ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

[Second Reprint]

ASSEMBLY, No. 4688

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 22, 2021

The Assembly Budget Committee reports favorably Assembly Bill No. 4688 (2R), with committee amendments.

As amended by the committee, this bill codifies and establishes certain network adequacy standards for pediatric primary and specialty care in the Medicaid program. The bill defines network adequacy to mean the adequacy of the provider network with respect to the scope and type of health care benefits provided by the managed care plan, the geographic service area covered by the provider network, and access to medical specialists pursuant to the standards in the regulations promulgated pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18) and in the existing contract between a managed care organization (MCO) and the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services (DHS).

Currently, pursuant to the contract between Medicaid MCOs and the DMAHS, all MCO networks are required to ensure that 90 percent of the enrollees must be within six miles of two primary care physicians (PCPs) in urban counties, and that 85 percent of enrollees must be within 15 miles of two PCPs in non-urban counties. Under the contract, no enrollee is to be more than 30 minutes from a PCP.

The existing network adequacy requirements for medical specialists are outlined under State regulation at N.J.A.C.11:24-6 et seq. Specifically, all Medicaid MCO networks are required to ensure that 90 percent of enrollees must be within 60 minutes or 45 miles of each type of medical specialist.

This bill enhances these existing network adequacy standards for pediatric primary and specialty care in the Medicaid program by incorporating certain federal network adequacy standards for the Medicare Advantage program.

Under the bill, the DMAHS, at the next regular opportunity, is required to amend the Medicaid MCO contract provisions on network adequacy to require:

(1) a sufficient number of pediatric PCPs to assure that: (a) at least two physicians eligible as PCPs are within five miles or 10 minutes

driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in urban counties; (b) at least two physicians eligible as PCPs are within 10 miles or 15 minutes driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in non-urban counties; and (c) 100 percent of all pediatric enrollees live no more than 30 minutes from at least one physician eligible as a PCP;

(2) a sufficient number of pediatric medical specialists to assure: (a) access within 15 miles or 30 minutes driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in urban counties; and (b) access within 40 miles or 60 minutes driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in non-urban counties;

(3) a sufficient number of pediatric oncologists and developmental and behavioral pediatricians and psychiatrists to assure: (a) access within 10 miles or 20 minutes driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in urban counties; and (b) access within 30 miles or 45 minutes driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in non-urban counties; and

(4) the following types of pediatric medical specialties represented within the plan's network: adolescent medicine; allergy and immunology; cardiology; developmental and behavioral pediatrics; psychiatry; emergency medicine; endocrinology and diabetes; gastroenterology and nutrition; general pediatrics; general pediatrics – dermatology; hematology; human genetics and metabolism; infectious disease; neonatology; nephrology; neurology; oncology; ophthalmology; orthopedics; otolaryngology; plastic surgery; pulmonary medicine, including sleep medicine; radiology; rehabilitative medicine; and rheumatology.

Under the bill, in each reporting period, a MCO may seek a waiver of a specific network adequacy provision established in paragraphs (2) through (3) of subsection a. of this section from the DMAHS. The division is required to establish a waiver process where, at a minimum, the MCO must demonstrate both an active, good faith effort to meet requirements for applicable specialties in each applicable county, and certify to the division which specialty or specialties, and in which counties, for which insufficient providers exist.

The division is also required to direct each MCO to establish a process by which a patient or provider may submit a grievance regarding the adequacy of the provider network. This process is to include response time frames, but no more than 30 days, and reporting defined in the managed care contract, including documentation of specific provider availability addressing each grievance.

Under the bill, in order to provide timely services to patients, when a MCO is notified that care is needed for a Medicaid beneficiary in a county where the MCO was unable to certify that it meets, or received a waiver of, the network adequacy standards as required under the bill, the MCO is to initiate negotiations with non-participating providers of that service, and provide timely authorization to ensure services can be provided to the beneficiary without delay and consistent with timeframes defined in the managed care contract for all routine and urgent services. Balance-billing of Medicaid beneficiaries is prohibited. Any copayments or other forms of cost-sharing imposed on services rendered under this provision are to be limited to the maximum amount allowed under State law for the Medicaid program. Furthermore, the Commissioner of Human Services is authorized to promulgate rules or regulations to resolve in a timely manner contracting disputes that arise under this provision.

The amended bill directs the division to establish an enhanced system to assess the network adequacy of a MCO contracted with the division to provide benefits under Medicaid, including, but not limited to, requiring the MCO to certify, at a minimum on an annual basis, that the MCO meets the network adequacy requirements contained in their contract. The division is to enforce appropriate sanctions for non-compliance with the bill, including, but not limited to, financial penalties that accrue during the period of non-compliance.

The amended bill also directs a MCO to annually provide a report of the number of out-of-network contracts and waivers sought and granted by pediatric specialty, as listed under the bill, and county to the DMAHS, which is required to make that information publicly available by request.

As amended by the bill, "urban county" means: Bergen, Burlington, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union counties, or as otherwise defined for the purposes of this section by the Commissioner of Human Services. "Non-urban county" means: Atlantic, Cape May, Cumberland, Gloucester, Hunterdon, Morris, Salem, Somerset, Sussex, and Warren counties, or as otherwise defined for the purposes of this section by the Commissioner of Human Services. The bill is to take effect on the first day of the third month following enactment, except that the Commissioner of Human Services may take such anticipatory administrative action in advance thereof as is necessary for the implementation of the bill.

As amended and reported by the committee, Assembly Bill No. 4688 (3R) is identical to Senate Bill No. 3000 (4R), which was also amended and reported by the committee on this date.

COMMITTEE AMENDMENTS

The committee amended the bill to remove two provisions that would have provided that no out-of-state pediatric specialty hospital,

and no out-of-state or in-state pediatric specialty provider, is to be denied the right to participate in an MCO network under the same terms and conditions currently applicable to all other contracting providers, provided that the provider is willing to accept the terms and conditions of the contract and: 1) the pediatric specialty hospital is willing to accept 125 percent of its home state Medicaid fee-for-service rate; and 2) the out-of-state or in-state pediatric specialty provider is willing to accept 100 percent of the State Medicaid fee-for-service rate.

The committee also amended the bill to require an MCO to initiate negotiations with non-participating providers when the MCO is notified that care is needed for a Medicaid beneficiary in a county where the MCO was unable to certify that it meets, or received a waiver of, the network adequacy standards as required under the bill, instead of when the MCO is notified by a provider of their willingness to participate in the MCO network under the provisions of the bill that were removed, as described above. The committee amendments authorize the Commissioner of Human Services to promulgate rules or regulations to resolve in a timely manner contracting disputes that arise under this provision.

FISCAL IMPACT

The Office of Legislative Services (OLS) concludes that the bill will result in an indeterminate impact on State costs and revenues due to the countervailing effects of enhancing network adequacy standards for pediatric primary and specialty care, as established under the bill, on the capitation rates paid by the DMAHS to the Medicaid MCOs. To the extent that State Medicaid expenditures are matched by federal Medicaid funds, State revenues may also be affected under this bill.

It is possible that any expenses incurred may be partially offset by an increase in State revenue due to the collection of fines imposed under the bill. However, the OLS cannot determine the nature and number of such infractions and, therefore, the amount of revenue that may be generated.