State of New Jersey

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BULLETIN

OMC Bulletin 2004-02

TO: **All Hospital Service Corporations, Medical Service Corporations, Health Service Corporations, Insurers Authorized to Transact Business in New Jersey, Health Maintenance Organizations**

FROM: **Marilyn Dahl, Deputy Commissioner**

DATE: **August 11, 2004**

RE: **Use of Side Agreements to Provider Agreements**

The Department of Health and Senior Services ("Department") has become aware of a practice wherein carriers are using "side agreements" that attempt to alter one or more terms of the underlying provider agreements that have been properly filed and approved by the Department. Based on information received in recent months, it appears that some carriers and others believe that it is permissible for carriers to enter into "side agreements" even though not filed or approved by the Department. Some of these "side agreements" are contained in the rate schedule which is an appendix or exhibit to the provider agreement and is not required to be submitted to the Department.

Requirement to File Forms and Amendments

Pursuant to N.J.S.A. 26:2J-3c, HMOs must submit a copy of any contract made or to be made between any providers as part of the HMO's application for a certificate of authority. Approval of the HMO's certificate of authority is contingent upon the Department being satisfied that the HMO may reasonably be expected to meet its obligations to enrollees and prospective enrollees (N.J.S.A. 26:2J-4b(3)). In determining whether the HMO can be expected to meet its obligations, the Department may consider the agreements the HMO has made or will make with providers for the provision of health care services (N.J.S.A. 26:2J-4b(3)(c)) HMOs are obligated, pursuant to N.J.S.A. 26:2J-3d(1), to provide the Department with prior notice of changes to provider agreements, and such changes are subject to review and disapproval of the Department.

The Department considers provider agreements to be an important component of the HMO's certificate of authority application, and as an ongoing measure of an HMO's ability to provide health care services to enrollees. The Department's general standards for provider agreements are set forth at N.J.A.C. 8:38-15, although additional standards are set forth throughout the regulations governing HMOs at N.J.A.C. 8:38. Among other things, N.J.A.C. 8:38-15.3(a) states that the forms of provider agreements and amendments thereto must be submitted to the Department for approval prior to use.

Non-HMO carriers offering health benefits plans that are managed care plans[1] must also submit the forms of their provider agreements and amendments thereto to the Department for approval prior to use in accordance with N.J.A.C. 8:38A-4.15(f). These rules were adopted by the Department under the authority granted at N.J.S.A. 26:2S-18, which required the Department to adopt rules and regulations necessary to carry out the Health Care Quality Act, N.J.S.A. 26:2S-1 et seq. The Department was required to promulgate regulations establishing consumer protections and quality standards governing carriers offering managed care plans consistent with the standards governing HMOs. In addition, several provisions of the Health Care Quality Act established standards for provider agreements applicable to both HMO and non-HMO carriers. Based upon the concepts set forth in the Health Care Quality Act and the regulatory mandate set forth at N.J.S.A. 26:2S-18, the Department determined it was appropriate to treat HMO and non-HMO carriers and their provider agreements similarly; hence, the promulgation of N.J.A.C. 8:38A-4.15, including paragraph (f).

Lastly, an Organized Delivery System (ODS) that wants to contract with a carrier to provide or arrange for the provision of health care services to a carrier's enrollees or covered persons covered under a managed care health benefits plan, must submit the forms of the provider agreements that will be used for the arrangement to the Department prior to use (N.J.S.A. 17:48H-4(e) and (f)). This same standard also applies with respect to amendments to the provider agreements. The Department promulgated rules regarding provider agreements at N.J.A.C. 8:38B-5 in order to implement provisions of the Organized Delivery System Act, N.J.S.A. 17:48H-1 et seq.

Side Agreements and Amendments

Some carriers and other parties appear to be under the impression that changes to the underlying contractual relationship using side agreements are not changes within the meaning of an amendment and thus, are not subject to filing with the Department prior to use. For instance, if a carrier presents a health care provider with a so-called "side agreement," which would require the health care provider to offer the carrier a reduction in rates whenever the health care provider offered a lower rate to another payer, the side agreement would constitute a contract amendment. In other words, such a side agreement is intended to assure that the carrier always receives whatever the lowest rate is that the health care provider is willing to offer to another payer (often referred to as a "most favored nation" clause, or "most favored customer" clause). Such a side agreement would have to be submitted to the Department for review.

The Department disagrees with the notion that documents (or practices) that alter the contractual relationship do not constitute amendments simply because the

[1] N.J.A.C. 8:38A-1.2 defines a managed care plan as "a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangement with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan."

documents are not referred to as amendments. It is the effect of the document that matters, not necessarily the document's name. Whenever a document is intended to add terms to, delete terms from, or alter the fundamental nature of the existing terms of the filed provider agreement, including all exhibits or appendices to the provider agreement, the document constitutes an amendment that must be filed with the Department prior to use. Any changes to a provider agreement that make the fundamental nature of its terms different from the terms of the specimen provider agreement approved by the Department are prohibited. Accordingly, carriers are on notice that the use of so-called side agreements that have not been filed and approved is prohibited, [2] and may subject the carrier to the assessment of penalties and fines.

It should be noted that carriers may submit amendments to contract forms using the certification process and form set forth in Bulletin 2004-01, issued April 20, 2004. Questions regarding the information contained in this bulletin may be directed to Sylvia Allen-Ware, Director, Office of Managed Care at (609) 633-0660.

[2] Carriers may propose an "unapproved" amendment to a health care provider's provider agreement before submitting the amendment to the Department for review with the contract form to which it will attach, but the carrier and health care provider cannot effectuate the amendment until the Department has approved the amendment or deemed it approved.