SENATE, No. 3913

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED JUNE 1, 2023

Sponsored by:
Senator NILSA I. CRUZ-PEREZ
District 5 (Camden and Gloucester)
Senator MICHAEL L. TESTA, JR.
District 1 (Atlantic, Cape May and Cumberland)

Co-Sponsored by:
Senator Durr

SYNOPSIS

Establishes minimum NJ FamilyCare reimbursement rate for certain out-of-state hospitals that provide services to NJ FamilyCare pediatric beneficiaries.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 11/30/2023)

AN ACT concerning the NJ FamilyCare reimbursement rate for certain out-of-state hospitals and amending P.L.2021, c.276.

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

1. Section 1 of P.L.2021, c.276 (C.30:4D-7ff) is amended to read as follows:

1. a. At the next regular opportunity, the Division of Medical Assistance and Health Services in the Department of Human Services shall amend the Medicaid managed care organization contract provisions on network adequacy to require:

(1) a sufficient number of pediatric primary care physicians (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

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

metabolism; infectious disease; neonatology; nephrology; neurology; oncology; ophthalmology; orthopedics; otolaryngology; plastic surgery; pulmonary medicine, including sleep medicine; radiology; rehabilitative medicine; and rheumatology.

b. An out-of-state hospital, licensed under the laws and regulations of the state in which the hospital is located, that provides care to 10,000 or more unique NJ Family Care pediatric beneficiaries within its hospital system annually, shall receive a reimbursement rate under NJ FamilyCare that is at least 125 percent of the Medicaid fee-for-service reimbursement rate provided in the state where the hospital is licensed.

c. In each reporting period, a managed care organization may seek a waiver of a specific network adequacy provision established in paragraphs (2) through (3) of subsection a. of this section from the Division of Medical Assistance and Health Services. The division shall establish a waiver process where, at a minimum, the managed care organization 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.

[c.**]** d. The Division of Medical Assistance and Health Services shall require each managed care organization to establish a process by which a patient or provider may submit a grievance regarding the adequacy of its provider network. This process shall include response timeframes, but no more than 30 days, and reporting defined in the managed care contract, including documentation of specific provider availability addressing each grievance.

[d.**]** e. In order to provide timely services to patients, when a managed care organization is notified that care is needed for a Medicaid beneficiary in a county where a managed care organization was unable to certify that it meets, or received a waiver of, the network adequacy standards as required in subsection a. of this section, the managed care organization shall initiate negotiations with non-participating providers of that service, and shall 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 shall be prohibited. Any copayments or other forms of cost-sharing imposed on services rendered under this paragraph shall be limited to the maximum amount allowed under State law for the Medicaid program. The Commissioner of Human Services may promulgate rules or regulations to resolve in a timely manner contracting disputes that arise under this subsection.

[e.**]** f. The Division of Medical Assistance and Health Services shall establish an enhanced system to assess the network

adequacy of a managed care organization contracted with the division to provide benefits under Medicaid, including, but not limited to, requiring the managed care organization to certify, at a minimum on an annual basis, that the managed care organization meets the network adequacy requirements contained in their contract. The division shall enforce appropriate sanctions for non-compliance with this section, including, but not limited to, financial penalties that accrue during the period of non-compliance.

[f.**]** g. A managed care organization shall annually provide a report of the number of out-of-network contracts and waivers sought and granted by pediatric specialty, as listed in paragraph (4) of subsection a. of this section, and county to the Division of Medical Assistance and Health Services, who shall make that information publicly available by request.

[g.**]** h. For the purposes of this section:

"Medicaid" means the program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Network adequacy" means 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 and the Division of Medical Assistance and Health Services in the Department of Human Services.

"NJ FamilyCare" means the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

"Non-urban county" shall mean: 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.

"Urban county" shall mean: 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.

(cf: P.L.2021, c.276, s.1)

2. The Commissioner of Human Services shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program.

3. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to implement the provisions of this act.

4. This act shall 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 shall be necessary for the implementation of this act.

STATEMENT

This bill amends existing statutory law, which codifies and establishes certain network adequacy standards for pediatric primary and specialty care in the Medicaid program, to establish a minimum NJ FamilyCare reimbursement rate for certain out-of-state hospitals that provide services to NJ FamilyCare pediatric beneficiaries.

Specifically, under the bill, an out-of-state hospital, licensed under the laws and regulations of the state in which the hospital is located, that provides care to 10,000 or more unique NJ Family Care pediatric beneficiaries within its hospital system annually, is to receive a reimbursement rate under NJ FamilyCare that is at least 125 percent of the Medicaid fee-for-service reimbursement rate provided in the state where the hospital is licensed.