SYNOPSIS

Synopsis: Prohibits Medicaid managed care organizations from reducing certain provider reimbursement rates without approval from DHS.

Type of Impact: Potential State expenditure increase.

Agencies Affected: Department of Human Services (DHS).

Executive Estimate

<table>
<thead>
<tr>
<th>Fiscal Impact</th>
<th>Fiscal Year 2014*</th>
<th>Fiscal Year 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Cost</td>
<td>$252,008</td>
<td>$511,892</td>
</tr>
<tr>
<td></td>
<td>* Assumes effective date of January 1, 2014</td>
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</tbody>
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Office of Legislative Services Estimate

<table>
<thead>
<tr>
<th>Fiscal Impact</th>
<th>Fiscal Year 2014</th>
<th>Fiscal Year 2015</th>
<th>Fiscal Year 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Cost</td>
<td>Indeterminate Potential Increase – See comments below</td>
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- Although the Executive’s estimate appears reasonable, the Office of Legislative Services (OLS) is unable to determine the bill’s precise fiscal impact. The OLS has no independent information to either verify or refute the Executive’s anticipated increase in staffing and consulting expenditures associated with implementing the rate review process.

- The OLS concurs that the bill expands Department of Human Services (DHS) administrative responsibilities associated with conducting rate reviews and public hearings, but cannot rule out that the DHS may be able to absorb those responsibilities and additional consulting expenses within current activities, at a lower cost than estimated by the Executive.

- Although not reflected in the Executive’s fiscal impact estimates, the DHS suggests that an additional $10 to $100 million in annual State costs from increased capitation payments may be generated if rate reductions are not upheld. The OLS cannot determine the likelihood of
such costs or the extent to which the bill’s requirements would significantly impact health maintenance organization’s (HMO) abilities to negotiate reduced provider reimbursement rates.

BILL DESCRIPTION

Assembly Bill No. 3409 (1R) of 2012 requires an HMO that provides benefits under a managed care plan to enrollees of the Medicaid or New Jersey FamilyCare (NJ FamilyCare) programs to obtain written approval from the DHS prior to reducing reimbursement rates under the managed care plan to any category of health care providers that: are regulated by the DHS or the Department of Health; or provide services through a Health Care Service Firm regulated by the Division of Consumer Affairs in the Department of Law and Public Safety. The applicable providers include, but are not limited to: pediatric and adult day health care facilities, hospitals, nursing homes, rehabilitation centers, intermediate care facilities, outpatient clinics, home health care agencies, laboratories; and health care service firms providing personal care assistance services.

When applying for approval of a provider rate reduction, an HMO would be required to:

- apply in a manner set forth by the Commissioner of Human Services (the commissioner);
- demonstrate to the commissioner’s satisfaction that the HMO has taken all appropriate actions to reduce the cost of providing benefits to Medicaid and NJ FamilyCare participants covered by a managed care plan, including, but not limited to: cost-effective utilization review measures; elimination of unnecessary administrative expenses; enhanced fraud detection and recovery efforts; and any other actions that the commissioner may require;
- demonstrate to the commissioner’s satisfaction that a proposed reduction in provider reimbursement rates would not adversely impact the quality and accessibility of health care services provided to Medicaid and NJ FamilyCare participants covered by the managed care plan; and
- comply with any other prospective requirements established by the commissioner at the time, and as a condition, of granting such approval.

The DHS would be required to conduct a public hearing on the proposed rate reduction at least 30 days after receiving an application for the proposed reduction but before making a decision regarding the reduction.

FISCAL ANALYSIS

EXECUTIVE BRANCH

In November 2012, the Executive estimated the fiscal impact of Assembly Bill No. 3409, as originally introduced, for Fiscal Year (FY) 2013 through FY 2015 and assumed an effective date of January 1, 2013. Adjusted by the OLS to assume an updated effective date of January 1, 2014, the DHS estimates suggest first-year State administrative costs of about $252,000 under the bill. Anticipated expenditures include:

- approximately $164,000 in State salary and operating costs (office space, supplies, computers, etc.) for five additional staff associated with a new unit that would monitor and evaluate all provider reimbursement rate reductions proposed by the HMOs; and
• approximately $88,000 for actuarial consulting expenses to analyze potential adjustments
to the State’s managed care capitation payments resulting from proposed changes in
provider reimbursement rates.

According to the DHS, the additional actuarial consulting expenses reflect a likely increase in the
frequency of capitation rate renegotiations and recalculation as a result of the State becoming
involved in evaluating and approving all applicable provider reimbursement rate reductions
(currently, the State typically renegotiates and recalculate capitation rates on an annual basis).

The first-year State administrative costs are prorated to reflect six months remaining in the
current fiscal year, assuming the effective date of January 1, 2014. These State costs exclude
$252,000 in additional expenditures that the DHS assumes would be supported by federal
Medicaid and Children’s Health Insurance Program (CHIP) matching funds for administrative
expenses, at a federal matching rate of 50 percent.

The DHS estimates State administrative costs of about $512,000 for the bill’s second year of
implementation. These second-year costs reflect the same administrative expenditures from the
first year (annualized) and assume three percent annual growth in salary costs and one percent
annual growth in consulting costs. The second-year State costs also assume federal
Medicaid/CHIP matching funds at a rate of 50 percent.

Although not reflected in the DHS fiscal impact estimates, the department also comments
that, if rate reductions are not upheld, additional $10 to $100 million in annual State costs
may be generated due to increased capitation rates (when negotiating future HMO contracts);
required to offset HMOs’ greater provider reimbursement costs. The data and methodology used
to generate this estimate are not provided.

The Office of Management and Budget (OMB) indicates that the DHS estimates for State
administrative costs are reasonable but that the OMB cannot independently verify the estimates.
The OMB concurs with the DHS assumption that State administrative costs would be partially
offset by federal Medicaid/CHIP matching funds.

It is noted that the DHS prepared its fiscal estimates for Assembly Bill No. 3409 as originally
introduced. The department has stated that the subsequent amendments reflected in the First
Reprint have not changed the bill’s fiscal impact.

OFFICE OF LEGISLATIVE SERVICES

The OLS is unable to determine the bill’s precise fiscal impact. Although the Executive’s
estimate appears reasonable, the OLS has no independent information to either verify or refute
the Executive’s anticipated increase in State administrative costs.

The OLS concurs with the Executive that the bill establishes new DHS administrative
responsibilities associated with conducting the rate reviews and public hearings. The OLS also
concurs that any increased State costs generated by these new responsibilities would be partially
offset by additional federal Medicaid/CHIP matching funds for administrative expenses.
However, the State’s current Medicaid managed care contract already requires HMOs to:
implement certain utilization review, fraud detection, and fraud recovery measures; meet medical
cost ratio standards that limit unnecessary administrative expenses; and adhere to quality of care,
provider access, and network adequacy standards. The DHS currently monitors and evaluates
HMOs’ performance in these and all other contract areas on an ongoing basis. The bill also
provides the DHS with discretion as to the rigor of application procedures, performance
analyses, and other requirements involved in the rate review and hearing process. Thus, it may
be possible for the DHS to design a rate review process that would be largely absorbed under
current staffing and operations, at a lower cost than the Executive anticipates.
The OLS notes that the State already incurs costs related to actuarial consulting under the annual capitation rate setting process. To the extent that the DHS can require the timing of HMO rate reduction requests and reviews to align with the existing capitation rate setting process, additional consulting expenses may also be minimized.

The DHS’ statement that the bill may produce long-term upward pressure on costs associated with State capitation payments (if rate reductions are not upheld) cannot be verified. If the bill’s rate review process constrains HMOs’ abilities to negotiate reduced provider reimbursement rates, it is theoretically possible that the HMOs may incur higher costs over time, potentially affecting future contract negotiations between the State and HMOs and resulting in increased capitation rates. However, the OLS cannot determine the likelihood, magnitude, or timing of any such increases, as sufficiently detailed historical data are not available to estimate: the probable timing or magnitude of HMOs’ proposed rate reductions in the future; the change in HMO expenditures associated with denied rate reductions; and the likely relationship between a change in HMO expenditures and impacts on the value of the State’s Medicaid and NJ FamilyCare managed care contracts.

It is also unclear whether the bill’s requirements would significantly constrain HMOs’ abilities to negotiate reduced reimbursement rates. The bill provides the commissioner with considerable discretion for defining satisfactory performance in the areas to be evaluated during rate reviews. If the commissioner does not apply more stringent performance standards to the rate reviews than are applied in currently overseeing HMO contracts (and ensuring that access and quality standards are met), it may be unlikely that an HMO would fail to demonstrate appropriate actions in the required areas and fail to obtain DHS approval for any reimbursement rate reductions.

Finally, the OLS notes that the DHS prepared its fiscal estimates for Assembly Bill No. 3409 of 2012 as originally introduced. That version of the bill did not specifically limit the HMO rate reduction review requirements to only those categories of providers that are regulated by the DHS or the Department of Health or that provide services through a Health Care Service Firm. If the DHS estimates assume a broader group of providers than the current bill requires, which would presumably trigger more numerous or frequent rate reviews, the department’s cost estimates may be somewhat overstated. Thus, the OLS is unable to either concur with or refute the DHS’ statement that the subsequent amendments have not changed the bill’s final impact.

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Approved: David J. Rosen
Legislative Budget and Finance Officer

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