference to “certification modification.”

N.J.A.C. 11:24B-3.1(a) and (c) are proposed to be deleted. Subsection (a) provides that if a contract between an ODS and a carrier delegates performance of one or more legal obligations of a carrier to the ODS, the ODS must comply with the applicable requirements related to the obligations delegated. Subsection (c) essentially provides that the delegation by a carrier to an ODS of performance of a legal obligation pursuant to Health Care Quality Act, N.J.S.A. 26:2S-1 et seq., and rules promulgated thereunder, shall cause the ODS to be obligated to comply with that statute and rules. The Department believes that these provisions are redundant and unnecessary, because ODSs are subject to the Health Care Quality Act pursuant to N.J.S.A. 17:48H-33.

N.J.A.C. 11:24B-3.3(c) is proposed to be deleted. This subsection provides that when a licensed or certified ODS contracts with both HMOs and other carriers for the performance of one or more of the functions listed in the chapter, the ODS shall demonstrate compliance with applicable statutes and rules specified in the chapter for both types of entities. The Department believes that this is redundant and unnecessary.

N.J.A.C. 11:24B-3.3(d) is proposed to be deleted for the same reason as is N.J.A.C. 11:24B-3.3(c) set forth above. This subsection provides that when a licensed or certified ODS contracts to perform one or more of the functions listed in the chapter with respect to health benefits plans that are managed care plans and with those that are not managed care plans, the

ODS shall demonstrate compliance with applicable rules specified in the chapter for both types of health care plans.

N.J.A.C. 11:24B-3.5(b) is proposed to be amended to replace references to N.J.A.C. 8:38A-4.10 and 8:38-6 with the proper cites of 11:24A-4.10 and 11:24-6. Similar changes to rule references are proposed at N.J.A.C. 11:24B-3.11 and 4.10(a).

N.J.A.C. 11:24B-3.6 is proposed to be amended to revise the wording of the section to clarify its operation and ensure consistency with other rules in the chapter. The reference to N.J.A.C. 11:24B-3.4(b) is proposed to be deleted. This rule provides that in order to be certified to arrange for the provision of health care services and one or more other categories of services as set forth in N.J.A.C. 11:24B-2.4(a), the ODS shall comply with N.J.A.C. 11:24B-3.4(a)2 through 4. Accordingly, a certified ODS must comply with that rule by its terms, and its inclusion in this rule is redundant. N.J.A.C. 11:24B-3.6 is also proposed to be amended to delete the phrase “but either does not offer network management services, or wishes to perform credentialing and recredentialing activities on behalf of a carrier with respect to providers outside of the ODS’ network” in that if an ODS is performing credentialing or recredentialing services, it is performing management services. The Department proposes to amend the rule to reference an ODS performing credentialing or recredentialing “whether with respect only to the ODS’ contracted providers or other providers that may be contracted with the carrier directly or through another ODS” to reflect that an ODS may be providing services outside the ODS’ network.

N.J.A.C. 11:24B-3.7 is proposed to be amended to delete the unnecessary reference to 11:24B-3.4(b) for the reasons set forth above and additionally to delete N.J.A.C. 11:24B-3.7(a)3, as it is redundant.

N.J.A.C. 11:24B-3.8(a) is proposed to be amended to delete the reference to N.J.A.C. 11:24B-3.4(b) for the reasons set forth above. In addition, N.J.A.C. 11:24B-3.8(a)3 and 4 are proposed to be deleted, with the references to applicable citations to applicable rules therein to be referenced within N.J.A.C. 11:24B-3.8(a), as a matter of form. The reference to N.J.A.C. 11:24A-4.11(b)2 in N.J.A.C. 11:24B-3.8(a)4 is not retained because it is redundant. This reference is to utilization management program requirements in the implementing rules to the Health Care Quality Act, to which ODSs are subject to N.J.S.A. 17:48H-33.

N.J.A.C. 11:24B-3.9(a) is proposed to be amended to revise and consolidate the wording therein as a matter of form. In addition, N.J.A.C. 11:24B-3.9(a)1 and 2 and (b) are proposed to be deleted as the Department, upon review, has determined they are no longer necessary. The proposed simplification of the rule is achieved by eliminating the unnecessary reference to N.J.A.C. 11:24B-3.4(b) for the reasons set forth above and deleting requirements for health benefits plans that are not managed care plans since it is unlikely that an ODS would provide services to such a plan. The rule is also proposed to be amended to refer to N.J.S.A. 26:2S-11 to reflect the requirements currently set forth in subsection (b).

N.J.A.C. 11:24B-3.10 is proposed to be amended to revise and consolidate the wording as a matter of form. In addition, N.J.A.C. 11:24B-3.10(a)1 and 2 are proposed to be deleted, as the Department, upon review, has determined that they are no longer necessary because the services referenced therein may only be provided in connection with a managed care plan. The proposed simplification of the rule is achieved by eliminating the unnecessary reference to N.J.A.C. 11:24B-3.4(b) for the reasons set forth above and deleting requirements for health benefits plans that are not managed care plans since it is unlikely that an ODS would provide services to such a

plan. The rule is also amended to replace reference to N.J.A.C. 11:24B-3.3(h) and (i) with the correct citation of N.J.A.C. 11:24B-3.5(h) and (i).

N.J.A.C. 11:24B-3.11 is proposed to be amended to eliminate the unnecessary reference to N.J.A.C. 11:24B-3.4(b) for the reasons set forth above and to replace the reference to N.J.A.C. 8:38-3.7(b) or 8:38A-4.6(b) with the citation of N.J.A.C. 11:24-3.7(b) or 11:24A-4.6(b) to reflect proper citation, for the reason set forth above.

N.J.A.C. 11:24B-3.12 is proposed to be amended to eliminate the unnecessary reference to 11:24B-3.4(b) for the reasons set forth above and, in addition, to delete the wording concerning network management services as the Department, upon review, believes it is not necessary, for the reason set forth above. This same phrase is proposed to be deleted from N.J.A.C. 11:24B-3.10 and 3.11.

N.J.A.C. 11:24B-4.4(c)2 is proposed to be amended to refer to P.L. 1999, c. 154 and P.L. 1999, c. 155, “as amended” to reflect that those statutes have been and may be amended in the future.

N.J.A.C. 11:24B-4.4(k)1 and 2 are proposed to be deleted as the Department, upon review, has determined that they are no longer necessary. These paragraphs set forth actions that will not constitute unfair discrimination by an ODS or carrier. However, the actions set forth in the paragraphs are not discriminatory but apply in general.

N.J.A.C. 11:24B-4.8 is proposed to be amended to delete the phrases “if performance only will be with respect to health benefits plans that are not managed care plans, or” and “if performance is with respect to one or more health benefits plans that are managed care plans,” as unnecessary, and adding the phrase “as applicable” as a matter of form. This rule requires that a contract shall specify how the ODS will comply with N.J.A.C. 11:24A-3.5 (if performance only

will be with respect to health benefits plans that are not managed care plans) or N.J.A.C. 11:24-8.4 through 8.6 or 11:24A-4.12 (if performance is with respect to one or more health benefits plans that are managed care plans). The referenced rules relate to appeals procedures for utilization management determinations applicable to HMO (managed care) and other (non-managed care) plans by their terms. Accordingly, the phrases are redundant and their inclusion could be confusing.

N.J.A.C. 11:24B-4.10(a) is proposed to be amended to delete the citation to N.J.A.C. 8:38-4.6(b) and replace it with the correct citation to N.J.A.C. 11:24B-4.6(b).

N.J.A.C. 11:24B-5.2(a)19i is proposed to be amended to delete the reference to specific statutes and instead refer to “applicable law” to provide that ODSs shall comply with all applicable law governing claims handling that may have been implemented since the rules were adopted, or that may be enacted in the future, including the Health Claims Authorization, Processing and Payment Act, N.J.S.A. 17B:30-48 et seq..

A 60-day comment period is provided for this notice of proposal, and, therefore, pursuant to N.J.A.C. 1:30-3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The rules proposed for readoption with amendments, repeals and new rules will continue to provide guidance with respect to requirements for certification of an ODS pursuant to the Act. Thus, compliance by an ODS seeking certification, as well as the performance of duties of carriers and ODSs related to contracts between such entities, will continue to be facilitated by the rules set forth in the chapter. The rules proposed for readoption will continue to implement the

Act by maintaining the accountability of those entities engaged in the delivery or allocation of health care services to New Jersey's citizens, and the financing of those services. Further, the rules proposed for reoption with amendments, repeals and new rules will continue to recognize the situation identified in the Act that health care and health care insurance markets have evolved over time and that the provision and allocation of health care services may be partially controlled by entities under contract with the carrier. The rules proposed for reoption with amendments, repeals and new rules will continue to facilitate the oversight of these entities and continue to permit the Department to apply the same or substantially similar standards to ODSs as are applied to carriers. The rules proposed for reoption with amendments, repeals and new rules will continue to promote the Department's ability to monitor the quality of services provided and continue to enhance the Department's ability to understand the relationship of ODSs and carriers with one another, monitor and evaluate problems that may arise in the provision of such services, and enable the Department to more effectively address such problems. The proposed amendments, repeals and new rules eliminate redundant or unnecessary requirements, and provide for the efficient ongoing regulation of certified ODSs.

Economic Impact

ODSs that are certified or that seek to be certified will continue to be required to bear costs associated with complying with the requirements for certification, including the preparation and filing of applications and related fees, and requirements related to agreements between carriers and providers and the ODS. However, the Department believes that the primary impact occurred upon the initial compliance with the rules. Continued compliance with the rules should impose a relatively minimal economic impact. As was noted when the rules were originally

proposed, these costs will depend upon the functions for which the ODS chooses to be certified, and the allocation of obligations between the ODS and carriers pursuant to their contracts. Accordingly, the potential adverse economic impact of all of the known and possible costs may be mitigated, depending on how the ODS markets itself, and the degree of confidence the carriers, other payers, and other entities that may utilize an ODS's services have in the ability of the ODS to perform the services it has contracted to perform. The proposed amendments, repeals and new rules eliminate redundant and unnecessary filings, and provide for a flat one-time fee structure, similar to that provided for licensed ODSs. Similarly, providing for automatic renewal through the filing of an annual report, rather than a triennial renewal through submission of a new application, will eliminate unnecessary filings. The information proposed in the annual report should be readily available to a certified ODS. Professional services that will continue to be required will include legal, accounting and administrative services. The Department does not believe that any additional professional services will be required to be employed in order to comply with the rules proposed for readoption with amendments, repeals and new rules.

Further, as noted above, the rules proposed for readoption provide a regulatory framework to implement the Act and through which an ODS may be certified and interact with carriers for the provision of health care services in this State. Failure to readopt these rules would result in additional costs to carriers and ODSs due to the lack of guidance and a consistent regulatory framework regarding such activities.

Federal Standards Statement

A Federal standards analysis is not required because the rules proposed for readoption with amendments, repeals and new rules are not subject to any Federal requirements or standards.

Jobs Impact

The Department does not anticipate that any jobs will be generated or lost as a result of the rules proposed for readoption with amendments, repeals and new rules.

The Department invites commenters to submit any data or studies on the potential jobs impact of the rules proposed for readoption with amendments, repeals and new rules with their comments on other aspects of the proposal.

Agriculture Industry Impact

The rules proposed for readoption with amendments, repeals and new rules will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The rules proposed for readoption with amendments, repeals and new rules will apply to “small businesses” as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the rules apply to small businesses, they will apply to entities domiciled in this State seeking to become certified as an ODS or to such entities already certified as an ODS. The compliance, recordkeeping and financial reporting requirements imposed by the rules are clearly defined in the rules themselves as outlined in the Summary above. The Economic Impact above describes the professional services that will continue to be required to

comply with the rules proposed for re-adoption, as well as with the proposed amendments, repeals and new rules. As was noted therein, no additional professional services should be required to comply with the rules proposed for re-adoption with amendments, repeals and new rules.

The Department has determined that the rules proposed for re-adoption with amendments, repeals and new rules continue to be reasonable and necessary to provide a regulatory framework for the certification of an ODS that contracts with a carrier for the provision of health care services in this State to implement N.J.S.A. 17:48H-1 et seq. The goal of the Act is to enable the Department to monitor and oversee these entities providing healthcare services on behalf of carriers. These goals, and the statute itself, provide for no different compliance requirements based on business size. Accordingly, the rules proposed for re-adoption with amendments, repeals and new rules do not provide any differentiation in compliance requirements based on business size.

Smart Growth Impact

The rules proposed for re-adoption with amendments and repeals will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Analysis

The rules proposed for re-adoption with amendments, repeals and new rules will not have an impact on housing affordability in this State in that the rules proposed for re-adoption with amendments, repeals and new rules relate to certified ODSs.

Smart Growth Development Impact

The Department believes that there is an extreme unlikelihood that these rules proposed for readoption with amendments, repeals and new rules would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Department and Redevelopment Plan because the rules proposed for readoption with amendments, repeals and new rules relate to certified ODSs.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:24B.

Full text of the proposed repeals may be found in the New Jersey Administrative Code at N.J.A.C. 11:24B-2.5, 2.8, 2.9 and 11:24B Appendix, Exhibits 3 through 8.

Full text of the proposed amendments, repeals and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:24B-1.2 Definitions

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

...

"Participating provider" means a provider that, under contract or other arrangement acceptable to the [DHSS] **Department** with the carrier, the carrier's contractor or subcontractor, has agreed to provide health care services or supplies to covered persons in the carrier's managed care plan(s) for a predetermined fee or set of fees.

...

11:24B-1.3 CODS: compliance time frames

[(a) Except as (b) below applies, no] **No** ODS required to become a CODS in accordance with N.J.A.C. 11:24B-2.1 shall execute or renew a contract with a carrier [on or after February 17, 2004] as a CODS unless the ODS has filed a complete application for certification in accordance with the requirements of this chapter, and the application has been approved by the Department.

[(b) If an ODS required to become a CODS has contracts in effect on February 17, 2004 and submits a completed application for certification by May 17, 2004, then nothing in this chapter shall be construed to operate to impair the terms of the contracts in effect on February 17, 2004 for up to 24 months after February 17, 2004.

1. An ODS that filed a preliminary application with the Department of Health and Senior Services pursuant to Bulletin 2000-17, issued jointly by the Department of Health and Senior Services and the Department on December 26, 2000, shall be deemed to be in

compliance with (b) above if the ODS submits the fee for filing an application set forth at N.J.A.C. 11:24B-2.9, and any information required by this chapter not previously submitted with the preliminary application (for instance, flow charts and summary tables) by May 17, 2004.]

11:24B-1.6 CODS: penalties

(a) - (b) (No change.)

[(c) The amount of fine associated with a first offense, without documented harm, is calculated by multiplying \$ 250.00 per violation by the known number of days during which the violation occurred, but the amount of fine associated with each subsequent offense of the same type as the first offense, without documented harm, is calculated based on the amount of time that has elapsed between the subsequent offense and the immediately preceding offense of the same type, which number is then multiplied by the number of days during which the violation occurred, as follows:

1. If the subsequent offense occurred within less than 12 months of the first or previous offense, then the dollar multiplier is determined by multiplying \$ 250.00 (and each subsequent result) by three, to a maximum of \$ 10,000.

2. If the subsequent offense occurred 12 and up to 24 months after the first or previous offense, then the dollar multiplier is determined by multiplying \$ 250.00 (and each subsequent result) by two and a half, to a maximum of \$ 10,000.

3. If the subsequent offense occurred 24 and up to 36 months after the first or previous offense, then the dollar multiplier is determined by multiplying \$ 250.00 (and each subsequent result) by two, to a maximum of \$ 10,000.

4. If the subsequent offense occurred 36 or more months after the first or previous offense, then the dollar multiplier is determined by multiplying \$ 250.00 (and each subsequent result) by one and a half, to a maximum of \$ 10,000.

5. Where the result (and next multiplier) ends in \$.50, the amount is rounded to the next highest whole number.

6. A schedule is set forth as Exhibit 1 in the Appendix to this Chapter.

(d) Whenever there is documented harm, the dollar multiplier is increased by \$500.00; however, in no instance may the dollar multiplier exceed \$10,000, regardless of the number of times the same offense is committed within any time period, or the degree of harm associated with it.]

11:24B-1.8 ODS: confidentiality of submitted information

(a) (No change.)

(b) The Department shall maintain confidentially documents that are not government records, as that term is defined at N.J.S.A. 47:1A-2 of the Open Public Records Act[, except that the Department shall not deem the following information to be trade secrets or proprietary, or information that would give an advantage to competitors, if disclosed:

1. Policies and procedures developed by an ODS with respect to the functions for which the ODS is seeking certification;

2. Basic organizational documents; and

3. Explanations of information system capacities and capabilities.]

11:24B-1.9 Carriers: contracts with organized delivery systems

[(a)] No [carrier] **ODS** shall maintain contracts, **either directly or indirectly,** with [an ODS] **a carrier** with respect to a health benefits plan for the performance of provision of services set forth at N.J.A.C. 11:24B-2.4(a) unless the ODS is certified or licensed by the Department.

[(b)] Nothing in this chapter shall relieve a carrier from compliance with any law or regulation, except as may be specifically stated within this chapter.]

11:24B-2.2 CODS: general filing instructions for applications for [initial] certification

(a) (No change.)

(b) **The** CODS shall submit **an** application[s] for certification no less than 90 days prior to the date that the CODS intends to execute its first contract with a carrier[, except as N.J.A.C. 11:24B-1.3 applies].

(c) **The** CODS shall submit **an** application[s] in a paper format subject to the following conditions:

1. (No change.)

2. **A** CODS shall clearly tab and segregate exhibits, presenting exhibits in the order in which the information requested is set forth at N.J.A.C. 11:24B-2.3 and 2.4[, with the information required by N.J.A.C. 11:24B-2.4 following the information required by N.J.A.C. 11:24B-2.3];

3. - 6. (No change.)

(d) - (e) (No change.)

11:24B-2.3 CODS: Part A of the application for certification

(a) Every ODS shall submit the following information:

1. A completed Application Cover Sheet, [contained in Exhibit 3 of the Appendix to this chapter, and incorporated herein by reference] **which can be found on the Department's website: www.state.nj.us/dobi/formlist.htm**;

2. A completed Irrevocable Consent to Jurisdiction of the Commissioner[s] and New Jersey Courts, [contained in Exhibit 4 of the Appendix to this chapter, and incorporated herein by reference] **which can be found on the Department's website: www.state.nj.us/dobi/formlist.htm**;

3. A completed Appointment of Attorney for the State of New Jersey, [contained in Exhibit 5 of the Appendix to this chapter, and incorporated herein by reference] **which can be found on the Department's website: www.state.nj.us/dobi/formlist.htm**;

4. A completed Financial Risk Affidavit, [contained in Exhibit 6 of the Appendix to this chapter, and incorporated herein by reference] **which can be found on the Department's website: www.state.nj.us/dobi/formlist.htm**;

5. - 6. (No change.)

7. A Biographical Affidavit, [contained in Exhibit 7 of the Appendix to this chapter, and incorporated herein by reference] **which shall include the filer's name and address, education and employment history, licenses held (including identification of those suspended or revoked), ownership or insurers or similar health entities for the filer and his or her immediate family, any bankruptcies, and whether the filer was in a position of control or authority with respect to an health plan entity whose authority was suspended or revoked, the for of which can be found on the Department's website:**

www.state.nj.us/dobi/formlist.htm, completed for each of the individuals who are, or are intended to be, responsible for the conduct of the affairs of the ODS, including:

i. - v. (No change.)

8. A business plan, consisting of:

i. - vi. (No change.)

[vii. A description of any reinsurance or stop loss arrangements;

viii. A plan, in the event of insolvency of the ODS, for continuation of the health care services to be provided in accordance with existing contracts and laws;]

Recodify existing ix. and x. as **vii. and viii.** (No change in text.)

9. A specimen copy of all provider agreements made or intended to be executed between the ODS and providers relative to the provision of health care services consistent with the standards of N.J.A.C. 11:24B-5;

i. The language of (a)9 above shall not be construed to prohibit an ODS from signing contracts prior to the date that the ODS is certified, but also shall not be construed to permit any ODS to execute any provider agreements for purposes of providing services as an ODS prior to the date of approval of the ODS' certification[, unless the ODS was contracted with a carrier prior to February 17, 2004 and the ODS is coming into compliance with this chapter in accordance with N.J.A.C. 11:24B-1.3];

10. (No change.)

11. A specimen copy of all management agreements made or to be executed between the ODS and one or more carriers, containing provisions establishing the respective duties of the ODS and carrier, and otherwise consistent with the standards of N.J.A.C. 11:24B-4.

i. The language of (a)11 above shall not be construed to permit any ODS or carrier to execute any contract for purposes of the ODS providing services as an ODS prior to the date of approval of the ODS's certification[, unless the ODS was contracted with a carrier prior to February 17, 2004 and the ODS is coming into compliance with this chapter in accordance with N.J.A.C. 11:24B-1.3];

12 (No change.)

13. A list of the carriers with which the ODS has contracted or intends to execute a contract pending the approval of the application.

i. The language of (a)13 above shall not be construed to permit any ODS or carrier to execute any contract for purposes of the ODS providing services as an ODS prior to the date of approval of the ODS's certification[, unless the ODS was contracted with a carrier prior to February 17, 2004 and the ODS is coming into compliance with this chapter in accordance with N.J.A.C. 11:24B-1.3];

14. - 15 (No change.)

(b) (No change.)

11:24B-2.4 CODS: Part B of the application for certification

(a) - (b) (No change.)

(c) An ODS that is performing or arranging for the performance of health care services shall provide the following:

1. - 2. (No change.)

3. A completed set of tables [as set forth in Exhibit 8 of the Appendix to the chapter, incorporated herein by reference], **which shall indicate the number of providers,**

general acute care hospitals, and ancillary, tertiary and specialized providers, which can be found on the Department's website: www.state.nj.us/dobi/formlist.htm.

(d) (No change.)

(e) If an ODS is engaging in credentialing and recredentialing [on behalf of a carrier, whether with respect only to the ODS' contracted providers or other providers that may be contracted with the carrier directly or through another ODS], the ODS shall submit [the information required in (c)1 above, and] the following information:

1. – 3. (No change.)

(f) An ODS that is engaging in utilization management development [on behalf of a carrier, whether for one or more types of health care services, and whether for a network the ODS manages or across a broader range of a carrier's business,] shall submit [the information required in (c)1 above, and] the following information:

1. – 3. (No change.)

(g) An ODS that is performing utilization management [on behalf of a carrier, whether for one or more types of health care services, and whether for a network the ODS manages or across a broader range of a carrier's business,] shall submit [the information required in (c)1 above and] the following information:

1. – 3. (No change.)

(h) An ODS that engages in one or both stages of the utilization management appeal process [on behalf of a carrier, whether for one or more types of health care services, and whether for a network managed by the ODS or across a broader range of a carrier's business,] shall submit [the information required in (c)1 above, and] the following information:

1. – 4. (No change.)

(i) An ODS that processes complaints of covered persons [on behalf of a carrier, whether for one or more types of health care services, and whether for a network managed by the ODS or across a broader range of a carrier's business,] shall submit [the information required in (c)1 above, and] the following information:

1. – 3. (No change.)

(j) An ODS that handles complaints of providers [on behalf of a carrier, whether for one or more types of services, and whether for a network managed by the ODS or a broader range of a carrier's business,] shall submit [the information required in (c)1 above, and] the following information:

1. – 4. (No change.)

(k) An ODS that engages in performance of continuous quality improvement [on behalf of a carrier, whether with respect to one or more the health care services, and whether with respect to a network managed by the ODS or for a broader range of the carrier's business,] shall submit [the information required in (c)1 above, and] the following information:

1. – 3. (No change.)

11:24B-2.5 (Reserved)

11:24B-2.8 Annual report and renewal

(a) The certification of an ODS shall expire three years after issuance. A certification shall automatically renew for another three-year period unless the Department finds that the ODS no longer complies with the Act or other applicable law, or if the ODS fails to file a complete annual report and information set forth in this section.

(b) An ODS shall file an annual report with the Department no later than March 1 of each year for the year ended December 31 immediately preceding on the form prescribed by the Department which can be found on the Department's website: www.state.nj.us/dobi/formlist.htm. The information required shall include:

1. The total number of provider and member complaints filed within the year being reported upon, categorized by type of complaint;

2. The total number of utilization management requests for authorization and the total number of denials;

3. The total number of utilization management appeals filed and the outcome of such appeals; and

4. The total number of claims paid, the total number of claim appeals filed and processed, and the resolution of such appeals.

(c) The annual report required in (b) above shall be accompanied by a current directory of the ODS' providers.

(d) In addition to the requirements in (b) and (c) above, the Commissioner may examine the operations of an ODS or request additional information from an individual ODS as deemed necessary by the Commissioner to determine compliance with N.J.S.A. 17:48H-1 et seq. or this subchapter.

11:24B-2.9 ODS: fees

The fee for review of an application for certification shall be \$ 2,500.

11:24B-2.10 Review of applications

(a) The Department shall determine whether an application is disapproved as incomplete within 30 days of the date of receipt of the application, and shall notify the ODS in writing of a determination of incompleteness, specifying the items that the ODS shall submit in order to make the application complete.

1. (No change.)

[2. With respect to an application for certification renewal, additional information shall be submitted prior to the date of expiration of the current certification in order to maintain the application for renewal as active, and avoid payment of a new certification fee.

(b) Notwithstanding that an application may be deemed or affirmatively found complete, the Department shall not be prohibited from requesting additional information from the ODS as may be necessary to answer questions that may arise subsequent to the deemed or affirmed determination of completeness, or pursuant to changed circumstances presented by either the ODS or one or more carriers with which the ODS contracts or proposes to contract.]

[(c)] **(b)** The Department may disapprove an application at any time during the review process if the Department believes that the compensation arrangement between the ODS and the carrier involves the transfer of financial risk as defined at N.J.A.C. 11:22-4, and shall notify the ODS in writing accordingly, specifying the reasons therefor.

1. If, following a hearing in accordance with [(f) or (g)] **(d)** below, it is determined, or an ODS otherwise proves to [The] **the** Department's satisfaction, that the ODS is not accepting a transfer of financial risk, notwithstanding the passage time involved, the Department shall reactivate review of the ODS' application without any additional application

fee, except as may be necessary to reflect a change in the functions for which the ODS may desire to be certified.

[(d)] **(c)** (No change in text.)

[(e)] Certification of an ODS to perform certain functions shall not be construed as certification by the ODS to perform other functions for which it may wish to contract with a carrier, but shall be limited to those functions for which the application was submitted, until such time as the ODS submits a complete application to amend its certification, and the amendment is approved or deemed approved.

1. Notwithstanding (e) above, a CODS may contract with more than one carrier for the performance of all or some portion of the functions for which the CODS has been certified, so long as all of the carriers with which the CODS contracts have received approval for such contracting, pursuant to N.J.A.C. 8:38, 8:38A and 11:4-37, as appropriate.]

[(f)] **(d)** When the Department disapproves an application for certification **or certification** modification for the reasons set forth in [(c)] **(b)** above, or failure of the ODS to meet the standards of [(d)] **(c)** above, the ODS may request a hearing within 30 days of receipt of the disapproval by submitting a request in writing to the Chief of the Valuation Bureau, setting forth with specificity the reasons that the ODS disputes the Department's notice of disapproval.

[(g)] When the Department disapproves an application for certification for the reasons set forth in (c) above, or failure of the ODS to meet the standards of (d) above, the ODS may request a hearing within 30 days of receipt of the disapproval by submitting a request in writing to the Chief of the Valuation Bureau, setting forth with specificity the reasons that the ODS disputes the Department's notice of disapproval, but otherwise shall comply with the provisions of

N.J.A.C. 11:24B-1.4(c), as if its certification has been revoked if the ODS was permitted to operate pursuant to N.J.A.C. 11:24B-1.3.]

[(h)] (e) (No change in text.)

11:24B-3.1 Carriers and CODs: mutual obligation to comply fully with certain standards

[(a) If the contract between an ODS and a carrier delegates performance of one or more of the legal obligations of the carrier to the ODS, the ODS shall establish policies and procedures to perform those obligations consistent with the standards, if any, set forth pursuant to regulation for the performance of those obligations by the type of carrier(s) with which the ODS has contracted or will contract.]

[(b) A carrier's delegation to an ODS of performance of a legal obligation of the carrier established by statute or regulation shall not relieve the carrier of its legal obligation to assure that performance of that obligation occurs consistent with standards established by law, nor shall the delegation be construed to prevent the Department from taking action against the carrier to enforce performance of the obligation, or for failure to assure appropriate performance of the obligation, notwithstanding that the Department may also take action against the ODS.]

[(c) Notwithstanding (b) above, delegation by a carrier to an ODS of performance of a legal obligation established pursuant N.J.S.A. 26:2S-1 et seq., and rules promulgated pursuant thereto, shall cause the ODS to be obligated to comply with N.J.S.A. 26:2S-1 et seq., and rules adopted pursuant thereto, to the same degree as the carrier may be obligated, except as may be specified otherwise in this chapter, and any action taken by the Department to enforce the performance of the obligation, or to fine the carrier for failure to assure appropriate performance of the obligation, shall not be construed either to prevent the Department from taking action

against the ODS, or to reduce any legal obligation of the ODS to appropriately perform in accordance with the statute or rules.]

11:24B-3.3 CODS and LODS: Application of statutes and regulations

(a) - (b) (No change.)

[(c) When an LODS or CODS contracts with both HMOs and other carriers for the performance of one or more of the functions listed in this chapter, the ODS shall demonstrate compliance with all applicable rules specified in this chapter for both types of carriers.

1. If the ODS demonstrates to the satisfaction of the Department that the ODS is in compliance with statutes and rules applicable to HMOs for a function, the Department shall deem the ODS to be in compliance with the statutes and rules applicable to non-HMO carriers with respect to that function.

(d) When an LODS or CODS contracts to perform one or more of the functions listed in this chapter with respect to health benefits plans which are managed care plans and health benefits plans which are not managed care plans, the ODS shall demonstrate compliance with all applicable rules specified in this chapter for both types of health benefits plans.

1. If the ODS demonstrates to the satisfaction of the Department that the ODS is in compliance with statutes and rules applicable to health benefits plans that are managed care plans with respect to a function, the Department shall deem the ODS to be in compliance with the statutes and rules applicable to health benefits plans that are not managed care plans with respect to that function.]

11:24B-3.5 ODS: network management

(a) (No change.)

(b) With respect to network adequacy, the ODS shall assure that the network meets the standards for determining network adequacy as set forth at N.J.A.C. [8:38A-4.10 or 8:38-6] **11:24A-4.10 or 11:24-6** for those categories of providers in the ODS' network with respect to those services that the providers are required to render.

1. (No change.)

(c) - (i) (No change.)

11:24B-3.6 ODS: credentialing

(a) If an ODS [agrees to] performs credentialing and recredentialing activities, [but either does not offer network management services, or offers network management services that wishes to perform credentialing and recredentialing activities on behalf of a carrier with respect to providers outside of the ODS' network] **whether with respect only to the ODS' contracted providers or other providers that may be contracted with the carrier directly or through another ODS**, the ODS shall demonstrate that it meets the **following** requirements [of N.J.A.C. 11:24B-3.4(b), and the following in order to be certified]:

1. - 6. (No change.)

11:24B-3.7 ODS: utilization management guidelines development

(a) In order for an ODS to be certified to perform development of UM guidelines, the ODS shall comply with [the requirements of N.J.A.C. 11:24B-3.4(b), and] the following:

1. The ODS shall designate a medical director to be responsible for its UM guidelines program who is licensed to practice medicine in New Jersey; or acknowledge that its

utilization management program is under the ultimate oversight of the medical director of the carrier with respect to the carrier's health benefits plans, and the carrier's medical director is licensed to practice medicine in New Jersey; **and**

2. The UM guidelines developed by an ODS shall:

i. (No change.)

ii. Be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers, and be based upon generally accepted medical standards[; and].

[3. If an ODS is responsible for development of UM guidelines with respect to at least one health benefits plan that is a managed care plan, the ODS shall also demonstrate that the UM guidelines are developed with involvement of the participating providers of the carriers with which the ODS contracts.]

11:24B-3.8 ODS: [Utilization] **utilization** management program

(a) In order for an ODS to be certified to operate a utilization management program [on behalf of a carrier], the ODS shall comply with the requirements of N.J.A.C. [11:24B-3.4(b)] **11:24-8.2 and 8.3 or 11:24A-3.4(c) through (f)**, and:

1. Have a mechanism that ensures consistent application of review criteria and uniform decisions; **and**

2. Develop measures for evaluating the UM guidelines and application thereof, including outcome and process measures when the carrier utilizes a gatekeeper system or practice guidelines for managed care products[;].

[3. Comply with N.J.A.C. 11:24-8.2 and 8.3 or 11:24A-3.4(c) through (f); and

4. Comply with N.J.A.C. 11:24A-4.11(b)2.]

11:24B-3.9 Utilization management appeal mechanism

[(a)] In order for an ODS to be certified to perform duties with respect to a carrier's utilization management appeal mechanism, the ODS shall comply with the requirements of N.J.A.C. [11:24B-3.4(b),] **11:24-8.4 through 8.6 or 11:24A-3.5 and 4.12, and N.J.S.A. 26:2S-**

11. [and demonstrate that its utilization management appeal mechanism is in compliance with:

1. N.J.A.C. 11:24A-3.5, if performance will only be with respect to health benefits plans that are not managed care plans; or

2. N.J.A.C. 11:24-8.4 through 8.6 or N.J.A.C. 11:24A-4.12, if performance will be with respect to one or more health benefits plans that are managed care plans.

(b) If an ODS elects to review utilization management appeals submitted by a provider without requiring the consent of the covered person prior to reviewing the appeal, the ODS shall provide notice to the provider, at least in writing, that the review is being performed as an alternative to the required utilization management appeal process established pursuant to N.J.A.C. 11:24-8.4 through 8.6 or 11:24A-4.12, and that if the provider wishes the standards of N.J.A.C. 11:24-8.4 through 8.6 or 11:24A-4.12 to apply throughout the appeal process, the provider shall obtain the written consent of the covered person.]

11:24B-3.10 ODS: continuous quality improvement

[(a)] In order for an ODS to be certified to perform continuous quality improvement on behalf of a carrier, [separate and apart from any network management services that the ODS may

otherwise have,] the ODS shall demonstrate compliance with the requirements of N.J.A.C. 11:24B-[3.4(b), and:] **3.5(h) and (i)**.

[1. That its continuous quality improvement program for the carrier meets all of the standards set forth at N.J.A.C. 11:24B-3.3(h) and (i), if performing with respect to one or more health benefits plans that are managed care plans; or

2. That its continuous quality improvement program for the carrier meets the standards of N.J.A.C. 11:24A-3.8, if performing solely with respect to health benefits plans that are not managed care plans.]

11:24B-3.11 ODS: provider complaint mechanism

In order for an ODS to be certified to perform provider complaint functions on behalf of a carrier, [separate and apart from any network management services that the ODS may have otherwise,] the ODS shall demonstrate that it is in compliance with the requirements of N.J.A.C. [11:24B-3.4(b), 8:38-3.7(b) or 8:38A-4.6(b)] **11:24-3.7(b) or 11:24A-4.6(b)**.

11:24B-3.12 ODS: member complaint mechanism

In order for an ODS to be certified to perform member complaint functions on behalf of a carrier, [separate and apart from any network management services that the ODS may have otherwise,] the ODS shall demonstrate that it is in compliance with the requirements of N.J.A.C. [11:24B-3.4(b),] 11:24-3.7(a) or 11:24A-4.6(a).

11:24B-4.4 Network management

(a) - (b) (No change.)

(c) The contract shall specify the compensation arrangement between the ODS and the health care providers in the network.

1. (No change.)

2. The provision shall specify the process by which the ODS will make payment to providers, which shall be consistent with the standards of P.L. 1999, c.154 (Health Information Technology Act), **as amended**, as well as P.L. 1999, c.155, **as amended**, and rules promulgated pursuant thereto, including N.J.A.C. 11:22-1.

(d) - (j) (No change.)

(k) The contract shall require the ODS to assure that its network providers treat a carrier's members without discrimination.

[1. Notwithstanding (k) above, the ODS and the carrier may agree that the ODS' network will be responsible for treatment of a limited number of the carrier's total number of covered persons, so long as the standards for the limitations are set forth in the management agreement, do not result in unfair discrimination, and the ODS is obligated to assure that its network providers abide by the limitations.

2. Notwithstanding (k) above, the ODS and the carrier may agree that a provider may limit the total number of a carrier's covered persons the provider treats, so long as the standards for the limitations are set forth in the management agreement, do not result in unfair discrimination, and the ODS is obligated to assure that its network providers abide by the limitations.]

(l) - (p) (No change.)

11:24B-4.8 Utilization management appeal program

(a) The contract shall specify how the ODS will comply with N.J.A.C. 11:24A-3.5, [if performance only will be with respect to health benefits plans that are not managed care plans, or N.J.A.C.] 11:24-8.4 through 8.6 or 11:24A-4.12, [if performance is with respect to one or more health benefits plans that are managed care plans] **as applicable**.

(b) - (d) (No change.)

11:24B-4.10 Complaint mechanisms

(a) The contract shall contain provisions demonstrating the ODS' compliance with N.J.A.C. 11:24-3.7(b) or [8:38A-4.6(b)] **11:24A-4.6(b)** if addressing provider complaints, or N.J.A.C. 11:24-3.7(a) or 11:24A-4.6(a) if addressing complaints of covered persons.

(b) - (c) (No change.)

SUBCHAPTER 5. PROVIDER AGREEMENTS

11:24B-5.2 General provisions

(a) All provider agreement forms shall contain:

1. - 18. (No change.)

19. A provision setting forth the procedures for submitting and handling of claims, including any penalties that may result in the event that claims are not submitted timely, the standards for determining whether submission of a claim has been timely, and the process for providers to dispute the handling or payment of claims.

i. Provisions addressing claims handling shall be consistent with [P.L. 1999, c.154 (Health Information Technology Act) as well as P.L. 1999, c.155, and rules promulgated pursuant thereto, including N.J.A.C. 11:22-1] **applicable law**.

ii. (No change.)

20. - 21. (No change.)

(b) – (d) (No change.)

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