New Jersey Addendum

State Specific Provider Requirements

# **General Terms.**

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# **Network Arranger Laws**

## As required by N.J. Stat. Ann. § 17:48H-18, in the event an Organized Delivery System (ODS) fails to pay or provide for comprehensive or limited health care services for any reason whatsoever, including, but not limited to, insolvency or breach of contract, neither the contract holder nor the covered person shall be liable to the Provider for any sums owed to the Provider under the Agreement. Additionally, no Provider, or agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the contract holder or covered person sums owed to the provider by the licensed ODS except that this subsection shall not be construed to prohibit collection of uncovered charges consented to or lawfully owed to providers by a contract holder or covered person.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(1), any section of the Agreement or this Addendum that conflicts with New Jersey or Federal law is effectively amended to conform with the requirements of the New Jersey or Federal law, solely in relation to this Addendum.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(2), to the extent that some portion of the provider compensation is tied to the occurrence of a pre-determined event, or the non-occurrence of a pre-determined event, the Provider has a right to receive a periodic accounting of the funds held, which shall be no less frequently than annually. The Provider has a right to appeal a decision denying the Provider additional compensation to which the Provider believes he or she is entitled under the terms of the Agreement.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(3), the Provider’s activities and records relevant to the provision of health care services may be monitored from time to time either by the ODS, the carrier, or another contractor acting on behalf of the carrier in order for the ODS or the carrier to perform quality assurance and continuous quality improvement functions.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(4), the Provider must comply with the quality assurance program, which is contained the Provider Manual. ODS shall be responsible for the day-to-day administration of the quality assurance program. The Provider can make complaints regarding the quality assurance program and otherwise provide feedback regarding the operations of the ODS and carrier to the ODS.

## As required by N.J. Admin. Code §§ 11:24B-5.2(a)(5) and (6), the Provider must comply with the utilization management (“UM”) program, which is that of a separate entity and is being adopted by both the carrier and the ODS or delegate with which the Provider is contracted. The separate entity is responsible for the day-to-day operation of the utilization management program. The Provider can contact the separate entity to obtain UM decisions, make UM appeals, obtain information regarding UM standards, or provide comment on applicable UM standards in the Provider’s practice area. The Provider has a right to the name and telephone number of the physician, or dentist if appropriate, denying or limiting an admission, service, procedure or length of stay. The Provider can rely upon the written or oral authorization of a service if made by the carrier or the entity identified as being responsible for the day-to-day operations of the UM program, and that the services will not be retroactively denied as not medically necessary except in cases where there was material misrepresentation or fraud. If an appeal instituted by a Provider on behalf of a covered person will be entertained as a member UM appeal without the covered person's consent, such appeals will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J. Stat. Ann. 26:2S-11, until the covered person's specific consent to the appeal is obtained. The Provider must obtain consent of the covered person in order for the appeal to be reviewed in accordance with the Stage 1 and Stage 2 process as set forth at N.J. Admin. Code. §§ 11:24-8 and 11:24A-3.5, and failure to obtain consent of the covered person results in review of the appeal using a separate process. This provision shall not limit the right of the Provider to submit an appeal on behalf of the covered person when the covered person may be financially liable for the costs of the health care services.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(7), the Agreement is governed by New Jersey law, as limited by the terms of this Addendum.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(10), the Provider is prohibited from billing or otherwise pursuing payment from a carrier's covered person for the costs of services or supplies rendered in-network that are covered, or for which benefits are payable, under the covered person's health benefits plan, except for copayment, coinsurance or deductible amounts set forth in the health benefits plan, regardless of whether the provider agrees with the amount paid or to be paid, for the services or supplies rendered.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(11), the Provider is obligated to be credentialed or otherwise eligible to participate in various programs (e.g. Medicare or Medicaid), as appropriate. To the extent time periods for credentialling or recredentialling are not contained in the Agreement, such time frames are contained in the Provider Manual. The Provider is obligated to cooperate with the credentialling process.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(12), the Provider is obligated to maintain malpractice insurance in the amount of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(13), the Provider shall provide health care services and supplies to covered persons as described in the Agreement and the Provider Manual.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(14), the Provider shall have the right and obligation to communicate openly with all covered persons regarding diagnostic tests and treatment options.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(15), the Provider shall not be terminated or otherwise penalized because of complaints or appeals that the Provider files on his or her own behalf, or on behalf of a covered person, or for otherwise acting as an advocate for covered persons in seeking appropriate, medically necessary health care services covered under the covered person's health benefits plan.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(16), the Provider shall not discriminate in his or her treatment of a carrier’s covered persons.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(17), to the extent not contained in the Agreement or the Provider Manual, claims shall be handled in accordance with applicable law and, if applicable, interest for late payment of claims shall be remitted to the Provider, but in no instance is the Provider obligated to request payment of the interest before the interest will be paid.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(18), the Provider may submit and seek resolution of complaints and grievances, separate and apart from submitting complaints and grievances on behalf of a covered person, and complaints addressing compensation and claims issues. Complaints and grievances submitted in accordance with this provision shall be resolved within 30 days following receipt of the complaint or grievance. The Provider has a right to submit complaints and grievances to the New Jersey Departments of Banking and Insurance or Health Services, depending upon the issue involved.

## As required by N.J. Admin. Code § 11:24B-5.2(a)(19), to the extent required by state and federal law, the parties shall maintain confidentiality of medical records, including, without limitation, compliance with the Title 42 of Code of Federal Regulation (CFR) 431.300 et seq. and HIPAA and other applicable laws or requirements contained in the Agreement.

## As allowed by N.J. Admin. Code § 11:24B-5.2(d), additional materials or details required by law may be set forth in the Provider Manual, which is available to or shall be made available to the Provider.

## As required by N.J. Admin. Code § 11:24B-5.3(c), when the Provider's status as a participating Provider in is being terminated, written notice shall be issued to the Provider no less than 90 days prior to the date of termination, except that the 90–day prior notice requirement need not apply when the contract is being terminated upon its date of renewal, or upon its anniversary date, if no annual renewal date is specified, or is being terminated because of breach, alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare. The written notice shall set forth the reason(s) for the termination. In the event that a written notice of termination does not contain a statement setting forth the reason(s) for termination, the Provider follow the process for obtaining such a written statement as contained in the Agreement or Provider Manual.

## As required by N.J. Admin. Code § 11:24B-5.3(d), the Provider shall have the right to request a hearing following a notice that the Provider's status as a participating Provider with a carrier is being terminated, except that the right to a hearing does not apply when the termination occurs on the date of renewal of the contract, or upon the contract's anniversary date, if no annual renewal date is specified, or termination is based on breach or alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the Provider presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

## As required by N.J. Admin. Code § 11:24B-5.3(e), the Provider shall have the right to request hearing from a carrier when a Provider is terminated from participation in the carrier's network according to the process laid out in N.J. Admin. Code §§ 11:24-3.6 or 11:24A-4.9, as appropriate.

## As required by N.J. Admin. Code § 11:24B-5.3(f), when the Provider's status as a participating Provider is terminated, or when the contract between the ODS and the Provider terminates, regardless of the party initiating the termination, the Provider, if a physician, shall remain obligated to provide services for covered persons in accordance with the following:

### For up to 4 months following the effective date of the termination in cases where it is medically necessary for the covered person to continue treatment with the health care professional, except as ii. through v. of below applies;

### In cases of the pregnancy of a covered person, through the postpartum evaluation of the covered person, up to 6 weeks after delivery;

### In the case of post-operative care, up to 6 months following the effective date of the termination;

### In the case of oncological treatment, up to 1 year following the effective date of the termination; and

### In the case of psychiatric treatment, up to 1 year following the effective date of the termination.

## As required by N.J. Admin. Code § 11:24B-5.4(c), if a hospital's status as a participating provider is terminated, regardless of who initiates the termination, or the reason for the termination, the hospital shall continue to abide by the terms of the contract for a period of at least 4 months from the effective date of the termination with respect to at least those covered persons enrolled with a carrier that is an HMO. The obligation shall apply to any health benefits plan underwritten by the HMO, regardless of the characterization of the health benefits plan (for example, regardless of whether the health benefits plan is for Medicare, Medicaid, a point-of-service plan, or a closed panel plan).

## As required by N.J. Admin. Code § 11:24B-5.5, the Provider and carrier must assure 24-hour, 7-day per week emergency and urgent care coverage to covered persons. The procedure to assure proper utilization of such coverage is contained in the Provider Manual.

## As required by N.J. Admin. Code § 11:24B-5.6, if the Agreement is with a hospital, the facility shall follow clear procedures for granting of admitting and attending privileges, and notify the ODS and/or carrier when such procedures change, the admission authorization procedures for covered persons, the procedures for notifying carriers when a covered person presents at emergency rooms, and procedures for billing and payment, schedules and negotiated arrangements. The procedures for admission authorization for covered persons, notifying the carrier when a covered person presents at an emergency room, and for billing and payment schedules and negotiated arrangements are contained in the Agreement or the Provider Manual.

## As required by N.J. Admin. Code § 11:24C-4.3(c)(1), to the extent not contained in the Agreement, compensation terms, the products with different compensation or other terms, the duration of the Agreement, the method by which the Agreement may be amended, renewed, and terminated, and the carrier’s internal dispute resolution mechanism will be provided in the Provider Manual.

## As required by N.J. Admin. Code § 11:24C-4.3(c)(3), to the extent not contained in the Agreement, unilateral changes shall only be made with sufficient advance notice to permit termination in advance of the effective date of the change.

## As required by N.J. Admin. Code § 11:24C-4.3(c)(5), carrier may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

# **General Insurance Laws**

## Subsections b. through r of Section II. of this Addendum are incorporated by reference into the Agreement to the extent such laws or regulations relate to general insurance operations or contracting.

# **Health Maintenance Organization (HMO)/Managed Care Organization (MCO) Specific Laws**

## Subsections b. through r of Section II. of this Addendum are incorporated by reference into the Agreement to the extent the laws and regulations apply to an HMO or MCO.

## As required by N.J. Stat. Ann. § 26:2S-9 and N.J. Admin. Code § 11:24-15.2(b)(13), Provider shall not be penalized or the contract terminated by the carrier because the Provider acts as an advocate for the patient in seeking appropriate, medically necessary health care services. Provider may communicate openly with a patient about all appropriate diagnostic testing and treatment options.

## As required by N.J. Admin. Code § 11:24-3.5(d), if Provider is not a hospital, then regardless of which party terminates the Agreement, or the reasons for the termination, the HMO and the Provider shall abide by the terms of the Agreement, including reimbursement terms, for 4 months following the date of the termination. Provider has no obligation under the Agreement to provide, and the HMO has no obligation to reimburse at the contracted rate, services which are not medically necessary to be provided by the Provider on and after the 31st day following the date of termination.

## As required by N.J. Admin. Code § 11:24-15.2(a), the Agreement shall be consistent with laws regarding confidentiality of information and with professional licensing standards including N.J. Stat. Ann. § 45:14B-31 et seq.

## As required by N.J. Admin. Code § 11:24-15.2(b)(1), the term of the Agreement and the reasons for which it may be terminated by one or more parties, including the procedures for notice and effectuation of such termination, and opportunities, if any to cure any deficiencies prior to termination, are subject to the following:

### If the Agreement is terminated prior to the Agreement’s termination date, the HMO shall give the Provider at least 90 days prior written notice; and, that in the event of such a termination, the Provider has a right to request a hearing following such notice except when termination of health care professionals is based on: nonrenewal of the contract, a determination of fraud, breach of contract by the provider, or the opinion of the HMO's medical director that the provider represents an imminent danger to a patient or the public health, safety and welfare;

### Termination notice shall contain a statement as to the right of the Provider to obtain a reason for the termination in writing from the HMO if the reason is not otherwise stated in the notice; the right of the Provider to request a hearing, and any exceptions to that right; and, the procedures for exercising either right;

### The procedures for obtaining a hearing may be contained in the Agreement or Provider Manual, and to the extent required, reformed to be consistent with the standards set forth at N.J. Admin. Code § 11:24-3.6;

### Provider's participation in the hearing process shall not be deemed to be an abrogation of the provider's legal rights; and

### In accordance with process contained in the Agreement and/or the Provider Manual, Provider may request from the HMO the reasons for the termination, which the HMO shall respond to in writing.

## As required by N.J. Admin. Code § 11:24-15.2(b)(2), Provider may not be terminated or penalized solely because of filing a complaint or appeal permitted by state law or regulations.

## As required by N.J. Admin. Code § 11:24-15.2(b)(3) Provider may not be terminated or penalized for acting as an advocate for the patient in seeking appropriate, medically necessary health services.

## As required by N.J. Admin. Code § 11:24-15.2(b)(4), Provider shall continue to provide services to members at the contract price following termination of the Agreement, in accordance with N.J. Admin. Code § 11:24–3.5.

## As required by N.J. Admin. Code § 11:24-15.2(b)(5), the method of reimbursement, including the method, events and timing of application of any penalties, bonuses or other types of compensation arrangements, are subject to the following:

### The Agreement shall not provide financial incentives to the Provider for the withholding of covered health care services that are medically necessary, but this shall not prohibit or limit the use of capitated payment arrangements between a carrier and Provider.

### To the extent that some portion of the Provider compensation is tied to the occurrence of a pre-determined event, or the nonoccurrence of a pre-determined event, such event is specified in the Agreement. Provider has a right to receive a periodic accounting (no less frequently than annually) of the funds held.

### A Provider may appeal a decision denying the Provider additional compensation, in whole or in part, in accordance with any compensation arrangement tied to the occurrence or nonoccurrence of a pre-determined event.

## As required by N.J. Admin. Code § 11:24-15.2(b)(6), the Provider shall provide health care services and supplies to covered persons as described in the Agreement and the Provider Manual.

## As required by N.J. Admin. Code § 11:24-15.2(b)(7), Provider shall hold the covered person harmless for the cost of any service or supply for which the carrier provides benefits, whether or not the provider believes its compensation for the service or supply from the carrier (directly or through a secondary contractor) is made in accordance with the reimbursement provision of the provider agreement, or is otherwise inadequate. Members shall not be held harmless for payment of required copayments, deductibles or coinsurance, if any. Providers shall not balance bill members who have obtained covered services or supplies through the HMO network mechanism.

## As required by N.J. Admin. Code § 11:24-15.2(b)(8), Provider shall not discriminate in their treatment of HMO patients.

## As required by N.J. Admin. Code § 11:24-15.2(b)(9), Provider shall comply with the HMO’s quality assurance and utilization review programs.

## As required by N.J. Admin. Code § 11:24-15.2(b)(10), Provider shall maintain licensure, certificate and adequate malpractice coverage. With respect to a physician and dentist malpractice insurance shall be at least $1,000,000 per occurrence and $3,000,000 in the aggregate per year. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

## As required by N.J. Admin. Code § 11:24-15.2(b)(11), Patient information shall be kept confidential, but HMO and the Provider shall have a mutual right to a member's medical records, as well as timely and appropriate communication of patient information, so that both the Provider and the HMO may perform their respective duties efficiently and effectively for the benefit of the member.

## As required by N.J. Admin. Code § 11:24-15.2(b)(12), to the extent the Agreement or Provider Manual contains an internal Provider complaint and grievance procedure used by participating Providers inconsistent with N.J. Admin. Code § 11:24-3.7, such procedure is reformed to conform with N.J. Admin. Code § 11:24-3.7.

## As required by N.J. Admin. Code § 11:24-15.2(c), the Provider may be required to acquire and maintain hospital admission privileges consistent with HMO policies and procedures. The HMO and Provider have a mutual responsibility to assure 24 hour, 7-day a week emergency and urgent care coverage to members, and the procedures to assure proper utilization of such coverage consistent with the requirements of N.J. Admin. Code § 11:24-5.2.

## As required by N.J. Admin. Code § 11:24-15.2(f), the HMO shall have privity of contract with the health care providers such that the HMO shall have standing to enforce any secondary contractor's contract(s) with the health care providers in the absence of enforcement by the secondary contractor.

## As required by N.J. Admin. Code § 11:24-15.2(h), to the extent the Agreement does not comply with N.J. Admin. Code § 11:24C-4, the Agreement is reformed to comply with N.J. Admin. Code § 11:24C-4.

## Any information which is required to be included in the Agreement under N.J. Admin. Code § 11:24-15.2 and which is not already included in the body of the Agreement or Provider Manual but has been provided to the Provider by the HMO separately shall be considered incorporated into the Agreement.