INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH

Organized Delivery Systems

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

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

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

Proposed: November 17, 2008 at 40 N.J.R. 6529(a)

Adopted: July 7, 2009 by Steven M. Goldman, Commissioner, Department of Banking and Insurance

Filed: July 8, 2009 as R. 2009 d. 243, without change.

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

Effective Date: July 8, 2009, Readoption;
August 3, 2009, Amendments, Repeals and New Rules

Expiration Date: July 8, 2014

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) timely received two written comments from the New Jersey Hospital Association and the Raritan Bay Medical Center.

COMMENT: The commenters generally supported the proposal to streamline and eliminate redundancy where possible, while maintaining the essence of the requirements related to the operations of organized delivery systems (ODS).

One commenter expressly supported the proposed new language in N.J.A.C. 11:24B-2.8 that requires the filing of a report by an ODS which would provide information on provider and member complaints, utilization management authorizations, denials and appeals, and claims

payment statistics, as well a directory of participating providers. The commenter "cautiously" supported the change in the certification process, allowing automatic renewal unless the Department finds that a certified ODS (CODS) is not compliant with its requirements. The commenter stated that it would not support an automatic renewal for licensed ODSs if such a proposal were put forward. The commenter noted, however, that with automatic renewal there is no longer a mechanism by which the Department can collect a fee for re-certification of a CODS and that the elimination of renewal fees may not be prudent.

The commenter also supported the deletion of N.J.A.C. 11:24B-3.1(a) and (c) to eliminate redundancy and appreciated the retention of the requirements at N.J.A.C. 11:24B-3.1(b) which states that a carrier is legally obligated to ensure that the performance of its contracted ODS is consistent with standards established by law.

RESPONSE: The Department appreciates the support of its proposal. The Department believes that the revision to N.J.A.C. 11:24B-2.8 is reasonable and appropriate in that it provides for automatic renewal of CODSs. The Department notes that this is consistent with the regulation of licensed ODSs and insurers. The Department believes that it is a more appropriate and efficient use of Department resources to utilize the automatic renewal process as provided in the new rules. The Department notes that while the fee for the review of applications for renewal will be eliminated, corresponding costs to the Department associated with reviewing applications for renewal each year will be eliminated as well.

COMMENT: The commenters stated that N.J.A.C. 11:24B-4.4(c) appears to address compensation arrangements between an ODS and the providers in the network of the carrier for

whom the ODS is managing the network. The commenters stated that if this is the case, the Department should amend this rule to provide more specific direction on how payment to providers in the carrier's network shall be made. The commenters believed that if there is no contract between an ODS and a provider, and the provider is rendering services to a carrier's plan member, the provider should be reimbursed at the rate it has negotiated with the carrier as part of the network arrangement. The commenters stated that often an ODS will reimburse a provider at a rate (often based upon a reduced fee schedule) that is not consistent with the contract between the provider and the carrier.

Similarly, the commenters suggested that under N.J.A.C. 11:24B-4.4(n) ODSs that are managing services and a network on behalf of a carrier should be obligated to treat the carrier's contracted providers as network providers for the purpose of selection and authorization for services for a carrier's plan member. The commenters stated that often an ODS, when selecting a provider for a carrier's plan member, will consider only the providers with which it has contracted directly, rather than all of the providers that have contracted with the carrier to provide services to its members. One commenter additionally stated that the ODS will tier its networks and the carrier will steer members to less costly providers when a member would prefer to go to elsewhere either due to continuity of care or geographic concerns. The commenter believed that members should be free to choose to have contracted services performed by any provider that has contracted with the carrier. The commenter stated that when a carrier contracts with an ODS for certain "carve-out" services, such as radiology, the provider should not be precluded from offering its contracted services to the carrier's members. In addition, the commenter believed that additional burdens, such as precertification or referral requirements, should not be placed on the provider because the provider does not have a direct

contract with the ODS, unless those same requirements are applicable to all providers that contract with the carrier to provide those services. The commenter believed that the same administrative requirements that the carrier has with its participating providers for the contracted services should apply to "carve-out" services being provided by the ODS.

RESPONSE: Upon review, the Department has determined that no change is required. The commenters appear to believe that a contract between a provider and a carrier that preceded the carrier's arrangement with an ODS remains in force for the service delegated to the ODS. This is not necessarily the case. Arrangements between an ODS and carriers vary with respect to the ODS's responsibilities for network management and often directly impact providers who had an existing contract with the carrier. Generally, an ODS requires providers to contract directly with the ODS. It should be recognized that an ODS is not obligated to accept all of the carrier's participating providers into its network, nor do providers who choose not to contract with the ODS have the right to continue to be considered a participating provider for the service delegated to the ODS. It is more often the case that, in the absence of a direct contract between the provider and the ODS, the provider is no longer considered a participating provider for purposes of the service delegated to the ODS. Even in cases when a carrier maintains its existing contract with a provider, the carrier may require the provider to contract directly with the ODS and become a participating provider in the ODS's network. Barring the inclusion of specific contract language providing otherwise, for the length of the agreement between the carrier and the ODS the terms of the ODS's provider contract terms would generally prevail, including compensation terms. The ODS has the right to direct members to its participating providers for the service

delegated to the ODS, and there is no statutory requirement that an ODS give equal consideration to all providers in the carrier's network.

COMMENT: The commenters requested that the Department amend N.J.A.C. 11:24B-5.2 governing provider agreements because it asserted that the current rules result in payer practices that are inappropriate and which could be considered coercion. The commenters specifically requested the following changes.

In N.J.A.C. 11:24B-5.2(a)1i(2), remove the exception to contract amendment reviews for amendments that do not alter the methodology. The commenters believed that any contract amendment that alters dollar figures should be subject to Department approval before presentation to a provider for consideration because payers typically present the amendments as already approved by the Department. The commenters believed that providers should have assurance that the amendment has undergone Department review to ensure that the process remains consistent and fair. The commenters suggested that a similar amendment be promulgated at N.J.A.C. 11:24B-5.9(b)2, which addresses the issuance of contracts on approved forms.

In N.J.A.C. 11:24B-5.2(a)4, the rule should provide more specificity as to how the compensation methodology would work. The commenters reiterated that a provider agreement should indicate whether the reimbursement will be in accordance with the rate that a provider has negotiated with a carrier, or with the ODS's own rate schedule.

In N.J.A.C. 11:24B-5.2(c)2i, the Department should eliminate the provision that would allow ODSs to unilaterally amend the provider agreement if the amendment is required by State or Federal law. The commenters stated that ODSs and other payers usually include a wide range

of provisions in a contract amendment that are well outside the scope of any new statutory requirement under the guise of being required to implement the provision. In addition, the commenters stated that even when a specific provision is required by law, ODSs and other payers write the amendment in such a way that it is not consistent with the new State or Federal requirement. The commenters thus believed that any such amendments should be reviewed by the Department before presentation to providers. One commenter additionally stated that amendments and the implementation thereof should be reviewable by regulators to determine if the amendment is in compliance with applicable law.

The commenters cited as an example, included in a "regulatory requirements appendix" may be provisions relating to the continuation of services following a contract termination, but the provisions are those required for physicians, not hospitals. The commenters have also reviewed contract amendments presented as required by State law that indicate that interest on late claims will be paid at 10 percent per annum, rather than 12 percent as is actually required.

In N.J.A.C. 11:24B-5.2(d), the commenters requested that the Department eliminate the provision that allows ODSs to include in the provider manual items that are essentially contract provisions. The commenters believed that this results in ODSs and other payers changing core terms through amending the provider manual, without going through the appropriate contract amendment process, which would otherwise allow for negotiation of such terms. The commenters believed that if hospitals are contractually required to comply with the policies spelled out in the manual, the manual is an extension of a contract and should be treated as such, subject to the same amendment procedures that would be required for amending the contract itself.

RESPONSE: Upon review, the Department has determined not to change these provisions. The commenters' proposed changes to the language would require the Department to become directly involved, on an ongoing basis, in the review and evaluation of aspects of the contract that are specific to compensation. The Department, however, has recognized the need for contracts to be balanced and for reasonable limitations to be placed upon the ability of payers, including ODSs, to unilaterally amend the contract after the terms of the agreement have been agreed upon. The Department recently proposed rules that would establish standards for provider contracts upon which all interested parties were provided an opportunity to comment. (See 41 N.J.R. 2426(a).) The Department believes that the proposed standards will address some of the issues raised by the commenters, though possibly not to the level of specificity being requested. The commenters appear to believe that any amendment to a contract should be subject to review and approval by the Department. The Department believes that this position is too far reaching and would impede the normal course of business.

Regarding the commenters' concerns that unfair terms may be added to the contract under the guise of compliance with State or Federal Law, in such cases the provider has the opportunity to make inquiries to the Department as to whether the amendatory language is consistent with the Department's interpretation of the State or Federal law at the time the provider receives notice of the change.

Federal Standards Statement

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

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 11:24B.

Full text of the adopted amendments and new rules follows:

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