ASSEMBLY, No. 3574

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED FEBRUARY 8, 2024

Sponsored by:
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District 29 (Essex and Hudson)
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District 18 (Middlesex)
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District 15 (Hunterdon and Mercer)

SYNOPSIS
Establishes Medicaid Managed Care Organization Oversight Program.

CURRENT VERSION OF TEXT
As introduced.

(Sponsorship Updated As Of: 5/10/2024)

AN ACT concerning Medicaid and NJ FamilyCare and supplementing Title 30 of the Revised Statutes.

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

1. The Legislature finds and declares that:

a. In 2011, the administration of health care benefits for a majority of individuals who receive health care through the Medicaid and NJ FamilyCare programs was shifted from the Department of Human Services to managed care organizations (MCOs) contracted with the Department of Human Services.

b. The Department of Human Services currently contracts with five MCOs to provide quality health care and needed medical services to individuals who are eligible for publicly subsidized health insurance through the Medicaid and NJ FamilyCare programs.

c. The contracts to provide this care include multiple provisions to ensure that the care received is of high quality, providers of care are accessible throughout the State, and the MCOs are held accountable for meeting the terms of the contacts.

d. The Office of the State Auditor conducted an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Networks for the period July 1, 2013 to May 31, 2016 and determined that the MCOs did not provide adequate access to: general acute care hospital service networks; dental providers; and accurate online provider directories. Additionally, the MCOs were not adequately reporting providers' claims inactivity to the department and had provider panel sizes which exceeded the eligible limits.

e. The audit recommended that the department take certain actions to ensure that the MCOs are meeting the contractual obligations regarding access to care and network adequacy.

f. It is essential that the Legislature act to ensure that the department takes action to provide oversight of the MCOs to improve provision of care and network adequacy to Medicaid and NJ FamilyCare enrollees.

2. As used in this act:

"Beneficiary" means an individual who has been determined eligible by the State for health benefits in the Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) or the NJ FamilyCare program pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

"Health benefits plan" means a plan which pays or provides hospital and medical expense benefits for covered services as defined by the MCO contractor.

"MCO contractor" means an insurance company, health service corporation, hospital service corporation, or health maintenance

organization authorized to issue health benefits plans in this State which has entered into a contract with the Department of Human Services to provide health benefits for eligible persons under the Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) or the NJ FamilyCare program pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

"Provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the MCO contractor's health benefits plan.

3. The Division of Medical Assistance and Health Services in the Department of Human Services shall establish a Medicaid Managed Care Organization (MCO) Oversight Program to ensure the availability of accessible, quality, health care for individuals who are enrolled in the NJ FamilyCare and Medicaid programs.

The Medicaid MCO Oversight Program shall coordinate its efforts with the Medicaid Fraud Division, established by the "Medicaid Program Integrity and Protection Act," P.L.2007, c.58 (C.30:4D-53 et seq.).

4. a. Each MCO contractor shall submit updated provider data and beneficiary data on a quarterly basis to the Medicaid MCO Oversight Program in a format designated by the Medicaid MCO Oversight Program. The format in which the data is submitted to the Medicaid MCO Oversight Program shall be consistent for each MCO contractor. The data submitted shall include updated contact and location information for every provider and every beneficiary.

b. The Medicaid MCO Oversight Program shall share any updated beneficiary information with county welfare offices, or any other entity which is responsible for the enrollment or re-enrollment of beneficiaries in the Medicaid or NJ FamilyCare program, to ensure that these county welfare offices and other entities have the most current beneficiary contact information.

c. The Medicaid MCO Oversight Program shall establish an independent verification system to verify, on an annual basis, the accuracy of the information provided to the program from the MCO contractors, as follows:

(1) the Medicaid MCO Oversight Program shall verify, at a minimum, that 20 percent of the provider contact and location information provided pursuant to subsection a. of this section is accurate; and

(2) the Medicaid MCO Oversight Program shall verify, at a minimum, that 20 percent of the provider contact and location information included in the MCOs' online directories is accurate.

d. The Medicaid MCO Oversight Program shall require, on an annual basis, the MCO contractors verify that 100 percent of the providers listed in the MCOs' public directories are eligible Medicaid providers.

e. The Medicaid MCO Oversight Program shall require, on an annual basis, the MCO contractors to submit claims inactivity reports for all providers that meet the claims inactivity criteria established by the Medicaid MCO Oversight Program for that MCO contractor. The Medicaid MCO Oversight program shall require MCO contractors to establish inactivity criteria for each provider specialty.

f. The Medicaid MCO Oversight Program shall require, on an annual basis, the MCO contractors to verify that the participating providers' panel sizes do not exceed criteria established by the Medicaid MCO Oversight Program for that MCO contractor. The Medicaid MCO Oversight Program shall require panel size criteria for each provider specialty to include all patients of the provider, notwithstanding the patient's health insurance carrier.

5. a. The Medicaid MCO Oversight Program shall subject an MCO contractor who fails to submit information as required pursuant to section 4 of P.L. c. (C.) (pending before the Legislature as this bill) to a fine of no less than $50,000 for each failure to submit information. The commissioner shall promulgate a schedule of penalties to be applied pursuant to this section.

b. If, after notice and a hearing pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), an MCO contractor is found by the commissioner to have failed to pay the fine pursuant to subsection a. of this section, the commissioner may bar that MCO contractor from participating as an MCO contractor for a period not to exceed five years.

6. a. The Medicaid MCO Oversight Program shall prepare an annual report, which shall be submitted to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1) no later than April 1 of each calendar year. The report shall contain the information provided to the program by the MCO contractors pursuant to section 4 of P.L. c. (C.) (pending before the Legislature as this bill), and any fines imposed on, and fines collected from, the MCO contractors pursuant to section 5 of P.L. c. (C.) (pending before the Legislature as this bill).

b. Three years from the enactment of P.L. c. (C.) (pending before the Legislature as this bill), the Office of State Auditor shall conduct a follow-up audit on MCO provider networks.

7. 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 as the commissioner determines necessary to effectuate the purposes of this act.

8. This act shall take effect 180 days after the date of enactment, except the Commissioner of Human Services may take

any anticipatory administrative action in advance as shall be necessary for the implementation of this act.

STATEMENT

This bill would require the Division of Medical Assistance and Health Services in the Department of Human Services to establish a Medicaid Managed Care Organization (MCO) Oversight Program to ensure the availability of accessible health care for individuals who are enrolled in the NJ FamilyCare and Medicaid programs.

The Office of the State Auditor conducted an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Networks for the period July 1, 2013 to May 31, 2016. Information from the audit indicated that managed care organizations (MCOs) which are contracted with the State to provide health benefits to Medicaid and NJ FamilyCare beneficiaries did not provide adequate access to: general acute care hospital service networks; dental providers; and accurate online provider directories. Additionally, the MCOs were not adequately reporting claims inactivity for providers and had provider panel sizes which exceeded the eligible limits. Furthermore, the audit recommended that the department take certain actions to ensure that the MCOs are meeting the contractual obligations regarding access to quality care and provider availability.

This bill requires each MCO contractor to submit updated provider data and beneficiary data on a quarterly basis to the Medicaid MCO Oversight Program in a format designated by the Medicaid MCO Oversight Program. The submitted data will allow the Medicaid MCO Oversight Program to accurately determine if the MCOs are providing adequate network adequacy to the enrolled beneficiaries.

Additionally, the audit disclosed that the MCOs are collecting updated beneficiary information but there is no currently implemented mechanism to share this data with the department. Without updated beneficiary information, the department is not able to ensure network adequacy.

The updated beneficiary information collected by the MCOs could also streamline the work of entities, such as county welfare offices, which enroll individuals in Medicaid and NJ FamilyCare. To ensure the sharing of information, this bill requires the Medicaid MCO Oversight Program to share any updated beneficiary information with county welfare offices, or any other entity which is responsible for the enrollment or re-enrollment of beneficiaries in the Medicaid or NJ FamilyCare program.

The audit also determined that the information in the MCOs' on-line directories containing eligible providers, and these providers' locations, was not always accurate. Therefore, this bill requires the

1 Medicaid MCO Oversight Program to establish an independent
2 verification system to annually verify that at least 20 percent of the
3 information provided to the program from the MCO contractors is
4 accurate and that 100 percent of the providers listed are eligible
5 Medicaid providers.
6 The audit also revealed that there was a need for the MCOs to
7 identify inactive providers. To rectify this situation, the bill requires
8 the MCO contractors to submit claims inactivity reports for all
9 providers that meet the claims inactivity criteria established by the
10 Medicaid MCO Oversight Program for that MCO contractor.
11 Additionally, the audit disclosed that a small number of MCO
12 contractors were listing providers as “eligible” who had patient
13 panel sizes that exceeded acceptable numbers. This bill would
14 require MCO contractors to verify that all of the participating
15 providers’ panel sizes do not exceed criteria established by the
16 Medicaid MCO Oversight program for that MCO contractor. The
17 bill also requires the panel size criteria for each provider specialty
18 to include all patients of the provider, notwithstanding the patient’s
19 health insurance carrier.
20 It is unclear what sanctions are currently being brought against
21 MCO contractors that do not comply with the current contracts.
22 Consequences for not meeting the requirements of this bill will be a
23 minimum $50,000 fine for each failure to submit information as
24 required pursuant to the bill. If, after an administrative hearing, the
25 MCO fails to pay the fine, the MCO may be barred from contracting
26 with the department for five years.
27 Lastly, the bill requires an annual report containing the
28 information provided to the program from the MCOs no later than
29 90 days from the first day of the calendar year. To evaluate longer
30 term changes, the bill requires the Office of State Auditor to
31 conduct a follow up audit on MCO provider networks three years
32 after enactment.