HMOs/health plans are prohibited from including in contracts most favored nation clauses, or clauses having a similar effect. *N.J.A.C. 11:24C-(c) 4.*

HMOs/health plans are required to provide participating providers a copy of the fully executed initial agreement and any amendments within 30 days after the effective date of the initial or amended agreement. *N.J.A.C. 11:24C-4.3(f).*

HMOs/health plans making an adverse change or amendment to an existing contract must provide 90 days notice to allow for termination in the event the provider does not accept the amendment. This applies to any source HMOs/health plans may use to introduce the change, including policy manuals. *N.J.A.C. 11:24C-4.2.*

HMOs/health plans are only permitted to make the terms of a provider agreement available to a third party, including a preferred provider organization (PPO), organized delivery system (ODS) or any other entity, if:

- The agreement specifically allows it;
- It identifies all third parties with which it is doing business upon contracting with the provider;
- The Web site includes a listing of all third parties which is updated every 90 days; and
- It requires each third party to identify the source of the discount on all remittance advices and/or explanations of payment under which a discount is taken. *N.J.A.C. 11:24C-4.3(c) 5.*

Provisions in the HMO regulations apply to any services of the managed care organization that are subcontracted to other entities. *N.J.A.C. 11:24A-1.1(c).*

CONTRACT TERMINATION

Hospitals whose contracts are not renewed, or are terminated by either party, must continue to provide services at the contract rate for a period of four months from a mutually agreed upon severance date. The HMO/health plan must notify in writing all contracting providers and all members residing in the hospital's county or an adjacent county within the HMO's service area within the first 15 business days of the four-month extension. *N.J.A.C. 11:24-3.5(e).*

Physicians and other healthcare professionals whose HMO/health plan contracts are not renewed or are terminated must continue to provide services at the contract rate for up to four months when medically necessary. Longer coverage periods, apply to pregnancy, post-operative care, oncology treatments and psychiatric services. *N.J.A.C 11:24-3.5(c) and N.J.A.C 11:24A-4.8(d).*

Physicians and other healthcare professionals and providers whose contracts have been terminated by an HMO/health plan must be provided 90-days written notice prior to the date of termination as well as notice of a right to a hearing. *N.J.A.C. 11:24-3.5(a) and 11:24A-4.8(a).*

HMOs/health plans must notify each member within 30 business days prior to the termination of a member's primary care physician from the HMO's provider network as well as any other physician or provider from which the covered person is currently receiving a course of treatment. *N.J.A.C. 11:24-3.5(b) and 11:24A-4.8(c).*

NETWORK ISSUES

HMOs/health plans must confirm that a provider is continuing to participate in their network if a provider either does not submit a claim within a 12–month period or communicate with the carrier in a way that would indicate an intention to continue to participate in the network. *N.J.A.C. 11:24C-4.6(d).*

HMOs/health plans must notify an applicant within 45 days whether the application is complete or incomplete when a provider applies for credentialing through CAQH's Universal Provider Datasource. The credentialing process must be completed within 90 days of receiving the complete application. *N.J.A.C. 11:24C-1.3(a) and (a)1.*

HMOs/health plans will be required to maintain a listing in the directory of in-network hospital outpatient facilities by the types of services the facilities provide. The directories will also prominently contain a statement informing subscribers that not all outpatient service providers located at in-network hospitals are in-network providers and urge members to confirm the provider status prior to receiving services. *N.J.A.C. 11:24C-4.5(c).*

MEMBER'S RIGHTS

HMO members shall be provided a member benefit handbook that clearly distinguishes any differences in the member's financial responsibility for accessing services within and outside of the HMO's network. *N.J.A.C. 11:24-9.1(3) (i).*

HMO members are held harmless from balance billing from medically necessary services that were authorized or covered by the HMO except as permitted by contract for copayments, coinsurance and deductibles. *N.J.A.C. 11:24-9.1(d) (9).*

NEW JERSEY HOSPITAL ASSOCIATION
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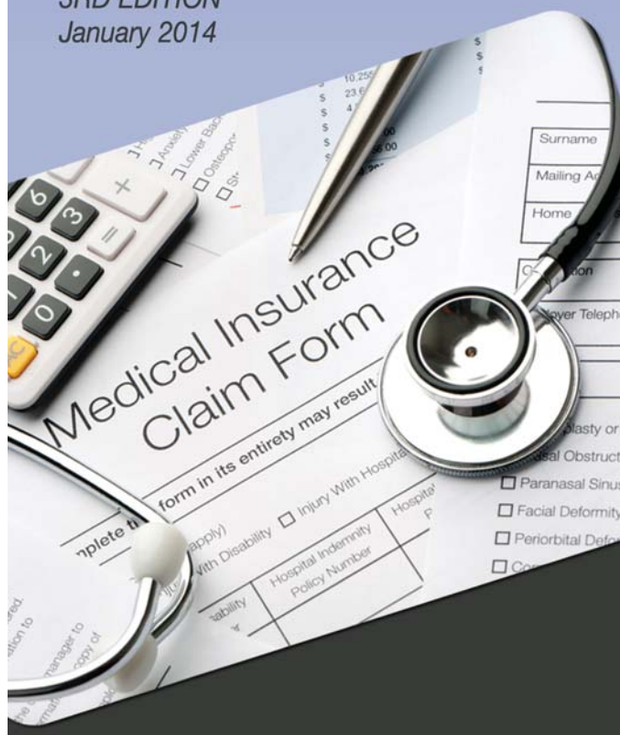
Managed Care Plan Responsibilities:

A Compilation of Statutory and Regulatory Expectations

3RD EDITION
January 2014



NEW JERSEY HOSPITAL ASSOCIATION
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PAYMENT ISSUES

HMOs/health plans must acknowledge receipt of all manual claims within 15 working days of receipt of the manual claim. HMOs/health plans must acknowledge receipt of all electronic claims within two working days following receipt of the transmission. ***P.L. 2005, c. 352 and N.J.A.C. 11:22-1.3.***

HMOs/health plans must pay, deny or contest clean claims within 30 calendar days for claims submitted electronically and 40 days for paper claims. ***P.L. 2005, c. 352 and N.J.A.C 11:22-1.5.***

Payment for a contested claim or contested portion of a claim that is subsequently corrected must be paid no later than 30 or 40 calendar days, as applicable, following the date that the HMO/health plan receives all of the requested information. ***P.L. 2005, c.352 and N.J.A.C 11:22-1.5(b).***

HMOs/health plans must post information on the Internet providing a description of claims for which additional information is required in order to adjudicate the claim. ***P.L. 2005, c. 352.***

HMOs/health plans must post the policy or procedure for reducing payment for duplicate or subsequent services provided by a healthcare provider on the same day of service. ***P.L. 2005, c. 352.***

HMOs/health plans cannot deny payment on all or a portion of a claim because the payer requests documentation or information that is not specific to the healthcare service provided to the covered person. ***P.L. 2005, c.352.***

HMOs/health plans cannot deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists. Good cause only exists if a payer's records indicate that other coverage exists. Routine requests to determine

if coordination of benefits exist do not constitute good cause. ***P.L. 2005 c.352***

HMOs/health plans must pay interest on claims paid after 30/40 days, accrued at the rate of 12 percent per annum. Interest is due at the time the claim is paid. When calculating interest, payers should calculate from the date the claim should have been paid. ***P.L. 2005, c.352.***

If the claim is overturned upon appeal, the payer has 30 days following the date of the appeal determination to pay the claim and interest due. If the claim is overturned after arbitration, the payer has 10 business days following the date of the arbitrator's determination. In both instances, interest is calculated from the date the appeal was received by the payer.

HMOs/health plans must pay interest on a claim when a determination against the provider is overturned following a provider's utilization of the appeal process established under HCAPPA. ***P.L. 2005, c.352.***

HMOs/health plans cannot seek reimbursement for overpayment of a paid claim later than 18 months after the date the first payment on the claim was made, except in instances in which claims were submitted fraudulently. ***P.L. 2005, c.352.***

HMOs/health plans cannot apply Multiple Procedure Logic or changes to billing requirements that would result in a material reduction in reimbursement if rates have been negotiated. ***N.J.A.C. 11:24C-4.3(c) 4.***

UTILIZATION MANAGEMENT

HMOs/health plans are required to post on their Internet sites, in a clear and conspicuous manner, a description of the source of all commercially-produced clinical criteria guidelines and a copy of all internally-produced clinical criteria guidelines used by the payer or its agent to determine the medical necessity of healthcare services. ***P.L. 2005 c.352.***

HMO/health plan decisions to deny, reduce or terminate a healthcare benefit, or to deny payment for a healthcare service, based on medical necessity, must be made by a physician. ***P.L. 2005, c. 352*** and ***N.J.A.C 11:24-8.3 and 11:24A-3.4(d) (1).***

HMOs/health plans are required to make a determination for authorization on a timely basis, as required by the exigencies of the situation, but no later than:*

- 24 hours for a person currently receiving inpatient hospital services or emergency department care;
- 15 days for a person who will receive inpatient hospital care; or
- 15 days for a person who will be receiving outpatient services, including but not limited to: a clinic, rehabilitation facility or nursing home. ***P.L. 2005, c. 352.***
- Payers and hospitals must have appropriate staff available between the hours of 9 a.m. and 5 p.m., seven days a week, to respond to authorization requests within the established time frames P.***L. 2005, c. 352.***

In the event a payer is unable to make an authorization determination within the time frames established due to the need for additional information, the payer shall have an additional period equal to the originally established timeframe in which to make a determination. ***P.L. 2005, c. 352.***

If HMOs/health plans fail to respond to authorization requests within the established timeframes, the request is deemed approved. ***P.L. 2005, c. 352.***

CONTRACT ISSUES

HMOs/health plans must include in a provider's agreement, in plain language, the terms and conditions of the agreement, including but not limited to:

- Compensation terms, including amount and timing of compensation;
- The specifics applicable to each product, if the agreement applies to products with different compensation or other terms;
- The term or duration of the agreement;
- The method(s) by which the contract may be amended, renewed and terminated;
- The provider's obligation to participate in preauthorization programs;
- The provider's obligation to maintain liability insurance; and
- A description of the carrier's internal dispute resolution mechanism. ***N.J.A.C. 11:24C-4.3***