30:4D-7ff & 30:4D-7gg
LEGISLATIVE HISTORY CHECKLIST
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LAWS OF: 2021 **CHAPTER:** 276

NJSA: 30:4D-7ff & 30:4D-7gg (Codifies and establishes certain network adequacy standards for pediatric primary and specialty care in Medicaid program.)

BILL NO: S3000 (Substituted for A4688 (3R))

SPONSOR(S) Weinberg, Loretta and others

DATE INTRODUCED: 10/8/2020

COMMITTEE: **ASSEMBLY:** Human Services
Appropriations
Budget

SENATE: Health, Human Services & Senior Citizens
Budget & Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 6/24/2021

SENATE: 6/30/2021

DATE OF APPROVAL: 11/8/2021

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Fourth Reprint enacted) Yes

S3000

INTRODUCED BILL (INCLUDES SPONSOR'S STATEMENT): Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes Human Services
Appropriations
Budget

SENATE: Yes Health, Human Serv. & Senior Citizens
Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes 3/10/2021
3/29/2021
6/29/2021

A4688 (3R)

INTRODUCED BILL (INCLUDES SPONSOR'S STATEMENT): Yes

COMMITTEE STATEMENT:	**ASSEMBLY:**	Yes	Human Services Appropriations Budget
	SENATE:	No	

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT:	No	
LEGISLATIVE FISCAL ESTIMATE:	Yes	6/21/2021 6/29/2021
VETO MESSAGE:	No	
GOVERNOR'S PRESS RELEASE ON SIGNING:		Yes

FOLLOWING WERE PRINTED:

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REPORTS:	No
HEARINGS:	No
NEWSPAPER ARTICLES:	No

RWH/JA.

§§1,2
C.30:4D-7ff and
30:4D-7gg
§3
Notes

P.L. 2021, CHAPTER 276, ***approved November 8, 2021***
Senate, No. 3000 ***(Fourth Reprint)***

AN ACT concerning network adequacy of pediatric providers in the Medicaid program and supplementing [3]**[**P.L.1997, c.192 (C.26:2S-1 et al.)**]** Title 30 of the Revised Statutes[3].

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

1. a. [3]**[**Pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), the commissioner shall only approve the network adequacy of a managed care plan provided by a managed care organization contracted with**]** At the next regular opportunity,[3] the Division of Medical Assistance and Health Services in the Department of Human Services [3]**[**to provide benefits under Medicaid if the plan has**]** shall amend the Medicaid managed care organization contract provisions on network adequacy to require[3]:

(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;

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 thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SHH committee amendments adopted January 14, 2021.
[2]Senate SBA committee amendments adopted March 22, 2021.
[3]Assembly AAP committee amendments adopted June 16, 2021.
[4]Assembly ABU committee amendments adopted June 21, 2021.

(3) a sufficient number of pediatric oncologists and developmental and behavioral pediatricians [3]and psychiatrists[3] 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; [2]psychiatry,[2] 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; [1]**[**orthopaedics**]** orthopedics[1]; otolaryngology; plastic surgery; pulmonary medicine, including sleep medicine; radiology; rehabilitative medicine; and rheumatology.

b. [4]**[**[3]**[**A managed care organization that violates any provision of this act shall be liable for penalties described under section 16 of [1]**[**P.L.2018, c. 32**]** P.L.1997, c.192[1] (C.26:2S-16)**]** No out-of-state pediatric specialty hospital shall be denied the right to participate in a managed care organization network under the same terms and conditions currently applicable to all other contracting providers, provided the pediatric specialty hospital is willing to accept 125 percent of its home state Medicaid fee-for-service rate and accepts the terms and conditions of the contract. Nothing in this section shall preclude any provider from negotiating a higher or lower rate for any service or set of services[3].

c. [3]No out-of-state or in-state pediatric specialty provider shall be denied the right to participate in a managed care organization network under the same terms and conditions currently applicable to all other contracting providers, provided the out-of-state or in-state pediatric specialty provider is willing to accept 100 percent of the State Medicaid fee-for-service rate and accepts the terms and conditions of the contract. Nothing in this section shall preclude any provider from negotiating a higher or lower rate for any service or set of services.

d.**]**[4] 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.

⁴[e.] c.⁴ 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.

⁴[f.] d.⁴ In order to provide timely services to patients, when a managed care organization is notified ⁴[by a provider of their willingness to participate under the provisions of subsections b. and c.] 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.⁴ of this section, the managed care organization shall initiate ⁴[contracting] negotiations with non-participating providers of that service,⁴ and ⁴shall⁴ 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. ⁴The Commissioner of Human Services may promulgate rules or regulations to resolve in a timely manner contracting disputes that arise under this subsection.⁴

⁴[g.] e.⁴ 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.

⁴[h.] f.⁴ 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.

⁴[i.] g.⁴ ³ 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 [1]of[1] 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.

"Non-urban county" shall mean: [1][Hunterdon, Morris, Somerset, Sussex, Warren,][1] Atlantic, Cape May, Cumberland, Gloucester, [1][and] Hunterdon, Morris,[1] Salem [1], Somerset, Sussex, and Warren[1] counties [3], or as otherwise defined for the purposes of this section by the Commissioner of Human Services[3].

"Urban county" shall mean: Bergen, [1][Hudson, and Passaic, Essex, Union, Middlesex, Mercer,][1] Burlington, Camden, [1][Monmouth and Ocean] Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union[1] counties [3], or as otherwise defined for the purposes of this section by the Commissioner of Human Services[3] [1].[1]

2. The [3][Commissioner of Banking and Insurance, in conjunction with the][3] Commissioner of Human Services [3][,][3] shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) [1],[1] to effectuate the purposes of this act.

3. This act shall take effect on the first day of the third month following enactment, except that the [3][Commissioner of Banking and Insurance, in conjunction with the][3] Commissioner of Human Services [3][,][3] may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

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

SENATE, No. 3000

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED OCTOBER 8, 2020

Sponsored by:
Senator LORETTA WEINBERG
District 37 (Bergen)

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning network adequacy of pediatric providers in the Medicaid program and supplementing P.L.1997, c.192 (C.26:2S-1 et al.).

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

1. a. Pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), the commissioner shall only approve the network adequacy of a managed care plan provided by a managed care organization contracted with the Division of Medical Assistance and Health Services in the Department of Human Services to provide benefits under Medicaid if the plan has:

(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 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 pediatrics – dermatology; hematology; human genetics and metabolism; infectious disease; neonatology; nephrology; neurology; oncology; ophthalmology; orthopaedics; otolaryngology; plastic surgery;

pulmonary medicine, including sleep medicine; radiology; rehabilitative medicine; and rheumatology.

b. A managed care organization that violates any provision of this act shall be liable for penalties described under section 16 of P.L.2018, c. 32 (C. 26:2S-16).

c. 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 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.

“Non-urban county” shall mean: Hunterdon, Morris, Somerset, Sussex, Warren, Atlantic, Cape May, Cumberland, Gloucester, and Salem counties.

“Urban county” shall mean: Bergen, Hudson, and Passaic, Essex, Union, Middlesex, Mercer, Burlington, Camden, Monmouth and Ocean counties

2. The Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act.

3. This act shall take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with 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 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. It is the sponsor's intent that this bill will improve the access to care for children within the Medicaid program.

Under the bill, the Commissioner of Banking and Insurance, pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), is required to only approve the network adequacy of a managed care plan provided by a MCO contracted with the DMAHS to provide benefits under Medicaid 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 pediatrics – dermatology; hematology; human genetics and metabolism; infectious disease; neonatology; nephrology; neurology; oncology; ophthalmology; orthopaedics; otolaryngology; plastic surgery; pulmonary medicine, including sleep medicine; radiology; rehabilitative medicine; and rheumatology.

Under the bill, "urban county" means: Bergen, Hudson, and Passaic, Essex, Union, Middlesex, Mercer, Burlington, Camden, Monmouth and Ocean counties. "Non-urban county" means: Hunterdon, Morris, Somerset, Sussex, Warren, Atlantic, Cape May, Cumberland, Gloucester, and Salem counties. These definitions reflect the definitions in the existing MCO contract.

Any MCO that violates any provision of the bill is liable for penalties described under section 16 of P.L.2018, c. 32 (C.26:2S-16). These penalties 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 if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the MCO has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. 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.

The bill is to take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the bill.

ASSEMBLY HUMAN SERVICES COMMITTEE

STATEMENT TO

[Second Reprint]
SENATE, No. 3000

STATE OF NEW JERSEY

DATED: JUNE 14, 2021

The Assembly Human Services Committee reports favorably Senate Bill No. 3000 (2R).

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 Commissioner of Banking and Insurance, pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), is required to only approve the network adequacy of a managed care plan provided by a MCO contracted with the DMAHS to provide benefits under Medicaid 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; 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 "urban county" means: Bergen, Burlington, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union counties. "Non-urban county" means: Atlantic, Cape May, Cumberland, Gloucester, Hunterdon, Morris, Salem, Somerset, Sussex, and Warren counties. These definitions reflect the definitions in the existing MCO contract.

Any MCO that violates any provision of the bill is liable for penalties described under section 16 of P.L.1997, c.192 (C.26:2S-16). These penalties 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 if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the MCO has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. 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.

The bill is to take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the bill.

As reported by the committee, Senate Bill No. 3000 (2R) is identical to Assembly Bill No. 4688 which was reported by the committee on this date.

ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

[Third Reprint]

SENATE, No. 3000

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 22, 2021

The Assembly Budget Committee reports favorably Senate Bill No. 3000 (3R), 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, Senate Bill No. 3000 (4R) is identical to Assembly Bill No. 4688 (3R) 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.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 3000

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 14, 2021

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 3000.

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 Commissioner of Banking and Insurance, pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), is required to only approve the network adequacy of a managed care plan provided

by a MCO contracted with the DMAHS to provide benefits under Medicaid 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 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.

As amended by the bill, "urban county" means: Bergen, Burlington, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union counties. "Non-urban county" means: Atlantic, Cape May, Cumberland, Gloucester, Hunterdon, Morris, Salem, Somerset, Sussex, and Warren counties. These definitions reflect the definitions in the existing MCO contract.

Any MCO that violates any provision of the bill is liable for penalties described under section 16 of P.L.1997, c.192 (C.26:2S-16). These penalties 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 if reasonable notice in writing is given of the intent to levy the

penalty and, at the discretion of the commissioner, the MCO has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. 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.

The bill is to take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the bill.

COMMITTEE AMENDMENTS

The committee amended the bill to correct a statutory citation and to make other grammatical and syntax changes.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 3000

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 22, 2021

The Senate Budget and Appropriations Committee reports favorably and with committee amendments Senate Bill No. 3000 (1R).

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 Commissioner of Banking and Insurance, pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), is required to only approve the network adequacy of a managed care plan provided by a MCO contracted with the DMAHS to provide benefits under Medicaid 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; 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.

As amended by the bill, "urban county" means: Bergen, Burlington, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union counties. "Non-urban county" means: Atlantic, Cape May, Cumberland, Gloucester, Hunterdon, Morris, Salem, Somerset, Sussex, and Warren counties. These definitions reflect the definitions in the existing MCO contract.

Any MCO that violates any provision of the bill is liable for penalties described under section 16 of P.L.1997, c.192 (C.26:2S-16). These penalties 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 if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the MCO has 30 days, or such additional time as the commissioner shall determine to

be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. 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.

The bill is to take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the bill.

COMMITTEE AMENDMENTS

The committee amended the bill to add psychiatry to the list of pediatric medical specialties that are required to be represented within the plan's network under the Medicaid program.

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 Division of Medical Assistance and Health Services to the Medicaid managed care organizations. 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.

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.).

LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

SENATE, No. 3000

STATE OF NEW JERSEY
219th LEGISLATURE

DATED: MARCH 29, 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; 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.

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.).

LEGISLATIVE FISCAL ESTIMATE

[Fourth Reprint]

SENATE, No. 3000

STATE OF NEW JERSEY
219th LEGISLATURE

DATED: JUNE 29, 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. The OLS notes, however, if MCOs are granted waivers of any network adequacy provision, as authorized under the bill, the fiscal impact of enhancing such network adequacy standards will be adjusted.

- The OLS also estimates that the DMAHS may incur certain indeterminate expenses to establish a waiver process and a system to assess MCO compliance with the network adequacy standards outlined in the Medicaid contract. To the extent that these provisions overlap with the division's current efforts, such costs may be minimized.

- 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 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) and 3) above 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. 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.

Finally, the 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.

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 OLS notes, however, if MCOs are granted waivers of any network adequacy provision, as authorized under the bill, the impact of enhancing such network adequacy standards will be adjusted.

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.

The OLS also estimates that the DMAHS may incur certain indeterminate expenses to establish a waiver process and a system to assess MCO compliance with the network adequacy standards outlined in the Medicaid contract. To the extent that these provisions overlap with the division's current efforts, such costs may be minimized.

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 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.).

ASSEMBLY, No. 4688

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2020

Sponsored by:
Assemblyman DANIEL R. BENSON
District 14 (Mercer and Middlesex)
Assemblyman ANTHONY S. VERRELLI
District 15 (Hunterdon and Mercer)
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)

Co-Sponsored by:
Assemblyman Johnson, Assemblywomen Reynolds-Jackson, Dunn and Lampitt

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 6/1/2021)

AN ACT concerning network adequacy of pediatric providers in the Medicaid program and supplementing P.L.1997, c.192 (C.26:2S-1 et al.).

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

1. a. Pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), the commissioner shall only approve the network adequacy of a managed care plan provided by a managed care organization contracted with the Division of Medical Assistance and Health Services in the Department of Human Services to provide benefits under Medicaid if the plan has:

(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 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 pediatrics – dermatology; hematology; human genetics and metabolism; infectious disease; neonatology; nephrology; neurology; oncology; ophthalmology; orthopaedics; otolaryngology; plastic surgery;

pulmonary medicine, including sleep medicine; radiology; rehabilitative medicine; and rheumatology.

b. A managed care organization that violates any provision of this act shall be liable for penalties described under section 16 of P.L.2018, c. 32 (C. 26:2S-16).

c. 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 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.

“Non-urban county” shall mean: Hunterdon, Morris, Somerset, Sussex, Warren, Atlantic, Cape May, Cumberland, Gloucester, and Salem counties.

“Urban county” shall mean: Bergen, Hudson, and Passaic, Essex, Union, Middlesex, Mercer, Burlington, Camden, Monmouth and Ocean counties

2. The Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act.

3. This act shall take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with 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 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. It is the sponsor's intent that this bill will improve the access to care for children within the Medicaid program.

Under the bill, the Commissioner of Banking and Insurance, pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), is required to only approve the network adequacy of a managed care plan provided by a MCO contracted with the DMAHS to provide benefits under Medicaid 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 pediatrics – dermatology; hematology; human genetics and metabolism; infectious disease; neonatology; nephrology; neurology; oncology; ophthalmology; orthopaedics; otolaryngology; plastic surgery; pulmonary medicine, including sleep medicine; radiology; rehabilitative medicine; and rheumatology.

Under the bill, "urban county" means: Bergen, Hudson, and Passaic, Essex, Union, Middlesex, Mercer, Burlington, Camden, Monmouth and Ocean counties. "Non-urban county" means: Hunterdon, Morris, Somerset, Sussex, Warren, Atlantic, Cape May, Cumberland, Gloucester, and Salem counties. These definitions reflect the definitions in the existing MCO contract.

Any MCO that violates any provision of the bill is liable for penalties described under section 16 of P.L.2018, c. 32 (C.26:2S-16). These penalties 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 if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the MCO has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. 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.

The bill is to take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with the Commissioner of Human Services, may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the bill.

ASSEMBLY HUMAN SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 4688

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 14, 2021

The Assembly Human Services Committee reports favorably and with committee amendments Assembly Bill No. 4688.

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 Commissioner of Banking and Insurance, pursuant to section 19 of P.L.1997, c.192 (C.26:2S-18), is required to only approve the network adequacy of a managed care plan provided by a MCO contracted with the DMAHS to provide benefits under Medicaid 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; 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.

As amended by the bill, "urban county" means: Bergen, Burlington, Camden, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union counties. "Non-urban county" means: Atlantic, Cape May, Cumberland, Gloucester, Hunterdon, Morris, Salem, Somerset, Sussex, and Warren counties. These definitions reflect the definitions in the existing MCO contract.

Any MCO that violates any provision of the bill is liable for penalties described under section 16 of P.L.1997, c.192 (C.26:2S-16). These penalties 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 if reasonable notice in writing is given of the intent to levy the penalty and, at the discretion of the commissioner, the MCO has 30 days, or such additional time as the commissioner shall determine to be reasonable, to remedy the condition which gave rise to the violation, and fails to do so within the time allowed. 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.

The bill is to take effect on the first day of the third month following enactment, except that the Commissioner of Banking and Insurance, in conjunction with 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 is identical to Senate Bill No. 3000 (2R) which was also reported by the committee on this date.

COMMITTEE AMENDMENTS

The committee amended the bill to add psychiatry to the list of pediatric medical specialties that are required to be represented within the plan's network under the Medicaid program.

The committee amended the bill to correct a statutory citation and to make other grammatical and syntax changes.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 4688

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 16, 2021

The Assembly Appropriations Committee reports favorably Assembly Bill No. 4688.

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.

The amended bill stipulates that no out-of-state pediatric specialty hospital shall be denied the right to participate in a MCO network under the same terms and conditions currently applicable to all other contracting providers, provided the pediatric specialty hospital is willing to accept 125 percent of its home state Medicaid fee-for-service rate and accepts the terms and conditions of the contract. The bill also stipulates that no out-of-state or in-state pediatric specialty provider shall be denied the right to participate in a managed care organization network under the same terms and conditions currently applicable to all other contracting providers, provided the out-of-state or in-state pediatric specialty provider is willing to accept 100 percent of the State Medicaid fee-for-service rate and accepts the terms and conditions of the contract. Further, nothing in the bill is to preclude any provider from negotiating a higher or lower rate for any service or set of services.

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 by a provider of their willingness to participate in subsections b. and c. of section 1 of the bill, the MCO is to initiate contracting 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.

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 (2R) is identical to Senate Bill No. 3000 (3R), which was also reported by the committee on this date.

COMMITTEE AMENDMENTS

The committee amended the bill to:

- remove all regulatory and administrative jurisdiction over the bill from the Commissioner of Banking and Insurance and instead provide the Commissioner of Human Services with that authority;
- replace the requirement that the Commissioner of Banking and Insurance only approve the network adequacy of a MCO if it meets the standards set forth in the bill with a requirement that the DMAHS amend the Medicaid MCO contract regarding the provisions on network adequacy established under the bill;
- provide that an MCO provides for a sufficient number of pediatric 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;
- remove a provision that would make a MCO liable for penalties described under current law for violations of the bill. These penalties 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 and authorize the Commissioner of Banking and Insurance to 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. The amended bill adds language which requires the DMAHS to establish an enhanced system to assess the network adequacy of an MCO, 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 also authorized 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;
- provide 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. Further, nothing in the bill is to preclude any provider from negotiating a higher or lower rate for any service or set of services;

- allows a MCO, in each reporting period, to seek a waiver of a specific network adequacy provision established under the bill from the division;
- requires the division 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;
- require the division to direct each MCO to establish a process by which a patient or provider may submit a grievance regarding its provider network;
- , require the MCO, in order to provide timely services to patients, when an MCO is notified by a provider of their willingness to participate under the provisions of the bill, to initiate contracting 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 are to be limited to the maximum amount allowed under State law for the Medicaid program;
- direct an 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 division, which is required to make that information publicly available by request; and
- allows the Commissioner of Human Services to define "urban county" and "non-urban county" outside of the parameters of that defined in the bill.

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.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY, No. 4688

STATE OF NEW JERSEY
219th LEGISLATURE

DATED: JUNE 21, 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; 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.

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 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.).

LEGISLATIVE FISCAL ESTIMATE

[Third Reprint]

ASSEMBLY, No. 4688

STATE OF NEW JERSEY
219th LEGISLATURE

DATED: JUNE 29, 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. The OLS notes, however, if MCOs are granted waivers of any network adequacy provision, as authorized under the bill, the fiscal impact of enhancing such network adequacy standards will be adjusted.

- The OLS also estimates that the DMAHS may incur certain indeterminate expenses to establish a waiver process and a system to assess MCO compliance with the network adequacy standards outlined in the Medicaid contract. To the extent that these provisions overlap with the division's current efforts, such costs may be minimized.

- 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 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) and 3) above 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. 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.

Finally, the 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.

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 OLS notes, however, if MCOs are granted waivers of any network adequacy provision, as authorized under the bill, the impact of enhancing such network adequacy standards will be adjusted.

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.

The OLS also estimates that the DMAHS may incur certain indeterminate expenses to establish a waiver process and a system to assess MCO compliance with the network adequacy standards outlined in the Medicaid contract. To the extent that these provisions overlap with the division's current efforts, such costs may be minimized.

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 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.).

Governor Murphy Takes Action on Legislation

11/8/2021

TRENTON – Today, Governor Murphy signed the following bills into law:

S-249/A-1259 (Singleton, Turner/Schaer, DeCroce, Vainieri Huttle) – Requires pharmacy benefits manager providing services within Medicaid program to disclose certain information to DHS

S-324/A-3533 (Diegnan, A.M. Bucco/Benson, Freiman, DeCroce) – Authorizes operators of motor vehicles to display electronic proof of registration; requires MVC to send application for registration renewal to lessee of leased vehicle

SCS for S-399 and 1645/ACS for A-869 and 1380 (Lagana, Weinberg, Stack, Turner, Cunningham/Chiaravalloti, Holley) – Requires residential landlords to install covers on steam radiators upon request of tenant

S-537/A-3110 (Codey/McKeon, Verrelli, Vainieri Huttle) – Establishes certain minimum and maximum temperatures in rooming and boarding houses, dementia care homes, and certain nursing homes and residential health care facilities

S-550/A-1616 (Codey, Pennacchio/Lampitt, Conaway, Vainieri Huttle) – Requires certain student identification cards to contain telephone number for suicide prevention hotline

SCS for S-647/A-4825 (Greenstein, Singleton/McKeon, Karabinchak, Stanley) – Revises cybersecurity, asset management, and related reporting requirements in "Water Quality Accountability Act"

S-828/A-2101 (Lagana, Greenstein/Swain, Tully, Verrelli) – Requires public utilities and local units to provide notice prior to initiating certain infrastructure projects

S-829/A-2135 (Lagana, Singleton/Tully, Swain, Murphy) – Requires property condition disclosure statement to indicate presence of lead plumbing in residential property

S-830/A-2134 (Lagana, Greenstein/Tully, Swain, Conaway) – Requires public water systems to offer drinking water tests to customers in certain circumstances

S-894/A-3874 (Pou, Greenstein/Lopez, Vainieri Huttle) – Prohibits sale of paint or coating removal products that contain methylene chloride unless purchaser meets certain safety standards for use

S-1010/A-2103 (Lagana, Turner/Swain, Tully, Johnson) – Permits counties and municipalities to bond for alternative fuel vehicles

S-1047/A-1712 (Cryan, Pou/Burzichelli, Karabinchak, Giblin) – Concerns disclosure of certain information prior to sale of real estate

S-1148/A-1221 (Ruiz, Pou/Chaparro, Speight, Wimberly) – Requires emergency contact information and access instructions for social services hotline to be provided to tenants of multiple dwellings

S-1239/A-5131 (Codey/McKeon, Danielsen, Jasey) – Authorizes imposition of fee for connection to municipal electric distribution system

S-1259/A-2628 (Singleton/Murphy) – Concerns labor contractors

S-1726/A-795 (Lagana, Pou/Verrelli, Swain, Zwicker) – Prohibits sale of cosmetic products that have been tested on animals

S-2727/A-4775 (Pennacchio, Pou/Vainieri Huttle, Jasey, McKnight) – Establishes Multigenerational Family Housing Continuity Commission; provides municipal guidance to periodically analyze local advancement of commission's senior citizen housing recommendations

S-2861/A-5390 (Singleton, Addiego/Quijano, McKnight, Speight) – Concerns certain restrictive covenants on real property

S-2996/A-5019 (Testa, Sweeney/McClellan, Taliaferro, Johnson) – Allows Board of Cosmetology and Hairstyling licensees to operate mobile facilities when providing services

S-3000/A-4688 (Weinberg, Greenstein/Benson, Verrelli, Vainieri Huttle) – Codifies and establishes certain network adequacy standards for pediatric primary and specialty care in Medicaid program

S-3032/A-4855 (Sweeney, Vitale/Benson, Vainieri Huttle, Chiaravalloti) – Requires DOH to develop Statewide plan for infection control and prevention infrastructure improvements in nursing homes

S-3091/A-4933 (Addiego, Bateman/Burzichelli, Benson, Mukherji) – Requires builders to offer unit concrete products that utilize carbon footprint-reducing technology as option in new construction; establishes tax incentives, and State and local purchasing requirements, for unit concrete products that utilize carbon footprint-reducing technology

S-3253/A-2619 (Singleton, Ruiz/Murphy, Speight, Mukherji) – Establishes alternate route to expedite certification of teachers at early college high school programs

S-3318/A-5893 (Sweeney, Pou/Vainieri Huttle, Caputo, Karabinchak) – Provides for voluntary contributions by taxpayers on gross income tax returns for Special Olympics New Jersey

S-3590/A-5536 (Diegnan, Turner/Burzichelli, Giblin) – Allows formation of limited liability companies by real estate salespersons and broker-salespersons to receive commission income and requires certain disclosures on promotions

S-3811/A-5769 (Sweeney, Scutari/Reynolds-Jackson, Quijano, Carter) – Establishes Kean University as public urban research university

S-3948/A-5896 (Addiego, Gopal/Houghtaling, Downey) – Authorizes supplemental State aid to school districts receiving certain federal Impact Aid; makes appropriation

SJR-41/AJR-33 (Cruz-Perez, Addiego/Lopez, McKnight) – Designates June 2 of each year as "Gun Violence Awareness Day"

SJR-109/AJR-208 (Weinberg, Pou/McKnight, Benson, Vainieri Huttle) – Condemns hate and violent extremism and commits to defense of safe and just democracy

A-637/S-2670 (Caputo, Dancer, Houghtaling/Beach) – Revises permit and license processes for sports pools operators and online sports pool operators; revises definitions of certain sports events; allows for transactional waiver for sports wagering lounge

A-853/S-797 (Chiaravalloti, Karabinchak, McKnight/Cunningham, Doherty) – Prohibits municipal licensure of children operating temporary businesses

A-2311/S-356 (Calabrese, Jasey/Cryan, Codey) – Establishes study commission to examine development of mutually beneficial relationships between institutions of higher education and municipalities

A-3027/S-793 (Lampitt, Jasey, Houghtaling/Cunningham, Singleton) – Commits $3 million from Supplemental Workforce Fund for Basic Skill to NJ Community College Consortium for Workforce and Economic Development

ACS for A-3352/S-3504 (Kennedy, Stanley, Calabrese/Smith) – Requires certain newly constructed warehouses to be solar-ready buildings

A-3897/S-3263 (Armato, Mazzeo, DiMaso/Beach, Gopal) – Increases fee for New Jersey Waterfowl Stamps

A-4138/S-2701 (Vainieri Huttle, Benson, Giblin/Gopal, Codey) – Requires Department of Human Services to develop public emergency response plan for licensed providers of services to individuals with developmental disabilities

A-4367/S-2794 (Mukherji, Sumter, Taliaferro/Pou, Scutari) – Provides that AOC shall administer program for municipal courts allowing defendants to engage in online plea negotiations, entry of guilty plea, and payment of fine or penalty

A-4484/S-3153 (McKnight, Kennedy, Mukherji, Gove/Pou, Vitale) – Requires State Long-Term Care Ombudsman to establish long-term care advocacy and educational training program

A-4538/S-3131 (Lampitt, Quijano/Pou, A.M. Bucco) – Requires dental insurers to provide credits for reduced usage during coronavirus disease 2019 pandemic

A-4544/S-3150 (Caputo, Jasey, Murphy/Pou, Codey) – Permits school nurse who is retired from TPAF to return to employment for up to two years without reenrollment in TPAF

A-4633/S-2856 (Giblin, DeCroce/Pou) – Permits certain nonresident Certified Public Accountants to provide attest services

A-4831/S-3953 (Chaparro, Kennedy, Murphy/Scutari) – Clarifies classification in this State of criminal offenses committed in other states or under federal law

A-4836/S-3313 (Giblin, Benson, Downey/Pou, Turner) – Establishes task force to evaluate quality, efficacy, costs, and educational outcomes of online courses offered by public and independent institutions of higher education and degree-granting proprietary institutions during COVID-19 pandemic

A-4861/S-3041 (Vainieri Huttle, Armato, Verrelli/Vitale, Gopal) – Requires DOH to publish total number of COVID-19 deaths and cases in long-term care facilities

A-4869/S-2414 (Wirths, Verrelli, Space/Singleton, Madden) – Requires certain bidders for prevailing wage public work to provide proof that prevailing wage will be paid

A-5059/S-3031 (Conaway, Vainieri Huttle, Benson/Sweeney, Vitale) – Requires DOH to establish certain nursing education and professional advancement programs

A-5212/S-3638 (Conaway, Verrelli, Karabinchak/Turner, Diegnan) – Permits dentists to administer vaccines under certain circumstances

A-5751/S-3823 (Swain, Timberlake, Carter, Johnson/Weinberg, Gopal) – Expands State corrections officers training to include topics contributing to their core mission of treating inmates with dignity, fairness, and respect

A-5817/S-3852 (Tully, Swain, Benson/Lagana, Diegnan) – Revises violation and fines for approving or assigning unauthorized individuals as school bus drivers

A-5818/S-3849 (Tully, Swain, Benson/Lagana, Diegnan) – Provides for debarment of school bus contractors for certain violations; requires certain information in pupil transportation contract bid

AJR-204/SJR-105 (Jasey, Benson, Reynolds-Jackson/Cunningham, T. Kean) – Designates April of each year as “Educational Opportunity Fund (EOF) Month” in New Jersey

AJR-238/SJR-123 (Burzichelli/Sweeney, Singleton) – Urges U.S. President and EPA to take appropriate action, through waivers and other reforms, to allow blending of renewable fuels under the federal “Clean Air Act”

Governor Murphy conditionally vetoed the following bills:

S-108/A-169 (Gill, Turner/Caputo, Wirths) – **CONDITIONAL -** Concerns speech rights of student journalists at public schools and public institutions of higher education

Copy of Statement

S-2078/A-5008 (Weinberg, Addiego/Lampitt, Benson, Vainieri Huttle) – **CONDITIONAL -** Establishes "Stillbirth Resource Center" and regional Fetal and Infant Mortality Review Committee, and programs for the prevention and reduction of incidences of stillbirth; expands list of professionals authorized to provide stillbirth-related care

Copy of Statement

S-2160/A-5701 (Sweeney, Oroho, Singer/Carter, Lampitt, Jasey) – **CONDITIONAL -** Creates special education unit within the Office of Administrative Law; requires annual report

Copy of Statement

S-2525/A-4274 (Rice, Singleton, Turner/Conaway, Sumter, Stanley) – **CONDITIONAL -** Expands powers and duties of State Chief Diversity Officer to promote diversity in State government and public contracting

Copy of Statement

S-2559/ACS for A-4179 and 4200 (Gopal, Gill/Downey, Conaway, Benson, Houghtaling, Karabinchak) – **CONDITIONAL -** Revises requirements for health insurance providers and Medicaid to cover services provided using telemedicine and telehealth; appropriates $5 million

Copy of Statement

S-2834/A-5312 (Ruiz, Cunningham/Quijano, Lampitt, McKnight) – **CONDITIONAL -** Mandates training on culturally responsive teaching for all candidates for teaching certification

Copy of Statement

S-2953/A-4785 (Sweeney, Cunningham/Quijano, Verrelli, Mukherji) – **CONDITIONAL -** Expands scope of inmate reentry assistance and benefits

Copy of Statement

S-3238/A-5213 (Ruiz, Pou/Verrelli, McKnight, McKeon) – **CONDITIONAL -** Establishes New Jersey Easy Enrollment Health Insurance Program

Copy of Statement

S-3488/A-5537 (Sweeney, Gopal, O'Scanlon/Burzichelli, Dancer, Spearman) – **CONDITIONAL -** Modifies certain procedures pertaining to school district regionalization; establishes grant program for cost reimbursement of conducting regionalization feasibility studies; and provides financial incentives for regionalization

Copy of Statement

S-3867/A-5868 (Addiego, Singleton/Benson, Verrelli, Vainieri Huttle) – **CONDITIONAL -** Establishes Opioid Recovery and Remediation Fund and Opioid Recovery and Remediation Fund Advisory Council; provides for funds received from opioid settlements to support substance use disorder prevention and treatment programs

Copy of Statement

S-3955/A-5905 (Ruiz/Timberlake, Speight, Spearman) – **CONDITIONAL -** Establishes "Rental Assistance Navigation Program" in DCA; makes appropriation

Copy of Statement

A-1533/S-3321 (Spearman, Reynolds-Jackson, Schaer/Stack, Turner) – **CONDITIONAL -** Requires reservation of portion of tenant-based vouchers under State rental assistance program for persons displaced due to redevelopment of an affordable housing development; provides displaced persons with affordable housing priority status

Copy of Statement

A-2455/S-2204 (Benson, Vainieri Huttle, DeAngelo/Greenstein, Oroho) – **CONDITIONAL -** Establishes pilot program in DOE to support FIRST Robotics Programs in school districts

Copy of Statement

A-3062/S-1196 (Pintor Marin, Moen, Reynolds-Jackson/Pou, Cruz-Perez) – **CONDITIONAL -** Establishes three year Financial Empowerment Pilot Program

Copy of Statement

A-4002/S-2257 (Caputo, Dancer, Murphy/Gopal, Sarlo) – **CONDITIONAL -** Allows deduction of promotional gaming credit from gross revenue on sports wagering

Copy of Statement

A-4433/S-2715 (Greenwald, Mukherji, Lampitt/Beach, Corrado) – CONDITIONAL - Creates grant program to encourage school districts to partner with institutions of higher education in training school-based mental health services providers

Copy of Statement

A-4435/S-2717 (Verrelli, Greenwald, Speight, Lampitt/Beach, Corrado) – **CONDITIONAL -** Requires DCF to give priority to certain school districts with student mental health counseling centers in awarding grants under School Based Youth Services Program

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A-4630/S-577 (Burzichelli/Madden, Singleton) – CONDITIONAL - Concerns labor harmony agreements in retail and distribution center projects

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A-4746/S-3947 (Mosquera, Lopez, Chaparro, Dunn/Vitale, Turner) – **CONDITIONAL -** Requires that certain provider subsidy payments for child care services be based on enrollment

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A-4834/S-3474 (Mazzeo, Quijano, Downey/Pou, Turner) – **CONDITIONAL -** Requires disclosure letter be included with mail falsely implying State government connection

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A-4850/S-3095 (Karabinchak, Freiman, Calabrese, Greenwald/Diegnan) – **CONDITIONAL -** Establishes expedited construction inspection program

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A-5033/S-3279 (Benson, Dancer, Verrelli/Gopal) – **CONDITIONAL -** Authorizes motor vehicle dealers to sell motor vehicles online and obtain electronic signatures for motor vehicle transactions

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A-5353/S-3421 (Conaway, Vainieri Huttle, Benson/Madden, Turner) – CONDITIONAL - Provides for certification of temporary nurse aides

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A-5599/S-3916 (Chiaravalloti, Vainieri Huttle, McKnight/Scutari, Gill) – **CONDITIONAL -** Establishes order of protection for current or former judge; upgrades and clarifies harassment against current or former judge; bars firearms possession by persons against whom current or former judge order of protection is entered

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A-5864/S-3939 (Speight, Pintor Marin, Chaparro, McKnight, DeAngelo, Bergen/Gopal, Cryan) – CONDITIONAL - Allows law enforcement officers to review body worn camera recordings prior to creating initial report

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Governor Murphy absolute vetoed the following bills:

S-415/A-4685 (Turner/Quijano, Verrelli) – **ABSOLUTE -** Requires reentry assistance to be provided to certain inmates who have served their maximum sentence

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S-969/ACS for A-2687 (Ruiz, Turner/Mazzeo, Lampitt, Moen) – **CONDITIONAL -** Establishes loan redemption program for teachers in certain fields to redeem loan amounts received under New Jersey College Loans to Assist State Students Loan Program through employment in certain low performing schools

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S-2261/A-4265 (Singleton/Conaway) – **ABSOLUTE -** Revises law relating to common interest communities

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S-2347/A-4030 (Sweeney, Greenstein, T. Kean/Mukherji, Benson, Murphy) – **ABSOLUTE -** Establishes Employment and Business-Related Tax Deferral Assistance Program in EDA to allow small businesses to defer the payment and remittance of certain employment and business-related taxes during COVID-19 public health emergency

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S-3093/A-4910 (Gopal, Sweeney, Singleton/Burzichelli, Johnson, Danielsen) – **ABSOLUTE -** Establishes county-based mitigation plan to allow businesses to operate during pandemic

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S-3505/A-5371 (Scutari, Weinberg/Mukherji, Johnson, Quijano) – **ABSOLUTE -** Requires assignment of unemployment claims handlers to legislative districts and partisan offices during COVID-19 pandemic state of emergency; appropriates $1.8 million

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S-3868/A-5895 (Sarlo/Giblin) – ABSOLUTE - Concerns construction code enforcing agency fee revenue

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A-2722/S-1862 (Mukherji/Gopal, Oroho) – **ABSOLUTE -** Requires Commissioner of Corrections to institute 30-minute shift overlap in State correctional facilities

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A-4297/S-2631 (Houghtaling, Downey, Space/Gopal, Oroho) – **ABSOLUTE -** Permits conduct of bingos and raffles remotely; permits online sale of tickets for all bingos and raffles

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A-5231/S-3806 (Lopez, Coughlin, Freiman/Vitale) – **ABSOLUTE -** Allows county or municipal governing body to enter into revenue sharing agreement for alcoholic beverage sales by concessionaire permit holder

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