STATE OF NEW JERSEY
DEPARTMENT OF HEALTH AND SENIOR SERVICES

IN THE MATTER OF HORIZON HEALTH CARE OF NEW JERSEY, INC. AND THE PROMPT PAYMENT OF CLAIMS PURSUANT TO N.J.S.A. 26:2J-5.1	))))	ADMINISTRATIVE CONSENT ORDER

This Administrative Consent Order ("ACO") is entered into pursuant to the authority vested in the Commissioner of the New Jersey Department of Health and Senior Services ("DHSS") by N.J.S.A. 26:2J-1 et seq. with Horizon Health Care of New Jersey, Inc. ("Horizon") in order to amicably resolve the matters set forth below without need of formal hearing or further litigation, and without any specific admission of liability or fact by either party, with the hope of achieving a more cooperative relationship in the future.

BACKGROUND

1. N.J.S.A. 26:2J-5.1 established certain guidelines regarding the timeliness of the handling of claims by health maintenance organizations[1]. Among other things, the statute set forth the maximum appropriate timeframes for the payment of eligible claims for which no dispute existed, as well as the payment of undisputed portions of eligible claims that were otherwise subject to dispute, and notices regarding disputes. In addition, the statute set forth a requirement that interest be paid for failure to make payments timely on eligible claims, or undisputed portions of claims. DHSS adopted rules interpreting N.J.S.A. 26:2J-5.1 effective October 1998, at N.J.A.C. 8:38-16.

[1] L. 1999, c. 154 § 17 repealed N.J.S.A. 26:2J-5.1, and established new standards for the timeliness of claims payments for various carriers, including HMOs (see, N.J.S.A. 26:2J-8.1). However, N.J.S.A. 26:2J-5.1, and rules promulgated pursuant thereto apply to the time period at issue for this ACO.

2. DHSS received complaints of failure by Horizon to make timely payments in accordance with N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16 on various claims submitted. Pursuant to complaints received with respect to 12 specific health care providers who alleged multiple unpaid claims totaling approximately $174,526[2], and subsequent correspondence between the Office of Managed Care and Horizon regarding these complaints, DHSS issued a letter to Horizon on June 15, 1999, requiring Horizon to respond by resolving those items that were indicated as unresolved, and to make interest payments accordingly. It should be noted that some of the disputed claims of each provider appeared to have been paid, and in those instances the only issue remaining was the payment of interest by Horizon because of its alleged failure to pay the claim(s) promptly, as required by N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16.4.

3. Horizon performed an investigation of the complaints presented to it by DHSS. Subsequently, Horizon admitted that some of the alleged violations were factually correct, stated that some of the claims listed as outstanding had been paid already in a timely manner, and stated that some of the claims listed as outstanding would be paid, but without interest, because the claims were being handled consistent with the statute and rules. Horizon did not admit an obligation to comply with N.J.A.C. 26:2J-5.1 and N.J.A.C. 8:38-16 with respect to all of the claims forwarded in the June 15, 1999 letter. Furthermore, Horizon stated in later follow-up correspondence dated October 1, 1999, that interest for late claims generally had not yet been paid on those claims for which Horizon admitted interest payment was due,[3] and indicated that interest would not be paid if the amount owed was less than $1.00.[4]

[2] Because some of the claims had, indeed, been paid, and because some of the claims may have been in excess of contracted fees, the $174,526 total submitted by the providers is not necessarily an accurate accounting of sums that may have been owed by Horizon.
[3] Horizon apparently makes its interest payments separately from its claims payments, typically on a quarterly basis.
[4] It may be noted that Horizon's position actually is that it does not *routinely* pay interest that is less than $1.00, but it does make the nominal interest payments if so requested by the health care provider on an individual basis.

4. DHSS sought additional information regarding all of the claims, the process for resolution of those claims, and the basis for the determination by Horizon that some of the claims either are not their liability, or are not subject to N.J.S.A. 26:2J-5.1.

5. With respect to those claims for which Horizon admitted responsibility, but did not admit any violations, Horizon contended that they did not have to meet the standards of N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16 for eight of the claims because they were HMO claims that pre-dated the rules at N.J.A.C. 8:38-16, while an additional 127 of the claims were HMO claims for services delivered to Horizon enrollees who were Medicare beneficiaries.

6. With respect to those claims for which Horizon admitted no responsibility, and hence, admitted no violation of New Jersey law, Horizon did so because 41 of the claims were not HMO claims; one claim was the responsibility of another Blue Cross Blue Shield Association member company; and, approximately 20 of the claims were from health care providers that were contracted with FPA Medical Group of New Jersey ("FPA") [5] on the date the claims arose.[6]

7. Horizon did not include information on the claims of two of the 12 healthcare providers.

8. DHSS agrees that N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16 are applicable only to claims arising pursuant to an HMO health benefits plan. Thus, any claims submitted to Horizon that arise pursuant to a non-HMO policy or a self-funded welfare plan are not subject to N.J.S.A.

[5] FPA and Horizon (as successor to Medigroup, Inc., acting on behalf of five Medigroup subsidiaries) had contracted for the provision of various health care services for several years. During that time, FPA handled a substantial portion of the claims submitted by FPA-contracted health care providers for services rendered to a large segment of Horizon's members. However, FPA ultimately filed for bankruptcy in 1998.

[6] Horizon states that it offered health care providers who stated that they were not contracted with FPA an opportunity to certify that they had no such contract at the time the service was delivered, and upon receipt of such a certification, Horizon would undertake to pay the claim.

26:2J-5.1 or N.J.A.C. 8:38-16, even if Horizon is the entity that processes the claim.[7] DHSS agrees that any claims that are actually the obligation of another Blue Cross Blue Shield Association member are not the ultimate responsibility of Horizon, and thus, *Horizon* is not obligated to process such claims pursuant to N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16. DHSS does not agree with Horizon that N.J.S.A. 26:2J-5.1 lacks applicability with respect to any of the remaining claims, or that N.J.A.C. 8:38-16 lacks applicability to most of the remaining claims.

Claims Pre-dating N.J.A.C. 8:38-16

9. Horizon contends that some of the HMO claims pre-dated the effective date of N.J.A.C. 8:38-16, and thus, are not subject to the claims-handling standards of either the statute or the rules. DHSS's position is that N.J.S.A. 26:2J-5.1 had force and effect following its enactment in 1992,[8] regardless of whether N.J.A.C. 8:38-16 was ever promulgated. DHSS contends that Horizon violated N.J.S.A. 26:2J-5.1 with respect to its HMO claims whether or not N.J.A.C. 8:38-16 may have been applicable.

Without conceding the alleged violations, Horizon has agreed to the payment of a monetary penalty, as set forth in the Order below, for the alleged aforesaid violation of N.J.S.A. 26:2J-5.1.

Claims for Services Rendered to Medicare Beneficiaries

10. Horizon contends that 127 of the claims forwarded by DHSS were for services provided to members who were Medicare beneficiaries, and that federal rules regarding claims handling by Medicare-contracting HMOs (Medicare+Choice) supercede or preempt any state

[7] Notably, similar New Jersey statutes and rules applied to other types of health coverage (other than self-funded plans), so the issue is not a matter of whether the claims had to be processed to meet the general timeliness standards, but rather, whether DHSS has jurisdiction to require accountability for the processing of non-HMO claims by Horizon Health Care of New Jersey, Inc.

[8] N.J.S.A. 26:2J-5.1 was enacted as part of L. 1991, c. 187.

laws on the matter. DHSS does not concede that claims for services provided to Medicare beneficiaries are beyond the scope of the provisions of New Jersey's prompt pay laws, or that federal law preempts or supercedes state laws in this instance. DHSS alleges that Horizon has violated N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16 by failing to administer claims for services rendered to Medicare beneficiaries consistent with state laws in addition to federal laws.[9] DHSS contends that Horizon had a legal obligation to comply with N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16 for all of its HMO claims, regardless of whether the claim related to a Medicare beneficiary or not.

Without conceding the alleged violations, Horizon has agreed to the payment of a monetary penalty, as set forth in the Order below, for the alleged aforesaid violations of N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16.

Claims submitted by FPA-contracted Health Care Providers

11. Horizon contends that it has no responsibility to adjudicate or pay claims submitted by FPA-contracted health care providers because Horizon alleges that the relationship between FPA and the health care providers was essentially one of employer and employee. Thus, Horizon's contention is that, once it paid FPA, Horizon satisfied any responsibility it may have had with respect to payment of claims submitted by FPA-contracted health care providers for services rendered to Horizon members.

DHSS is not aware of the existence of an employer-employee relationship between FPA and the health care providers that rendered services to Horizon members, whether the health care

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[9] It may be noted that DHSS is not aware of any fines or other sanctions being levied against Horizon for failure to meet the claims paying requirements of the Health Care Financing Administration, which oversees the Medicare program. The criteria for determining compliance with claims payment requirements with the federal rules and state rules are not the same, and thus, whether Horizon may be in compliance with the technical requirements established by HCFA is not dispositive of whether Horizon is in compliance with the technical requirements established by the state for payment of claims.

provider contracted with FPA or not. DHSS alleges that FPA was an intermediary, and thus, DHSS contends that claims submitted, or which would have been submitted, to FPA are subject to the requirements of N.J.A.C. 26:2J-5.1 or N.J.A.C. 8:38-16. N.J.A.C. 8:38-16.5 states that handling of claims by an intermediary (whether a subcontractor, secondary contractor or primary contractor of the HMO that agrees to perform one or more of the HMO's claims-handling functions) does not reduce the HMO's legal responsibility to comply with the rules at N.J.A.C. 8:38-16. DHSS's position is that the HMO has an obligation pursuant to N.J.A.C. 8:38-16.5 to assure that payments to the provider are being made in accordance with the statutes and rules, and is accountable for payment if the intermediary is not performing pursuant to law. DHSS contends that Horizon had an obligation to have all HMO claims handled in accordance with N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16, regardless of whether the claims were submitted to Horizon or to FPA.

Horizon also contends that at least some of its contracts with FPA-contracted health care providers specified that the health care providers were to look only to FPA for payment. DHSS is not aware of any such provision having been approved by DHSS or the Department of Banking and Insurance at any time. The contract entered into between FPA and Horizon when Horizon was doing business as Medigroup, Inc., acting on behalf of five Medigroup subsidiaries, included a statement that Medigroup, not FPA, was ultimately responsible for the payment of claims to health care providers under contract with FPA, pursuant to a supplemental addendum to the original contract that apparently became effective on April 1, 1995. The supplemental addendum also states that each provider under contract with FPA is deemed to be under contract also with Medigroup. This version of the contract is consistent with subsequently-enacted rules at N.J.A.C. 8:38-15 regarding provider agreements, is in line with N.J.A.C. 8:38-16.5, and

demonstrates that Horizon understood in 1995 DHSS's position as it was later codified in regulation in 1997: specifically, that the HMO is ultimately responsible for the appropriate payment of claims for services rendered.

DHSS contends that Horizon must adjudicate and pay claims (consistent with the terms of the health benefits plans under which the claim arose, and consistent with the compensation criteria set forth in the provider agreements, if any) in the event the intermediary fails to perform, or fails to perform appropriately. DHSS contends that Horizon violated N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16 when Horizon failed to adjudicate and make appropriate payments on claims submitted to it by FPA-contracted health care providers following the bankruptcy of FPA, and that it was inappropriate for Horizon to require any health care provider to submit a certification that the health care provider had not been contracted with FPA at the time the claim arose in order for the health care provider to receive payment.

Without conceding the alleged violations, Horizon has agreed to the payment of a monetary penalty, as set forth in the Order below, for violations of N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16.

Missing Information

12. DHSS contends that Horizon has not provided information with respect to two of the providers whose claims DHSS submitted to Horizon, despite consistent inclusion of the provider claims in the data sent by DHSS to Horizon. The health care providers allege that Horizon has failed to make payments timely, or to pay appropriate interest.

In addition, DHSS requested that Horizon provide DHSS with specific information as to whether claims were clean when initially received, and if not clean, when the necessary

documentation or corrections were received to make the claims clean, thereby affording a more accurate means by which to calculate the duration of certain types of violations, if any.

DHSS alleges that Horizon has violated N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16 for failing to make appropriate and timely payment on at least some of the claims submitted by DHSS to Horizon, that such violations may include the failure to pay promptly and appropriately the health care providers about whom Horizon has failed to provide specific information, and that Horizon has prevented DHSS from being able to determine the degree of the violations because it has not provided DHSS with appropriate information. Without conceding the alleged violations, Horizon has agreed to the payment of a monetary penalty, as set forth in the Order below, for violations of N.J.S.A. 26:2J-5.1 and N.J.A.C. 8:38-16.

ORDER

NOW, THEREFORE, DHSS and Horizon agree and stipulate to the following terms and conditions:

1. DHSS and Horizon stipulate that the number of days of occurrence of any alleged violations, whether or not admitted to by Horizon, is uncertain and can not be definitively determined, and thus, the monetary penalty is not based on a calculation of days of alleged violation, but rather, on flat dollar amounts determined to be mutually agreeable to DHSS and Horizon. Accordingly, Horizon shall pay a penalty of a single sum of Thirty-Five Thousand Dollars ($35,000), composed of the aforementioned monetary penalties agreed to above as follows: One Thousand Dollars ($1,000) for the admitted violations; Two Thousand Dollars ($2,000) for the HMO claims that pre-dated the effective date of N.J.A.C. 8:38-16; Ten Thousand Dollars ($10,000) for the Medicare-related claims; Twenty Thousand Dollars

($20,000) for the FPA-related claims; and Two Thousand Dollars ($2,000) for the missing information.

2. Within ten (10) business days following the execution by all parties of this ACO, Horizon shall submit the single sum of Thirty-Five Thousand Dollars ($35,000) by bank draft payable to the Treasurer, State of New Jersey, through the New Jersey Department of Health and Senior Services, P.O. Box 360, Trenton, New Jersey, 08625-0360, sent to the attention of Elisabeth Salberg, Director, Office of Managed Care.

3. In the event that Horizon does not remit the sum of Thirty-FiveThousand Dollars ($35,000) as set forth in Paragraph 2 above, DHSS may institute a summary proceeding for collection of such penalty in accordance with the Penalty Enforcement Law, N.J.S.A. 2A:58-1 et seq.

4. This ACO shall not serve as satisfaction of any contractual or regulatory obligation that may attach to Horizon with respect to any of the specific claims at issue under this ACO, or any other claims. Nothing in this ACO shall be interpreted to prejudice the interests of any health care providers or members in any legal action that has been or may be brought against Horizon for the payment of claims by Horizon.

5. Horizon shall adjudicate and pay claims that have been and may be submitted by FPA-contracted health care providers, and shall submit proof to DHSS and the Department of Banking and Insurance that FPA claims have been adjudicated and paid.

Force Majeure

6. If any event occurs that Horizon believes will or may cause delay in the achievement of any provision of the ACO, Horizon shall notify DHSS in writing within three (3) calendar days of becoming aware of the delay or anticipated delay, referencing this paragraph and

describing the anticipated length of the delay, the precise cause or causes of the delay, any measures taken or to be taken to prevent or minimize the delay, and the time required to take any such measures to prevent or minimize the delay. Horizon shall take all necessary action to prevent or minimize any such delay.

7. If DHSS finds that (a) Horizon has complied with the notice requirements of the preceding paragraph, (b) any delay or anticipated delay has been or will be caused by fire, flood, riot, strike or other circumstances beyond the control of Horizon, and (c) Horizon has taken all necessary actions to prevent or minimize the delay, DHSS shall extend the time for performance hereunder for a period no longer than the delay resulting from such circumstances.

8. If DHSS determines that either Horizon has not complied with the notice requirements of paragraph 6, or that the event causing the delay is not beyond the control of Horizon, or that Horizon has not taken all necessary actions to prevent or minimize the delay, failure to comply with the provisions of the ACO shall constitute a breach of the requirements of this ACO. The burden of proving that any delay is caused by circumstances beyond the control of Horizon and the length of any such delay attributable to those circumstances shall rest with Horizon. Increases in costs or expenses incurred by Horizon in fulfilling the requirements of this ACO shall not be a basis for an extension of time.

General Provisions

9. This ACO shall be binding on Horizon, its successors, assigns, any trustee in bankruptcy or other trustee, or any receiver appointed to a proceeding in law or equity.

10. Nothing in this ACO shall preclude DHSS from taking enforcement action against Horizon for matters not set forth herein or the investigations conducted in connection therewith, and Horizon reserves all rights to appeal, challenge or otherwise contest should any such action

be taken. If Horizon complies with the terms and conditions of this ACO, then DHSS shall not take enforcement action against Horizon for the alleged violations set forth herein. However, if Horizon violates any of the terms of this ACO, then DHSS may take any enforcement action it deems appropriate for any violations set forth herein.

11. Horizon's failure to comply with any of the terms and conditions of this ACO shall entitle DHSS to enforce as a Final Agency Order the terms and conditions of this ACO.

12. Obligations under this ACO 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 which may be limited or discharged in a bankruptcy proceeding.

13. Horizon shall not contest the authority or jurisdiction of DHSS to issue this ACO, nor shall Horizon contest its terms in any action to enforce the provisions of this ACO.

14. Nothing in this ACO shall constitute a waiver of any statutory right of DHSS to require Horizon to undertake additional measures regarding the alleged violations contained herein as determined necessary by DHSS to protect the health, safety or welfare of Horizon's members or the general public, nor of any statutory right of Horizon to contest such requirements, should DHSS act pursuant to this paragraph.

15. No modification or waiver of this ACO shall be valid except by written amendment made to this ACO, duly executed by Horizon and DHSS.

16. This ACO shall be governed and interpreted under the laws of the State of New Jersey.

17. The individuals executing this ACO have the authority to bind Horizon and DHSS respectively to the terms of the ACO.

18. This ACO shall be effective from the latest date of execution by either party.

_____	_____
CHRISTINE GRANT, COMMISSIONER NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES	DATE
_____	_____
CHRISTY BELL PRESIDENT AND COO HORIZON HEALTH CARE of NJ, INC.	DATE

Effective December 18, 2000