LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

SENATE, No. 3000

STATE OF NEW JERSEY
219th LEGISLATURE

DATED: MARCH 10, 2021

SUMMARY

Synopsis: Codifies and establishes certain network adequacy standards for pediatric primary and specialty care in Medicaid program.

Type of Impact: Indeterminate impact on State Medicaid Costs and Revenue.

Agencies Affected: Department of Human Services, Division of Medical Assistance and Health Services.

Office of Legislative Services Estimate

Fiscal Impact	**Annual**
State Cost Impact	Indeterminate
State Revenue Impact	Indeterminate

- 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 Division of Medical Assistance and Health Services (DMAHS) to the Medicaid managed care organizations (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.

BILL DESCRIPTION

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 State law and in the existing contract between a MCO and the DMAHS in the Department of Human Services.

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. 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.

Under the bill, the Commissioner of Banking and Insurance is required to approve the network adequacy of a managed care plan provided by a MCO contracted with the DMAHS to provide benefits under Medicaid only if the plan has:

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 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; emergency medicine; endocrinology and diabetes; gastroenterology and nutrition; general pediatrics; general pedicatrics – 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.

Any MCO that violates any provision of the bill is liable for penalties described in current State law, which include a civil penalty of not less than $250 and not greater than $10,000 for each day that the MCO is in violation of the bill under certain circumstances. The Commissioner of Banking and Insurance may also issue an order directing a MCO to cease and desist from engaging in any act or practice in violation of the provisions of the bill.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The 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.

The division pays MCOs based on a per-beneficiary per month capitation rate. Federal regulations require that capitation rates be approved by the Centers of Medicare and Medicaid Services and be actuarially sound, meaning the rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. When developing capitation rates, the contracted actuary utilizes encounter claims data from the fiscal year that is two years prior to the rate setting period, MCO financial reports, and monthly beneficiary data collected by the MCOs and the division.

The OLS assumes that over time the enhanced network adequacy standards imposed under the bill would influence capitation rate setting through the application of both downward and upward pressure. For example, research demonstrates the potential for long-term reduction in utilization and costs with better patient access to primary care, as provided for under the bill. Essentially, ready access to primary care would appropriately shift care away from more intensive and expensive care provided in urgent care, emergency departments, specialty departments, and inpatient settings. The resultant lower costs may provide for a decreased capitation rate. Similarly, improved access to specialty care, as provided for under the bill, can result in improved medical outcomes, while also avoiding potentially higher costs from emergency department visits and hospitalizations.

Conversely, in order to comply with the increased access standards required under the bill, particularly regarding costly specialty care, MCOs may have to increase provider reimbursement rates to draw the necessary providers into the Medicaid network. Generally, low Medicaid reimbursement rates are the main barrier for beneficiaries to access specialty care in a timely manner. However, the OLS does not have access to current managed care rates, and cannot predict the magnitude of the impact the bill may have on such rates and, as a result, on any increase in the MCO capitation rate.

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.

Section:	*Human Services*
Analyst:	*Sarah M. Schmidt* *Senior Research Analyst*
Approved:	*Thomas Koenig* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).