

**INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE**

Managed Care Plans

Provider Networks

Proposed Amendments: N.J.A.C. 11:4-37.4; 11:22-4.2; 4.4 and 4.5; 11:24-15.2; 11:24A-4.15; 11:24B-5.2; 5.3 and 5.10; and 11:24C-1.3

Proposed New Rules: N.J.A.C. 11:24C-4

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

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 26:2S-1 et seq. and 17B:30-1, et seq.

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

Proposal Number: PRN 2009-170

Submit comments by August 14, 2009 to:

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The agency proposal follows:

Summary

Pursuant to various statutes, including N.J.S.A. 26:2J-3, 17:48E-10 and 17:48H-4c, 6a, 12e and 14a, the Department of Banking and Insurance (Department) currently maintains approval authority over provider network agreements between health care

providers and carriers. To date, however, the Department has restricted its exercise of that authority to disapproving such agreements only for their failure to meet certain minimum criteria (for example, that agreements must specify the method of reimbursement). Thus, the Department's current regulatory oversight has not addressed other, more basic standards presumed by applicable law to be present when agreements are entered into (for example, fundamental terms that are not subject to change during the term of the agreement).

Health care providers contend that they are at a disadvantage in their negotiations of network agreements with carriers, and that this unfair bargaining position ultimately results in their acceptance of terms and conditions that are one-sided and not in the best interest of themselves and covered persons. Some specific areas of concern providers have identified include credentialing, precertification, fee schedules and claim denials. In recent years, in part as a result of settlements reached in class action lawsuits filed against them, a majority of the major carriers in this State have taken action or committed to take action to address some of the providers' concerns.

The Department recognizes that, given the current circumstances surrounding their contract negotiations with carriers, many providers have been unable to enter into network agreements that they consider to be fair and equitable. The Department further recognizes that it is in the public interest to maintain provider networks as an efficient means of promoting affordable health care to consumers. Accordingly, the Department is proposing these new rules and amendments in an attempt to strike an

appropriate balance between these competing interests. The Department's proposal includes the following:

N.J.A.C. 11:4-37, Selective Contracting Arrangements of Insurers, is being amended to add a provision at N.J.A.C. 11:4-37.4(f) requiring carriers that contract directly with network providers to comply with the requirements of the new provider networks rules being proposed concurrently at N.J.A.C. 11:24C-4.

N.J.A.C. 11:22-4, the Department's organized delivery systems (ODS) rules relating to entities seeking to become licensed ODSs, are being amended at N.J.A.C. 11:22-4.2, 4.4 and 4.5 to remove all references to the Department of Health and Senior Services (DHSS). Reorganization Plan No. 005-2005 transferred all of the DHSS's Office of Managed Care functions to the Department and incorporated DHSS's rules into the Department's rules in Title 11 of the New Jersey Administrative Code. Accordingly, the references requiring the Department to consult with the DHSS are no longer needed. This chapter is also being amended to add language to N.J.A.C. 11:22-4.5(b)4 requiring that the standard forms of provider agreements used by ODSs comply with the requirements of the new provider networks rules being proposed at N.J.A.C. 11:24C-4.

N.J.A.C. 11:24, the Department's health maintenance organizations (HMO) rules, are being amended at N.J.A.C. 11:24-15.2(h) to require all provider contracts with HMOs to comply with the requirements of the new Provider Networks rules being proposed at N.J.A.C. 11:24C-4.

N.J.A.C. 11:24A, the Department's Health Care Quality Act (HCQA) application to insurance companies, health service corporations, hospital service corporations and

medical service corporations rules, are being amended to require that all provider contracts comply with the new rules being proposed at N.J.A.C. 11:24C-4. N.J.A.C. 11:24A-4.15 is being amended to delete the requirement that the form of provider agreements, and any amendments thereto, are to be submitted to the Department for prior approval.

N.J.A.C. 11:24B, the Department's organized delivery systems rules relating to entities seeking to become certified as ODSs, is being amended to require that all provider agreements with ODSs comply with the new rules being proposed at N.J.A.C. 11:24C-4 in addition to N.J.A.C. 11:24B. N.J.A.C. 11:24B-5.3 is also being amended to include language stating that in cases when a provider is terminating an agreement with an ODS without cause, the non-cause termination must comply with the requirements of N.J.A.C. 11:24C-5.3.

N.J.A.C. 11:24C-1, the Department's physician credentialing rules for managed care plans, is being amended to add a new subsection at N.J.A.C. 11:24C-1.3(a) containing standards and procedures for the credentialing application process. The amendment includes the requirement that carriers complete the credentialing process within 90 days. The amendment also includes timeframes and procedures for a carrier to notify an applicant of an incomplete application and for an applicant to correct any deficiencies in the application. The amendment also requires carriers to accept credentialing application and other information electronically, but do not require electronic submissions. The requirement that carriers accept electronic submissions does not imply that carriers may not request additional information or a replacement

submission from a provider if the information initially received electronically does not meet reasonable quality standards (for example, a poor quality fax transmittal).

N.J.A.C. 11:24C-4.1 contains the purpose and scope of the proposed new provider networks rules that establish standards relating to agreements entered into between carriers and health care providers. This section exempts from the rules' requirements those contracts entered into between a carrier and Medicaid to provide Medicaid Only coverage and NJ FamilyCare coverage. This section further describes the extent of the Commissioner's regulatory oversight of carriers' provider networks and his authority to obtain information related to the functioning of a carrier's network pursuant to N.J.S.A. 17:1-16.

N.J.A.C. 11:24C-4.2 contains definitions of terms used throughout the subchapter.

N.J.A.C. 11:24C-4.3 addresses various issues relating to provider agreements with carriers. Unless otherwise required by statute, provider agreements will not be subject to the Department's prior approval. This section requires that at least 20 days before an agreement is entered into, the carrier must deliver to a provider contemplating joining the carrier's network the complete "provider-specific" or "specialty-specific" fee schedule(s) for the health benefits plan(s) offered by the carrier in which the provider intends to participate. Both types of fee schedules are more fully defined in N.J.A.C. 11:24C-4.2. The provider-specific fee schedule is negotiated by the provider and carrier. The specialty-specific fee schedule is a standard fee schedule established by a carrier without any negotiations between the carrier and the provider.

The fee schedule(s) must be delivered in writing, or electronically if agreed to in writing by both parties. Carriers are also required to make available online the complete specialty-specific fee schedules and they must be accessible by those providers engaging in a particular specialty or practice area.

This section also establishes certain criteria that all provider network agreements must meet. An agreement that includes a specialty-specific fee schedule shall have a maximum term of one year, whereas the term of an agreement including a provider-specific fee schedule is determined by negotiation of the parties. All agreements must contain a summary disclosure form that includes all the terms and conditions of the agreement. This section prohibits the inclusion of "most favored nation" clauses in agreements, as that term is defined in the proposed new rules. Mandatory binding arbitration provisions relating to breach of contract issues are also prohibited, although a provider may elect binding arbitration on a case-by-case basis.

This section requires agreements to include a provision stating that the agreement is the final, complete and exclusive statement of the "core terms" of the agreement as that term is defined in these proposed new rules. Subject to a carrier's right to deem fee schedules proprietary and confidential as set forth in N.J.A.C. 11:24C-4.4, agreements may not restrict a provider's right to discuss other terms of the agreement with any third party. Carriers are required to deliver to new participating providers a fully-executed initial agreement and any amendments thereto within 10 days of the effective date of the initial or amended agreement.

Except as otherwise provided at N.J.S.A. 17:48E-10a regarding health service corporations, providers may terminate an agreement having a multi-year term without cause at the conclusion of each year in the multi-year term or as otherwise agreed to by the parties. Agreements with a term of one year or less may be terminated without cause at any time during the term of the agreement. In both cases, providers must give written notice to the carrier no less than 60 days prior to the termination date. Provider agreements with hospitals are governed by N.J.S.A. 16:2J-11.1.

This section further requires agreements to include complete copies of provider-specific or specialty-specific fee schedules applicable to services or supplies provided pursuant to the agreement, as well as all edits and significant edits to be used by the carrier as of the effective date of the agreement. That information is to be printed in at least 12 point type. All agreements are to contain a provision stating that all terms of the agreement comply with New Jersey law and a list of citations to specific New Jersey statutes and/or regulations with which the terms of the agreement must comply. If Federal standards that are more specific than New Jersey law apply to any term of the agreement, the agreement must either comply with the Federal standards or exempt the plans to which the Federal standards apply.

This section requires that all agreements identify all preferred provider organizations (PPOs), organized delivery systems (ODSs) and other entities from whom carriers lease networks and to whose fees the provider is subject under the agreement. Carriers must also give prior notice to providers of any intent to add or delete such a

third party, and providers have the right to terminate the agreement if they elect not to accept the fees payable by the third party.

This section further establishes a mandatory agreement renewal process whereby a carrier gives a provider written notice of renewal of an agreement and the provider has the option, within certain timeframes, to either accept or reject the terms and conditions of the proposed renewal agreement. A provider's decision to nonrenew is effective as to all plans, affiliates, subsidiaries and third parties with which the carrier has contracted. Additionally, the carrier's website will have a "success screen" that will allow a provider to terminate a contract, then document and print out his or her election to terminate.

This section also permits certain amendments to an agreement to be made during the term of the agreement, but only with the consent of both parties. All amendments to "core terms," other than certain fee schedules, included in an agreement require written notice and the written acceptance of the parties within specified timeframes.

N.J.A.C. 11:24C-4.4 addresses various issues related to provider reimbursement. This section requires carriers to establish and maintain one or more specialty-specific fee schedules, and to reimburse providers pursuant to the specialty-specific or provider-specific fee schedule(s) included in the agreement. If a provider participates in multiple plans, the carrier must provide electronic access to the complete fee schedule(s) for each plan in which the provider participates. The requirements applicable to and restrictions upon amendments to the various types of fee schedules during the term of

an agreement that are adverse to the provider are also addressed in this section. Adverse amendments to specialty-specific fee schedules for agreements having a term of one year or less may be made only upon renewal of the agreement. In addition, adverse amendments to the individual codes appearing on such a fee schedule may be made once per code during the term of the agreement. Provider-specific fee schedules, however, may be amended more than once per calendar year as negotiated and consented to by the parties. Regarding an agreement in which a provider is explicitly notified that adverse amendments beyond the control of the carrier may be made during the term of the agreement, such amendments may be made without the provider's consent and the provider may elect to terminate the agreement. Amendments to either a specialty-specific or provider-specific fee schedule must be implemented as of the effective date of the amendment.

This section further requires that upon request by a participating provider, carriers must electronically deliver to the provider all current and complete specialty-specific or provider-specific fee schedules that are part of that provider's agreement with the carrier. Carriers are required to post on their websites the contact information providers may use to make such requests

Carriers are permitted to designate fee schedules supplied to providers as proprietary and confidential and to provide that a provider's distribution of any fee schedule to another carrier is a basis for termination of the agreement. Carriers are prohibited from requesting that participating providers disclose proprietary and confidential fee schedule information of other carriers.

Carriers must disclose on their websites all significant edits to any provider agreements and any customized edits (that is, changes) to standard claims auditing software the carrier uses. For providers reimbursed on a basis other than fee-for-service, the agreement must specify the formula used by the carrier to determine reimbursement.

Pursuant to the Unfair Trade Practices Act at N.J.S.A. 17:29B-1 et seq., carriers are subject to penalties of up to \$5,000 per violation for violations of N.J.A.C. 11:24C-4.4.

N.J.A.C. 11:24C-4.5 contains requirements related to the carriers' provider network directories. The Department believes that up-to-date provider network directories are essential for consumers to have reliable and current information regarding the healthcare providers participating in a particular network at any given time. The Department is also aware that networks are constantly changing, making it difficult for carriers to maintain accurate directories at all times. Accordingly, the Department believes that rules are needed to address this issue and establish common, enforceable standards for network directories in order for directories to be more reliable and less likely to mislead consumers contemplating joining a network-based health benefits plan or when they attempt to obtain in-network healthcare services and supplies. This section requires that carriers maintain and make available provider network directories in both electronic and written formats. The directories must contain accurate and current information on all participating providers and must include specific information about each provider. In addition to containing a listing of the

carrier's in-network hospital facilities, directories must also include a listing of the carrier's in-network hospital outpatient facilities, and a statement advising members that not all outpatient service providers located at in-network hospitals are in-network providers. Carriers are required to request updated information from participating providers on a quarterly basis. Also, if a provider has not submitted any claims to a carrier within a four-month period, the carrier is required to contact the provider requesting that the provider confirm his or her intention to continue to participate in the carrier's network. If the provider responds to the carrier's request, the carrier is required to update its printed and electronic directories pursuant to procedures set forth in these proposed rules. If the provider fails to respond to the carrier, the carrier must make a follow-up request by certified mail, return receipt requested. If the provider again fails to respond within 30 days, the carrier must remove the provider from its network and update its directories as set forth in these rules.

The proposed rule contains requirements specific to a carrier's printed directory. Carriers are required to deliver, upon request, their current printed directory to newly enrolled members of the carrier's health benefits plans. Printed directories must accurately reflect the content of the carrier's electronic directory as of the date the printed directory was submitted for publication, and certain information set forth in these proposed rules must be clearly displayed on the cover page. Carriers are required to retain copies of all printed directories for at least three years. Information in a carrier's printed directory that is confirmed by the provider as inaccurate or that

otherwise needs to be changed must be corrected in the next printed edition of the directory.

The proposed rule also contains requirements specific to a carrier's electronic directories. Electronic directories must include functions designed to facilitate the ability of members to customize their provider searches, such as searches by a provider's specialty area and county location. If a network provider terminates his or her contract with the carrier, the carrier must remove the provider from its electronic directory within 10 business days after the effective date of the termination. Carriers must also maintain a history of their electronic directories for three years. Information in an electronic directory that is confirmed by the provider to be inaccurate or that requires changing must be corrected within 10 days of the carrier's receipt of the provider's notice pursuant to a procedure set forth in these proposed rules. Carriers additionally must submit to the Department a certified annual report stating the extent to which their electronic directories are updated to reflect accurate information on providers, including a quarterly percentage of accuracy.

Carriers' websites must contain instructions for providers and consumers to notify the carrier of any inaccuracies contained in their directories, and carriers must provide an electronic confirmation of receipt to a provider or consumer who has electronically notified the carrier of any inaccurate or changed information. This section includes a process and timeframes for carriers to correct inaccurate or changed information in electronic and printed provider network directories, as well as for a carrier to dispute alleged inaccurate information. Pursuant to N.J.S.A. 17B:30-4.4,

penalties may be imposed on carriers for errors appearing in a provider network directory, and additional penalties may be imposed for recurring errors.

N.J.A.C. 11:24C-4.6 requires carriers to make available to the Department upon request reports demonstrating compliance with all requirements related to provider agreements, directories and the other matters referenced in this chapter and with all other applicable regulations and statutes.

As a 60-day comment period is provided for this notice of proposal pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

These proposed new rules and amendments will have a positive impact on all providers and carriers entering into agreements, as well as an indirect positive impact on covered persons. Because the proposed new rules and amendments address many concerns of providers related to the negotiation and implementation of their agreements with carriers, the Department anticipates that providers will be more willing to enter into or remain a party to such agreements, thereby making network-based health benefits plans more comprehensive and their networks of participating providers more stable. This, in turn, will support efforts to contain the costs of health care and health insurance and to reduce the uncertainty, anxiety and inconvenience that consumers frequently experience as a result of decisions by providers to leave network-based plans or curtail the extent to which they participate in such plans. Consumers will also benefit because the proposed network directory requirements will facilitate the

process of identifying and locating network providers that will meet their individual healthcare needs. Carriers will experience a reduction in the number of complaints received from providers related to the issues addressed in the proposed new rules and amendments. Both providers and carriers will benefit because the proposed requirements will enhance the parity between the two parties in their agreement negotiations and ongoing contractual relationship.

Economic Impact

These proposed new rules and amendments will have a favorable impact on carriers, providers and consumers. As mentioned above in the Social Impact statement, it is anticipated that the adoption of these proposed new rules and amendments will result in an increasing number of providers being willing to enter into or remain a party to provider agreements with carriers. This increased participation in provider networks will result in more stable and comprehensive networks.

Carriers will benefit because they will be able to pay a greater number of providers at an in-network standard or negotiated rate, thereby reducing their costs. Consumers will ultimately benefit because the cost savings experienced by carriers will be passed along to them in the form of lower health coverage premiums

Providers also will be favorably impacted economically. Because the proposed rules require carriers to complete provider credentialing within 90 days of the provider's submission of an application, providers will be able to join a network and receive reimbursement as a network provider without undue delay. Providers will benefit from the requirements that carriers reimburse providers in accordance with the fee schedule

that is part of the agreement and that any reimbursement formula for providers paid on a basis other than fee-for-service be included as part of the agreement. These requirements will give providers advance knowledge of the payment amounts they can expect to receive from carriers for the services they render, as well as reasonable assurance that they will actually receive those amounts. Providers will also benefit from the requirement that carriers reimburse providers pursuant to an amended fee schedule as of the effective date of the amendment, and not as of a later date determined by the carrier. Providers additionally will benefit economically from the requirements that automatic renewal of an agreement is not permitted and that their consent is required for certain changes to an agreement, including certain adverse changes to a fee schedule, during the term of an agreement because providers may elect to reject an unfavorable amendment or a reduced reimbursement rate. Providers will also be favorably impacted economically by the prohibition upon the inclusion in agreements of "most favored nation" clauses and clauses having a similar effect because such clauses may compel providers to accept a lower reimbursement rate from a carrier than they might otherwise agree to. Providers will also benefit from the prohibition upon the inclusion in agreements of mandatory binding arbitration provisions regarding breach of contract issues because it may be more beneficial for providers to seek resolution of such issues through other avenues. Providers may also benefit economically from the provider network directory requirements because consumers will have up-to-date information concerning network providers, which may result in an increase in the number of patients for some providers. Both providers and carriers will benefit from

the provision permitting termination of an agreement without cause because neither party will be required to remain in a contract that it has concluded is no longer in its best interest.

Carriers may initially incur some increased administrative costs, but only to the extent that they do not currently perform the requirements imposed by these new rules and amendments. As was noted in the Summary, a majority of the major carriers in this State have already taken action to address some of the requirements included in this proposal. Among the requirements to be imposed by these new rules and amendments that certain carriers have previously committed to fulfill are: credentialing providers within 90 days; delivering copies of provider agreements and complete fee schedules to providers; establishing and maintaining specialty-specific fee schedules; limiting adverse amendments to specialty-specific fee schedules to once per calendar year; updating and distributing provider network directories on a regular basis; prohibiting the use of "most favored nation" clauses and clauses having a similar effect; and maintaining certain information relating to fee schedules and provider network directories on their websites.

Carriers will experience an additional negative economic impact to the extent they do not currently perform, or have not committed to perform, other requirements to be imposed by these new rules and amendments. However, by having clear, enforceable rules prescribing the standards applicable to provider agreements that should improve long-term network stability and benefit all market participants, these initial costs will be outweighed. Carriers are required to deliver to providers a complete

agreement, including a summary disclosure form; carriers may not automatically renew agreements and, with certain limited exceptions, may not amend core terms of provider agreements, without prior notice to and the consent of the provider, which may result in terms and conditions less favorable to carriers. Carriers also must reimburse providers pursuant to the fee schedule(s) made part of the agreement and, for providers reimbursed on a basis other than fee-for-service, carriers must disclose the formula used for reimbursement in the agreement. Accordingly, carriers may not reimburse providers at a rate different from that which the providers reasonably anticipated receiving based upon the previously agreed upon fee schedule or formula. Carriers are also required to reimburse providers pursuant to an amended fee schedule as of the effective date of the amendment, and not at some later date determined by the carrier.

The rules' prohibition on "most favored nation" clauses and clauses having a similar effect, and upon mandatory arbitration provisions related to breach of contract issues, will negatively impact carriers. Carriers will not be permitted to reimburse providers at a lower rate than the one contracted for by the provider by invoking a most favored nation clause. Carriers may also be required to resolve breach of contract issues through avenues other than mandatory binding arbitration in which the outcome may be more favorable to providers, although providers may elect binding arbitration. Carriers also will be unfavorably impacted by the rules' prohibition on requests by carriers that providers disclose proprietary and confidential fee schedule information of other carriers because carriers will not be able to obtain and use such information to

negotiate lower reimbursement rates with providers. Carriers will additionally be required to make annual submissions to the Department, including a report prepared by an external independent auditing firm and a certification by a senior officer of the carrier reflecting the extent of the carrier's compliance with the requirements contained in these amendments and new rules. The cost of procuring such a report from an external auditing firm will vary depending on the size of the carrier's network-based health benefit plan operations.

Federal Standards Statement

A Federal standards analysis is not required because the Department's proposed new rules and amendments addressing provider network agreements entered into by health care providers and carriers are not subject to any Federal standards or requirements .

Jobs Impact

The Department does not anticipate that these proposed new rules and amendments will result in the generation or loss of jobs.

Agriculture Industry Impact

The proposed new rules and amendments will have no agriculture industry impact.

Regulatory Flexibility Analysis

Some carriers and providers required to comply with these proposed new rules and amendments may be “small businesses” as that term is defined at N.J.S.A. 52:14B-16 et seq. Further, the proposed new rules and amendments include numerous reporting, recordkeeping and compliance requirements as set forth in the Summary above. Carrier requirements include, but are not limited to, completing provider credentialing within specific timeframes; delivering provider agreements, amendments to agreements and fee schedules to providers within specific timeframes; including a summary disclosure form of a provider agreement with the agreement; following a specific process within certain timeframes for amending and renewing provider agreements; excluding most favored nation type clauses in provider agreements; establishing and maintaining one or more standard fee schedules and reimbursing providers pursuant to the fee schedule(s) included in the carrier’s agreement with the provider; maintaining on their websites certain information concerning fee schedules and provider network directories; maintaining directories in written and electronic format, retaining copies of written directories and a history of electronic directories for at least three years ; obtaining current directory information from providers on a quarterly basis and updating written directories at least every six months; and annually submitting confirmation of compliance with these new rules and amendments to the Department.

While these requirements impose certain administrative, reporting and/or recordkeeping responsibilities on carriers who enter into agreements with carriers, it is

unlikely that the requirements will necessitate any additional professional services. The attendant cost to carriers for complying with these requirements is discussed above in the Economic Impact statement. The proposed new rules and amendments do not establish differing compliance or reporting requirements or timetables applicable to small business carriers or exempt them from any of the requirements. However, as stated in the Summary above, the purpose of these new rules and amendments is to resolve some significant issues related to the terms and conditions to which providers must frequently agree in order to join carriers' provider networks. If left unresolved, those terms and conditions will negatively impact the delivery of health care in the State. Accordingly, the Department believes that these new rules and amendments must be applied uniformly. Therefore, no exemption from, or relaxation of, the requirements is made based on carrier size.

Smart Growth Impact

The proposed amendments and new rules will have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The proposed amendments and new rules will have no impact on housing affordability. The amendments and new rules affect managed health care plans.

Smart Growth Development Impact

The proposed amendments and new rules will have no impact on housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan. The proposed amendments and new rules affect managed health care plans.

Full text of the proposal follows: (additions indicated in boldface **thus**; deletions indicated in brackets, **[thus]**):

CHAPTER 4

ACTUARIAL SERVICES

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

11:4-37.4 Selective contracting arrangement approval and amendment procedures

(a) - (e) (No change.)

(f) In addition to the requirements set forth in this section, a carrier contracting directly with network providers shall comply with the requirements set forth at N.J.A.C. 11:24C-4.

CHAPTER 22

HEALTH BENEFIT PLANS

SUBCHAPTER 4 ORGANIZED DELIVERY SYSTEMS

11:22-4.2 Definitions

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

["DHSS" means the New Jersey Department of Health and Senior Services.]

11:22-4.4 Application procedures

(a) An application for a license to operate an organized delivery system shall be filed with the Commissioner, and shall contain a completed application, containing the information and in the format set forth in Exhibit A in the Appendix to this subchapter, incorporated herein by reference. In addition, the application shall be accompanied by:

1. (No Change.)

2. Any additional information as may be required from a particular applicant by the Commissioner [or the Commissioner of DHSS].

(b) (No change.)

11:22-4.5 Application review procedures

(a) The Commissioner [, in consultation with the Commissioner of DHSS,] shall review an application for licensure and notify the applicant of any deficiencies contained therein within 60 days of receipt. An applicant shall address any deficiencies in its application within 60 days of notice thereof.

(b) Upon receipt and review of a complete application that contains all of the information set forth in N.J.A.C. 11:22-4.4, the Commissioner shall issue a license to an organized delivery system if he or she finds that the system meets the following standards:

1. – 3. (No change.)

4. The standard forms of provider agreements to be used by the organized delivery system are acceptable, **and comply with all requirements set forth at N.J.A.C. 11:24C-4;**

5. – 8. (No change.)

(c) - (d) (No change.)

[(e) The Commissioner shall refer all standard forms of provider agreements, quality assurance programs and utilization management programs to be used by the organized delivery system to the Commissioner of DHSS for review pursuant to standards and requirements established by DHSS. The Commissioner shall consult with the Commissioner of DHSS regarding provider agreements, quality assurance programs and utilization management programs in determining whether the applicant for a license:

1. Has demonstrated the potential ability to assure that health care services will be provided in a manner that will assure the availability and accessibility of the services;

2. Has adequate arrangements for an ongoing quality assurance program, where applicable;

3. Has established acceptable forms for provider agreements to be used by the system; and

4. Has demonstrated that the persons who are to perform the health care services are properly qualified.]

[(f)](e) The Commissioner[,in consultation with the Commissioner of DHSS,] may deny an application for a license if the applicant fails to meet any of the standards provided in this subchapter or on any other reasonable grounds. If the license is denied, the Commissioner shall notify the applicant and shall set forth the reasons for

the denial in writing. An existing organized delivery system seeking licensure whose application is denied may request a hearing by notice to the Commissioner within 30 days of receiving the notice of denial. The hearing shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and Uniform Administrative Procedure Rules, N.J.A.C. 1:1. Upon such denial, the applicant shall submit to the Commissioner a plan for bringing the organized delivery system into compliance or providing for the closing of its business.

CHAPTER 24

HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER 15. PROVIDER AGREEMENTS AND RISK TRANSFERENCE

11:24-15.2 Minimum standards for provider agreements

(a) - (g) (No change.)

(h) In addition to the requirements set forth in this section, all provider contracts with the HMO shall comply with the requirements set forth at N.J.A.C. 11:24C-4.

CHAPTER 24A

HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, AND MEDICAL SERVICE CORPORATIONS

SUBCHAPTER 4. PROVISIONS APPLICABLE TO CARRIERS OFFERING ONE OR MORE HEALTH BENEFITS PLANS THAT ARE MANAGED CARE PLANS

11:24A-4.15 Minimum standards for provider contracts

(a) (No change.)

(b) In addition to complying with N.J.A.C. 11:4-37 **and 11:24C-4**, all provider contracts shall specify:

1. – 11. (No change.)

(c) - (e) (No change.)

[(f) The form(s) of the provider agreements, and any amendments thereto, shall be submitted to the Department for prior approval.]

[(g)] **(f)** (No change in text.).

CHAPTER 24B
ORGANIZED DELIVERY SYSTEMS
SUBCHAPTER 5. PROVIDER AGREEMENTS

11:24B-5.2 General provisions

(a) All provider agreement forms shall **comply with the requirements set forth at N.J.A.C. 11:24C-4 and shall** contain:

1. – 21 (No change.)

(b) – (d) (No change.)

11:24B-5.3 Termination and continuity of care standards for contracts with health care professionals

(a) (No change.)

(b) The provider agreement may specify that the contract may be terminated without cause, so long as non-cause termination is permitted by either party subject to reasonable prior notice and the terms of the provision otherwise comply with the remainder of this section. **In cases when the provider is terminating the agreement without cause, the non-cause termination shall also comply with the requirements set forth at N.J.A.C. 11:24C-4.3**

(c) – (g) (No change.)

11:24B-5.10 Review and approval of provider agreements

(a) Provider agreements submitted with the initial application for certification or an application for licensing shall be subject to the **requirements set forth at N.J.A.C. 11:24C-4 and the** standards for submission, review and approval as set forth at N.J.A.C. 11:24B-2.

(b) – (g) (No change.)

CHAPTER 24C MANAGED CARE PLANS SUBCHAPTER 1 PHYSICIAN CREDENTIALING

11:24C-1.3 Credentialing standards

(a) Carriers shall complete provider credentialing within 90 days of receipt of a complete credentialing application in accordance with this

subchapter. A failure to do so will subject carriers to penalties and other remedies as set forth in N.J.A.C. 11:24C-1.6.

1. Within 30 days of receipt of a credentialing application, a carrier shall notify the applicant whether the application is complete or incomplete. If the application contained an e-mail address, the carrier may provide the notice electronically. If the application did not contain an e-mail address, the carrier shall provide the notice in writing. If an application is incomplete, the notice shall identify all deficiencies and specify all additional information required to be submitted by third parties and, if applicable, by the applicant in order for the application to be considered complete. The notice shall also specify the due date for receipt of any additional information required from the applicant.

2. The notice referenced in (a)1 above shall include the name, phone number and e-mail address of the carrier's contact person to whom the applicant may submit the information required to complete the application and direct questions or otherwise obtain assistance regarding the carrier's credentialing process and the status of a credentialing application. All information regarding the carrier's contact person shall also be prominently displayed on the carrier's website. Carriers shall respond to all credentialing inquiries within five business days.

3. Carriers shall accept all credentialing application additional application information and inquiries submitted electronically, but shall not require electronic submissions.

Recodify existing (a) - (c) as **(b) - (d)** (No change in text.)

SUBCHAPTER 4. PROVIDER NETWORKS

11:24C-4.1 Purpose and scope

(a) The purpose of this subchapter is to establish standards relating to agreements entered into between carriers and health care providers.

(b) This subchapter shall apply to all insurance companies, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations (HMOs) authorized to issue health benefits plans in this State and to organized delivery systems. This subchapter shall not apply to those contracts entered into between a carrier and Medicaid to provide Medicaid Only coverage or NJ FamilyCare coverage.

(c) The Commissioner's regulatory oversight of carriers' provider networks shall extend to all aspects of the relationships between carriers and participating providers, including, but not limited to, credentialing, provider agreements and fee schedules as set forth in N.J.S.A. 26:2S-1 et seq. and 17B:30-1 et seq. Consistent with the foregoing, the Commissioner shall have the authority pursuant to N.J.S.A. 17:1-16 to obtain from any

source information related to the functioning of a carrier's network, including information deemed proprietary and confidential by a carrier, and to a carrier's compliance with the provisions of this chapter and all other applicable laws and rules.

11:24C-4.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Adverse change" or "adverse amendment" means any action taken by a carrier that has the effect of reducing the reimbursement amount payable to a provider for a particular service or supply set forth in the specialty-specific or provider-specific fee schedule that is part of the provider agreement. Examples include, but are not limited to, a carrier's refusal to reimburse for a particular service (CPT code); and a carrier's refusal to pay, or payment of decreased reimbursement, based on the professional designation of the individual providing the service. An adverse change shall not include specialty-specific fee schedule changes attributable to a third party and over which the carrier has no control (for example, the Medicare fee schedule).

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation and health maintenance organization authorized to issue health benefits plans in this

State. "Carrier" also includes organized delivery systems as defined in N.J.A.C. 11:22-4.2 and 11:24B-1.2.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Core terms" means the time period covered by the agreement, compensation provisions, the method by which the agreement can be amended and terminated, the carrier's internal dispute resolution mechanisms and such other provisions as the parties may agree shall constitute core terms.

"CPT code" means the American Medical Association's current procedural terminology code.

"Department" means the Department of Banking and Insurance.

"Edit" means a practice or procedure pursuant to which one or more adjustments are made by the carrier to CPT codes or HCPCS codes included in a claim that result in:

1. Payment being made based on some, but not all, of the CPT codes or HCPCS codes included in the claim;

2. Payment being made based on different CPT codes or HCPCS codes than those included in the claim;

3. Payment for one or more of the CPT codes or HCPCS codes included in the claim being reduced by application of Multiple Procedure

Logic;

4. Payment for one or more of the CPT codes or HCPCS codes being denied; or

5. Any combination of 1 through 4 above.

"Fee schedule" means the complete provider-specific fee schedule or the complete specialty-specific fee schedule applicable to and part of an existing or contemplated provider agreement.

"HCPCS code" means the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System code.

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health benefits plan shall not include one or more, or any combination, of the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health

benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. §1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§1071 et seq.); and similar supplemental coverage provided under a group health plan.

“Health care provider” or “provider” means an individual or entity that, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits plan. Health care provider

includes, but is not limited to, a physician or other health care professional licensed pursuant to Title 45 of the Revised Statutes, and a hospital or other health care facility licensed pursuant to Title 26 of the Revised Statutes.

“Most favored nation clause” means any clause in a provider agreement that refers to the rate(s) the provider has agreed to accept from a third party(ies) for providing a covered service or supply. A most favored nation clause includes, but is not limited to, the following:

1. A clause that requires the provider to notify the carrier with whom it has entered into an agreement of a rate that the provider has agreed to accept from a third party(ies);

2. A clause that requires the provider to maintain or reduce the rate specified in the agreement based upon a lower rate the provider has accepted or has agreed to accept from a third party(ies) for providing the same or a comparable service or supply; or

3. Any other clause having the same or similar effect including, but not limited to, a “rate guarantee” or “parity representation” clause.

“Multiple Procedure Logic” means the practices or procedures used by a carrier to reduce the allowable amount for one or more of the CPT codes or HCPCS codes included in a claim as a result of multiple surgical procedures or multiple services having been performed on the same patient on the same date of service.

“Participating provider” means a provider who is a party to a provider agreement with a carrier.

“Practice limitation” means any restriction a provider imposes on his practice that affects the access of covered persons to his services including, but not limited to, treating only persons who are confined to a hospital or other institution, treating only persons of certain ages, refusing new patients at certain office locations, and refusing to perform certain procedures (for example, obstetrician/gynecologists who will not perform deliveries).

“Proprietary and confidential information” means information related to the competitive business strategy of the owner of the information and which, if disclosed, would give an advantage to competitors.

“Provider agreement” or “agreement” means a contract between a carrier and a provider under the terms of which the carrier agrees to pay the provider for, and the provider agrees to provide covered health care services or supplies to persons covered by a health benefits plan issued by the carrier.

“Provider agreement” or “agreement” includes the agreement, any fee schedule that is part of the agreement, and any appendices, attachments or amendments to the agreement.

“Provider-specific fee schedule” means a complete schedule of all fee-for-service dollar amounts for all services or supplies that a participating provider agrees to provide under the terms of the agreement, actually provides, and may provide acting within the scope of his or her professional

license applicable to an individual provider or a particular provider entity, as negotiated between that provider and a carrier.

“Significant edit” means an edit for a particular CPT code or HCPCS code that a carrier reasonably believes, based on its experience with submitted claims, will cause, on the initial review of submitted claims, a denial of or reduction in payment for that particular CPT code or HCPCS code on more than 250 occasions per year in any one state in which the carrier operates.

“Specialty-specific fee schedule” means the complete schedule of the fee-for-service dollar amounts for the up to 100 services or supplies that are most commonly billed by participating providers in the specialty or practice area of a provider and all other codes for services that a provider in that specialty or practice area may reasonably be expected to provide within the scope of his or her professional license, and other codes which the provider specifically requests be included, applicable to an individual provider or a particular provider entity, as established by a carrier and included in a provider agreement without any variation as a result of negotiations between the carrier and the provider.

11:24C-4.3 Provider agreements

(a) Unless otherwise provided by statute and except as set forth in this section, no agreement between a participating provider and a carrier

shall be subject to prior approval by the Commissioner. In the case of HMOs, only the proposed form of provider agreement submitted to the Department with the HMO's initial application for a certificate of authority pursuant to N.J.S.A. 26:2J-3 shall be subject to prior approval by the Commissioner.

(b) At least 20 days prior to the date a provider agreement is entered into, the carrier shall supply to the provider contemplating becoming a participating provider all complete provider-specific or specialty-specific fee schedule(s) that are to be included in the agreement and any edits and significant edits. Fee schedules, edits and significant edits shall be supplied in writing, or in an electronic format if agreed to in writing by the carrier and the provider.

1. When a provider is contemplating participating in multiple health benefits plans offered by a carrier and such plans have different fee schedules, the carrier shall provide the complete proposed provider-specific or specialty-specific fee schedule, as applicable, for each plan in which the provider participates.

2. The carrier shall make available online all specialty-specific fee schedules it utilizes. Network providers engaging in a particular specialty or practice area shall have access to the specialty-specific fee schedule for that specialty or area of practice.

(c) All agreements between carriers and participating providers shall meet the following criteria:

1. If the agreement includes a specialty-specific fee schedule, the term of the agreement shall be for a maximum of one year. If the agreement includes a provider-specific fee schedule, the term of the agreement shall be as established by negotiation between the parties.

2. All agreements shall contain a summary disclosure form which shall disclose in plain language the terms and conditions of the agreement, including but not limited to, the following:

i. Compensation terms;

ii. The term or duration of the agreement;

iii. The method(s) by which the contract may be amended and terminated;

iv. The carrier's preauthorization process;

v. The identity of, the phone and fax numbers, and the e-mail and street addresses for the person or entity responsible for the processing of the provider's claims;

vi. The location of the portals on the carrier's website through which the provider can access any provider-specific or specialty-specific fee schedule that is a part of the provider's agreement with the carrier and through which the provider can notify the carrier of any inaccurate information on the provider contained in the carrier's network directory; and

vii. A description of the carrier's internal dispute resolution mechanism.

3. Most favored nation clauses, or clauses having a similar effect, are prohibited.

4. Mandatory binding arbitration provisions related to any breach of contract issue are prohibited. The agreement may include a provision stating that the provider has the right to elect binding arbitration on a case-by-case basis.

5. All agreements shall include a provision stating that the agreement shall constitute the final, complete and exclusive statement of the core terms of the agreement between the parties. No agreement shall incorporate by reference other documents that contain, revise or qualify core terms, including, but not limited to, provider manuals and administrative protocols, except for fee schedules that are attributable to a third party and over which the carrier has no control (for example, the Medicare fee schedule).

6. Subject to N.J.A.C. 11:24C-4.4(d) with respect to carriers deeming fee schedules to be proprietary and confidential and prohibiting providers from discussing fee schedules with other carriers, no agreement shall contain a provision that purports to restrict the freedom of a participating provider to discuss other terms of the agreement with any third

party, including, but not limited to, a recipient or prospective recipient of the services or supplies provided by the provider.

7. Carriers shall deliver to participating providers a copy of the fully executed initial agreement and any amendments thereto within 10 days after the effective date of the initial or amended agreement.

8. Except as otherwise provided by N.J.S.A. 17:48E-10a with respect to health service corporations, a provider may terminate an agreement having a multi-year term without cause at the conclusion of each year in the multi-year term or at such other times during the multi-year term as the parties may agree upon and specify in the agreement. Provider agreements with a term of one year or less may be terminated without cause at any time during the term of the agreement. Such terminations shall require the provider to give written notice to the carrier, which notice shall be delivered no less than 60 days prior to the termination date. Terminations of provider agreements with hospitals shall be governed by the provisions of N.J.S.A. 26:2J-11.1.

9. When providers are reimbursed on a basis other than capitation, the agreement shall include the complete provider-specific or specialty-specific fee schedule(s) for the CPT codes or HCPCS codes, as appropriate, for services or supplies provided pursuant to the agreement and all edits and significant edits that will be utilized by the carrier as of the

effective date of the agreement. The fee schedule(s) included in the agreement shall be printed in at least 12 point type.

10. All agreements shall include a provision which states that all terms of the agreement comply with New Jersey law, and which includes citations to specific New Jersey statutes and/or rules with which the terms of the agreement are required to comply (for example, the Health Care Quality Act, N.J.S.A. 26:2S-1 et seq., HCQA provides a right to notice and hearing for termination of provider agreements; the HCQA and the Health Maintenance Organization (HMO) Act, N.J.S.A. 26:2J-1 et seq., contain continuity of care requirements following termination of a participating provider; and the Health Claims Authorization, Processing and Payment Act, P.L. 2005, c. 352, contains certain requirements regarding submission and processing of claims and recoupment of overpaid claims). If Federal standards applicable to any term of the agreement are more specific than New Jersey law (for example, Federal standards applicable to Medicaid plans), the agreement shall either comply with the Federal standards or exempt those plans to which the Federal standards apply.

11. All agreements shall identify, as of the date the agreement is entered into, all preferred provider organizations (PPOs), organized delivery systems (ODSs) and other entities from whom carriers lease networks and to whose fees the provider shall be subject under the agreement. If, during the term of the agreement, a carrier intends to add such a third party to the

agreement or delete such a third party from the agreement, the carrier shall provide prior notice of the amendment to the provider as set forth in (e) below and the provider shall have the right to terminate the agreement as set forth in (c)8 above, which termination shall become effective 30 days prior to the effective date of the proposed amendment.

(d) Renewal of an agreement shall be completed as follows:

1. The carrier shall submit to the participating provider a written notice of renewal no later than 90 days prior to the expiration of the current agreement. The notice shall contain all the core terms and conditions of the proposed renewal agreement and identify any amendments the carrier proposes to make to the terms of the expiring agreement. The notice shall clearly state that the contract will renew automatically unless the provider notifies the carrier of his or her rejection of the carrier's renewal notice and election to terminate the contract either in writing within 30 days of the provider's receipt of the notice of renewal, or within any longer period as may be specified by the carrier, or electronically through the provider portal on the carrier's website.

2. The carrier's website shall have the capability to produce a "success screen" to memorialize the provider's rejection of the offer to renew the agreement. The "success screen" shall include all information essential to adequately document the provider's election to terminate and shall be printable by the provider.

3. A provider's decision to nonrenew the agreement with a carrier shall be effective as to all plans, affiliates, subsidiaries and third parties with which the carrier contracts to make available its network of providers.

(e) All amendments to core terms other than fee schedules that are to be effective during the term of a provider agreement and that are not prohibited by this subchapter or by any other law shall require the consent of both parties either in writing or electronically. All amendments to fee schedules shall comply with N.J.A.C. 11:24C-4.4(b). All amendments to core terms other than fee schedules shall be made as follows:

1. The party proposing the change or amendment to the core term(s) shall provide the other party with at least 90 days' written notice of the change and specify in such notice the effective date of the change. The posting on a carrier's website of any revision to a core term in the provider agreement shall not, in the absence of some additional direct written or electronic notice of the change to the provider, constitute the supplying of advance notice as required by this rule.

2. The party receiving notice of the proposed change or amendment to the core term(s) shall, within 30 days of receipt of the notice of the proposed change, provide written or electronic notice of acceptance or rejection of the revision. A failure to provide such a response to a notice of a proposed change shall not be deemed acceptance. Should the parties fail to

agree, the terms of the agreement as previously accepted by the parties shall remain in effect until the agreement expires or is terminated in accordance with (c)8 above.

11:24C-4.4 Provider reimbursement

(a) A carrier shall establish and maintain one or more specialty-specific fee schedules. A carrier shall reimburse participating providers pursuant to the specialty-specific or provider-specific fee schedule(s) included in the agreement initially and as amended in accordance with this subchapter. When a provider participates in multiple plans offered by a carrier, the carrier shall provide electronic access to the complete provider-specific or specialty-specific fee schedule for each plan in which the provider participates.

(b) Subject to (b)1 and 3 below, any adverse change or amendment to the fee schedule(s) during the term of the agreement is prohibited unless consented to by the provider pursuant to N.J.A.C. 11:24C-4.3(e).

1. Specialty-specific fee schedules may be amended in a manner that is adverse to participating providers as follows:

- i. Upon renewal of the agreement.
- ii. An adverse amendment to any one individual code appearing on the fee schedule may be made no more than once during the term of the agreement. Prior to making any such amendment, the carrier

shall notify the provider at least 90 days prior to the effective date of the amendment of the carrier's intention to make the adverse amendment. If the provider declines to accept the amendment, the provider may terminate the agreement as set forth in N.J.A.C. 11:24C-4.3(c)8.

iii. The posting on a carrier's website of a revised fee schedule or of a notice of a prospective reduction in one or more fees in any fee schedule shall not, in the absence of some additional direct written or electronic notice of the change to the provider, constitute the supplying of advance notice as required by this subsection.

2. An unlimited number of amendments to specialty-specific fee schedules that are not adverse to providers may be made during the term of an agreement that includes such a schedule. Such amendments shall be made in accordance with N.J.A.C. 11:24C-4.3(e).

3. Provider-specific fee schedules may be amended at any time during the term of the agreement, as negotiated between the parties and consented to by the provider in accordance with N.J.A.C. 11:24C-4.3.

4. If a provider enters into an agreement that contains a provision explicitly notifying the provider of the possibility that adverse amendments to any fee schedules which are a part of the agreement may be made for reasons beyond the control of the carrier (for example, Medicare rate changes), such amendments may be made during the term of the agreement and shall not require notice to or the consent of the affected

provider(s) as set forth in N.J.A.C. 11:24C-4.3(e). A provider affected by such an amendment may terminate the agreement in accordance with its termination provisions and N.J.A.C. 11:24C-4.3(c)8.

5. A carrier shall implement any amendment to a specialty-specific or provider-specific fee schedule as of the effective date of the amendment.

(c) Within five days of receipt of a written or electronic request from a participating provider, the carrier shall deliver electronically to the provider all current and complete provider-specific or specialty-specific fee schedules that are a part of the carrier's agreement with that provider. If a participating provider requests a written copy of a fee schedule, the carrier shall provide such written fee schedule, printed in at least 12-point type, within 15 days of receipt of the request.

1. The carrier shall post on its website the carrier's street and e-mail addresses for providers to use in submitting requests for fee schedules and a phone number to call for further information.

(d) Carriers may designate fee schedules supplied to participating providers or to providers contemplating becoming participating providers as proprietary and confidential information, and that a participating provider's distribution of any fee schedule to another carrier may be a basis for termination of the agreement.

(e) No carrier shall request that a participating provider disclose the proprietary and confidential fee schedule information of another carrier.

(f) Carriers shall make available to participating providers on the carrier's website any information provided to members related to the fee schedule that is a part of the provider agreement between the carrier and the participating provider. At least 30 days before the effective date of any provider agreement or renewal agreement, the carrier shall disclose on its website:

1. All significant edits to any provider agreement(s); and
2. All customized edits to standard claims auditing software used by the carrier.

(g) When participating providers are reimbursed on a basis other than fee-for-service (for example, capitation, per diem or percent of charges), the agreement shall specify the formula used by the carrier to determine reimbursement.

(h) A carrier found to be in violation of the provisions of this section shall be subject to a penalty of not more than \$5,000 per violation. Pursuant to N.J.S.A. 17:29B-18, each failure to timely respond to a request for a fee schedule shall be a separate violation.

11:24C-4.5 Provider network directories

(a) Carriers shall be responsible for maintaining accurate and current information on all providers listed in a network directory. Standards of accuracy and methods for updating printed and electronic directories are more fully described in this section.

(b) Directories shall include, at a minimum, the following information on all participating providers: name, gender, office locations, office hours and days, phone numbers, professional designation, specialty, acceptance of new patients, practice limitations and languages spoken other than English.

(c) Carriers shall make directories available electronically on their websites and in written form upon request. Printed directories shall be published no less frequently than on an annual basis.

(d) Directories shall contain a listing of the carrier's in-network hospital outpatient facilities by the types of services the facilities provide. Directories shall also prominently display a statement advising members that not all outpatient service providers located at in-network hospitals are in-network providers, and urging members to confirm whether an outpatient service provider is or is not a member of the network before obtaining services from such provider.

(e) Carriers shall request updated provider network directory information from participating providers on a quarterly basis. Carriers may

make such requests by telephone or any other means of communication, and shall maintain a verifiable record of the procedure used in making such requests, the information obtained from the providers in response to such requests, and the date on which the information was obtained.

(f) If no claims have been submitted to a carrier by a provider for a period of four months, the carrier shall contact the provider, by a method whereby a record of the provider's receipt or non-receipt of the communication from the carrier will be preserved, requesting that the provider confirm his or her intention to continue to participate in the carrier's provider network. Based on the provider's response, the carrier shall update its printed and electronic directories as necessary, as set forth below. If the provider fails to respond to a communication for which the carrier has confirmation of receipt of the communication by the provider, the carrier shall mail a follow-up request to the provider by certified mail, return receipt requested. If the provider fails to respond to such request within 30 days, the carrier shall remove the provider from its network and update its printed and electronic directories as necessary, as set forth below.

(g) The following shall apply to a carrier's printed network directories:

1. Upon request, carriers shall deliver their current printed directory to newly enrolled members of the health benefits plans offered by the carrier.

2. Printed directories shall accurately reflect the content of the carrier's electronic directory as of the date the printed directory was submitted for publication. The following information shall be clearly and prominently displayed on the cover page of the printed directory:

i. The date of publication of the printed directory;

ii. A statement that the directory is accurate as of the date on which the printed directory was submitted for publication;

iii. A statement that more current directory information is available on the carrier's electronic directory available on the carrier's website;

iv. The anticipated date on which the next printed edition will be published; and

v. The carrier's website address where the electronic directory information can be found.

3. Carriers shall retain as business records copies of each version of its printed provider network directory, updated as set forth in this section, for at least three years from the publication date.

4. Information on a provider maintained in a carrier's printed directory that is confirmed as inaccurate or subject to change through the carrier's receipt of a notice or verification pursuant to (i) below shall be corrected in the next printed edition of the directory.

(h) The following shall apply to a carrier's electronic network directories:

1. A carrier's electronic directory shall include functions designed to facilitate the ability of members to customize their search for providers. Search functions shall include, but not be limited to, specialty area and county.

2. If a network provider has terminated its contract with the carrier pursuant to N.J.A.C. 11:24C-4.3, the carrier shall remove the provider from its electronic directory within 10 business days after the effective date of the termination.

3. Carriers shall maintain a history of their electronic directories for three years.

4. Information on a provider maintained in a carrier's electronic directory that is confirmed as inaccurate or subject to change through the carrier's receipt of a notice or verification pursuant to (i) below shall be corrected within 10 days of the carrier's receipt of notice from the provider.

5. In addition to the reports carriers are required to make available to the Department pursuant to N.J.A.C. 11:24C-4.6, carriers shall submit to the Department a report stating the extent to which their electronic directories are updated to reflect accurate information on providers, including the percentage of accuracy of the information on the providers listed in the electronic directory on the first day of the second

month in each quarter of the calendar year. The report shall be certified by an in-house officer of the carrier, and shall be submitted by March 1 of each year for the immediately preceding calendar year. The report shall be submitted in a form and pursuant to instructions prescribed by the Department and posted on the Department's website at www.njdobi.org.

(i) Carriers shall comply with the following to correct inaccurate information contained in a carrier's printed or electronic directories:

1. Carriers shall make available on their website portals through which providers and consumers may notify the carrier that inaccurate information on the provider is contained in the carrier's directory. The portals shall be equipped with a "success screen" with print capability for the provider or consumer to adequately document the date and content of the provider's or consumer's communication to the carrier. Carriers shall post on their websites instructions to providers and consumers for notifying the carrier in writing or electronically of any inaccurate information appearing in the carrier's provider directory related to a participating provider.

2. Carriers shall provide an electronic confirmation of receipt to a provider or consumer who has electronically notified the carrier of any inaccurate or changed information. Within two business days after the carrier's receipt of such a notification, the carrier shall contact the provider electronically to verify whether the information reported is correct.

3. If information maintained by a carrier on a provider is confirmed as inaccurate or subject to change through the carrier's receipt of such a notice or verification from a provider, the carrier shall update its printed and electronic directories as set forth in this section and modify its claims system within 20 days to reflect the provider's status as a non-participating provider and pay claims submitted for services rendered by that provider accordingly. The carrier shall also be required to comply with the requirements of the Health Claims Authorization, Processing and Payment Act (HCAPPA), N.J.S.A. 17B:30-48 et seq., any rules promulgated thereunder, and any other applicable claims payment statutes and rules.

4. When a carrier disputes that its information on a provider is inaccurate, the carrier shall, within 15 days of receipt of a notice from a provider or consumer asserting that the information is inaccurate, respond to the notice in writing and include in its response the reason(s) supporting its position that the challenged information is accurate.

(j) The Department may impose penalties on a carrier for errors appearing in its provider network directory, including, but not limited to, incorrect participating provider addresses; the omission or erroneous description of a participating provider's practice limitations; provider terminations; and the inclusion of providers who are not in the network, are no longer in practice, or who are deceased. Each instance of the inclusion of erroneous information in a provider network directory shall be considered a

separate violation of the Unfair Trade Practices Act at N.J.S.A. 17B:30-4. The Department may additionally impose penalties on a carrier for errors appearing in a provider directory on a recurring basis pursuant to N.J.S.A. 17B:30-13.1.

11:24C-4.6 Reports on compliance

(a) Carriers shall make available to the Department upon request the following:

1. A report for each of the carrier's licensed companies on the extent of the company's compliance with all requirements set forth in this chapter pertaining to provider agreements, directories and the other matters referenced in this chapter and with any other statutes and rules imposing such requirements. Each report shall be prepared by an external independent auditing firm with whom the carrier has contracted for the purpose of conducting an audit of such compliance by the carrier; and
2. A certification of such compliance by the carrier signed by a senior officer of the carrier responsible for regulatory compliance.