

ASSEMBLY, No. 5873

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED JUNE 14, 2021

Sponsored by:

Assemblywoman ELIANA PINTOR MARIN

District 29 (Essex)

SYNOPSIS

Requires Medicaid and NJ FamilyCare managed care organizations to offer patient-centered medical home model or other alternative payment model to primary care providers.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning patient-centered medical homes and
2 supplementing Title 30 of the Revised Statutes.

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. As used in this act:

8 “Alternative payment model” means a payment approach that
9 gives providers financial incentives to deliver high-quality and cost-
10 efficient care and may apply to a specific clinical condition, care
11 episode, or population.

12 “Department” means the Department of Human Services.

13 “Division” means the Division of Medical Assistance and Health
14 Services in the Department of Human Services.

15 “Managed care organization” means a Medicaid managed care
16 organization, as that term is defined pursuant to 42 U.S.C.
17 s.1396b(m)(1)(A).

18 “Patient-centered medical home model” means a type of
19 alternative payment model that supports a clinical model of team-
20 based health care, led by a health care provider, to provide
21 comprehensive, person-centered, and continuous medical care to
22 patients in order to achieve maximal health outcomes.

23 “Primary care provider” means a licensed medical doctor, doctor
24 of osteopathy, or a licensed medical practitioner who, within the
25 scope of practice and in accordance with State certification or
26 licensure requirements, standards, and practices, is responsible for
27 maintaining continuity of patient care and providing all required
28 primary care services to enrollees, including periodic examinations,
29 preventive health care and counseling, immunizations, diagnosis,
30 and treatment of illness or injury, coordination of overall medical
31 care, record maintenance, and initiation of referrals to specialty
32 providers. A primary care provider shall include general or family
33 practitioners, pediatricians, internists, and shall include specialist
34 physicians, physician assistants, certified nurse midwives, certified
35 nurse practitioners, or clinical nurse specialists, provided that the
36 practitioner carries out all primary care provider responsibilities in
37 accordance with licensure requirements.

38
39 2. A managed care organization that provides benefits to
40 persons who are eligible for Medicaid under P.L.1968, c.413
41 (C.30:4D-1 et seq.) or NJ FamilyCare under P.L.2005, c.156
42 (C.30:4J-8 et al.) shall offer a patient-centered medical home model
43 to primary care providers in the managed care organization’s
44 network. The division, in its sole discretion, may waive the
45 requirements of this section if a managed care organization can
46 demonstrate that the managed care organization offers an
47 alternative payment model to primary care providers that is not a

1 patient-centered medical home model but that similarly incentivizes
2 high quality, efficient, and holistic care.

3

4 3. a. A managed care organization shall submit annually to the
5 division a description of the managed care organization's patient-
6 centered medical home model or, if waived by the division to offer
7 a patient-centered medical home model, the other alternative
8 payment model offered to primary care providers, which description
9 shall include, but not be limited to:

10 (1) the basic financial structure of the model, which shall
11 include incentive or population management payments which may
12 be available to providers participating in the model;

13 (2) whether participating providers are required to obtain any
14 certifications to participate in the model;

15 (3) quality or other performance metrics which affect provider
16 payment under the alternative payment model;

17 (4) the requirements for a provider to be eligible to participate
18 in the model, including but not limited to the number of unique
19 patients seen by a provider or past quality performance;

20 (5) whether the model qualifies as an "Other Payer Advanced
21 APM" as defined in 42 CFR 414.1305;

22 (6) a list of all providers participating in the model; and

23 (7) the number of enrollees provided services by providers
24 participating in the model, listed by county.

25 b. The managed care organization shall make the description
26 required pursuant to subsection a. of this section available to the
27 public on the managed care organization's Internet website, after
28 division approval. The division may also post such descriptions on
29 its Internet website.

30 c. The division may, in its discretion, establish a standardized
31 format for managed care organizations to use in providing the
32 description required pursuant to subsection a. of this section.

33 d. The division may, in its discretion, extend the requirements
34 of subsection a. of this section to any other alternative payment
35 models, which are targeted toward non-primary care provider
36 categories, offered by a managed care organization that contracts to
37 provide benefits to persons eligible for Medicaid or NJ FamilyCare.

38

39 4. a. Notwithstanding the provisions of the "Administrative
40 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) or any other
41 law to the contrary, the division shall establish standardized quality
42 metrics for patient-centered medical home models and other
43 alternative payment models offered to primary care providers in
44 accordance with this section.

45 b. The division shall develop, through a public stakeholder
46 process, standardized quality metrics for patient-centered medical
47 home models and other alternative payment models offered to

1 primary care providers and request public comment on such
2 standardized quality metrics.

3 c Following the public comment period, and periodically
4 thereafter, the division shall identify a list of standardized quality
5 metrics and shall mandate that managed care organizations utilize
6 only those standardized quality metrics when determining or
7 calculating payments to providers under the managed care
8 organization's patient-centered medical home model or other
9 alternative payment offered to primary care providers. To the
10 extent practicable, the standardized quality metrics shall promote
11 alignment with other non-Medicaid payers.

12 d. Nothing in this act shall be construed as precluding the
13 division from imposing additional requirements on managed care
14 organizations that relate to patient-center medical home models or
15 other alternative payment models offered to primary care providers.

16
17 5. The division shall specify a format and methodology through
18 which managed care organizations shall submit patient-level data
19 and provider-level data on participation and performance in a
20 patient-centered medical home model or other alternative payment
21 model in order to facilitate the division's evaluation of the
22 performance of such patient-centered medical home models and
23 alternative payment models offered to primary care providers.

24
25 6. The Commissioner of Human Services and the
26 Commissioner of Banking and Insurance may jointly waive any
27 provision of P.L.1999, c.409 (C.17:48H-1 et seq.) to the extent
28 necessary to support provider participation in Medicaid patient-care
29 medical home models or any other Medicaid alternative payment
30 models. Such waivers shall be granted, in writing, by both
31 commissioners and shall only be issued if the Commissioner of
32 Human Services and the Commissioner of Banking and Insurance
33 jointly determine, in their sole discretion, that any risk of adverse
34 consequences to the public are minimal.

35
36 7. The Commissioner of Human Services shall apply for such
37 waivers, federal approvals, or state plan amendments as may be
38 necessary to implement the provisions of this act and to secure
39 federal financial participation for State Medicaid expenditures
40 under the federal Medicaid program.

41
42 8. This act shall take effect one year following the date of
43 enactment provided that approval of any waivers, federal approvals,
44 or state plan amendments has been received prior to that date,
45 otherwise the effective date of this act is delayed until such
46 approvals are received. The Commissioner of Human Services may
47 take such anticipatory administrative action in advance thereof as
48 shall be necessary for the implementation of this act.

STATEMENT

This bill requires Medicaid and NJ FamilyCare beneficiaries managed care organizations to offer patient-centered medical home models or other alternative payment models to primary care providers. As defined under the bill, a “patient-centered medical home model” means a type of alternative payment model that supports a clinical model of team-based health care, led by a health care provider, to provide comprehensive, person-centered, and continuous medical care to patients in order to achieve maximal health outcomes. An “alternative payment model” means a payment approach that gives providers financial incentives to deliver high-quality and cost-efficient care and may apply to a specific clinical condition, care episode, or population.

Under the bill, a managed care organization that provides benefits to persons who are eligible for Medicaid under P.L.1968, c.413 (C.30:4D-1 et seq.) or NJ FamilyCare under P.L.2005, c.156 (C.30:4J-8 et al.) is to offer a patient-centered medical home model to primary care providers in the managed care organization’s network. The Division of Medical Assistance and Health Services in the Department of Human Services (division), in its sole discretion, may waive this requirement if a managed care organization can demonstrate that the managed care organization offers an alternative payment model to primary care providers that is not a patient-centered medical home model but that similarly incentivizes high quality, efficient, and holistic care.

The bill provides that a managed care organization is to submit annually to the division a description of the managed care organization’s patient-centered medical home model or, if waived by the division to offer a patient-centered medical home model, the other alternative payment model offered to primary care providers, which description is to include, but not be limited to: 1) the basic financial structure of the model, which is to include incentive or population management payments which may be available to providers participating in the model; 2) whether participating providers are required to obtain any certifications to participate in the model; 3) quality or other performance metrics which affect provider payment under the model; 4) the requirements for a provider to be eligible to participate in the model, including but not limited to the number of unique patients seen by a provider or past quality performance; 5) whether the model qualifies as an “Other Payer Advanced APM” as defined in 42 CFR 414.1305; 6) a list of all providers participating in the model; and 7) the number of enrollees provided services by providers participating in the model, listed by county.

Under the bill, the division is to establish standardized quality metrics for patient-centered medical home models and other alternative payment models offered to primary care providers. The

1 division is to develop, through a public stakeholder process,
2 standardized quality metrics for patient-centered medical home
3 models and other alternative payment models offered to primary
4 care providers and request public comment on such standardized
5 quality metrics. Following the public comment period, and
6 periodically thereafter, the division is to identify a list of
7 standardized quality metrics and is to mandate that managed care
8 organizations utilize only those standardized quality metrics when
9 determining or calculating payments to providers under the
10 managed care organization's patient-centered medical home model
11 or other alternative payment offered to primary care providers. To
12 the extent practicable, the standardized quality metrics are to
13 promote alignment with other non-Medicaid payers.

14 The bill provides that the division is to specify a format and
15 methodology through which managed care organizations are to
16 submit patient-level and provider-level data on participation and
17 performance in a patient-centered medical home model or other
18 alternative payment model in order to facilitate the division's
19 evaluation of the performance of such patient-centered medical
20 home models and alternative payment models offered to primary
21 care providers.