

30.40-7

LEGISLATIVE HISTORY CHECKLIST

NJSA: 30:4D-7

(Medicaid--permit
dental services
corporations)

LAWS OF: 1988

CHAPTER: 6

Bill No: S153

Sponsor(s): Lesniak

Date Introduced: Pre-filed

Committee: Assembly: -----

Senate: Institutions Health & Welfare

Amended during passage: Yes Amendments during passage
denoted by asterisks.

Date of Passage: Assembly: February 8, 1988

Senate: January 25, 1988

Date of Approval: March 17, 1988

Following statements are attached if available:

Sponsor statement: Yes

Committee Statement: Assembly: No

Senate: Yes

Fiscal Note: No

Veto Message: No

Message on signing: Yes

Following were printed:

Reports: No

Hearings: No

See Newspaper clipping--attached
"State readies bidding for Medicaid agent", 3-19-88 Star Ledger

DO NOT WRITE IN THESE SPACES

[FIRST REPRINT]

SENATE, No. 153

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1988 SESSION

By Senator LESNIAK

1 AN ACT concerning fiscal intermediaries for the Medicaid
program and amending P.L. 1968, c. 413.

3

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

1. Section 7 of P.L. 1968, c. 413 (C. 30:4D-7) is amended to
7 read as follows:

7. Duties of commissioner. The commissioner is authorized
9 and empowered to issue, or to cause to be issued through the
Division of Medical Assistance and Health Services, all
11 necessary rules and regulations and administrative orders, and to
do or cause to be done all other acts and things necessary to
13 secure for the State of New Jersey the maximum federal
participation that is available with respect to a program of
15 medical assistance, consistent with fiscal responsibility and
within the limits of funds available for any fiscal year, and to
17 the extent authorized by the medical assistance program plan;
to adopt fee schedules with regard to medical assistance
19 benefits and otherwise to accomplish the purposes of this act,
including specifically the following:

21 a. Subject to the limits imposed by this act, to submit a plan
for medical assistance, as required by Title XIX of the federal
23 Social Security Act, to the federal Department of Health and
Human Services for approval pursuant to the provisions of such
25 law; to act for the State in making negotiations relative to the
submission and approval of such plan, to make such
27 arrangements, not inconsistent with the law, as may be required
by or pursuant to federal law to obtain and retain such approval
29 and to secure for the State the benefits of the provisions of such
law;

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:
Senate SIH committee amendments adopted January 21, 1988.

1 b. Subject to the limits imposed by this act, to determine the
2 amount and scope of services to be covered, that the amounts to
3 be paid are reasonable, and the duration of medical assistance to
4 be furnished; provided, however, that the department shall
5 provide medical assistance on behalf of all recipients of
6 categorical assistance and such other related groups as are
7 mandatory under federal laws and rules and regulations, as they
8 now are or as they may be hereafter amended, in order to obtain
9 federal matching funds for such purposes and, in addition,
10 provide medical assistance for the foster children specified in
11 section 3i. (7) of this act. The medical assistance provided for
12 these groups shall not be less in scope, duration, or amount than
13 is currently furnished such groups, and in addition, shall include
14 at least the minimum services required under federal laws and
15 rules and regulations to obtain federal matching funds for such
16 purposes.

17 The commissioner is authorized and empowered, at such times
18 as he may determine feasible, within the limits of appropriated
19 funds for any fiscal year, to extend the scope, duration, and
20 amount of medical assistance on behalf of these groups of
21 categorical assistance recipients, related groups as are
22 mandatory, and foster children authorized pursuant to section
23 3i. (7) of this act, so as to include, in whole or in part, the
24 optional medical services authorized under federal laws and
25 rules and regulations, and the commissioner shall have the
26 authority to establish and maintain the priorities given such
27 optional medical services; provided, however, that medical
28 assistance shall be provided to at least such groups and in such
29 scope, duration, and amount as are required to obtain federal
30 matching funds.

31 The commissioner is further authorized and empowered, at
32 such times as he may determine feasible, within the limits of
33 appropriated funds for any fiscal year, to issue, or cause to be
34 issued through the Division of Medical Assistance and Health
35 Services, all necessary rules, regulations and administrative
36 orders, and to do or cause to be done all other acts and things
37 necessary to implement and administer demonstration projects
38 pursuant to Title XI, section 1115 of the federal Social Security
39 Act, including, but not limited to waiving compliance with
40 specific provisions of this act, to the extent and for the period
41 of time the commissioner deems necessary, as well as

1 contracting with any legal entity, including but not limited to
2 corporations organized pursuant to Title 14A, New Jersey
3 Statutes (N.J.S. 14A:1-1 et seq.), Title 15, Revised Statutes
4 (R.S. 15:1-1 et seq.) and Title 15A, New Jersey Statutes (N.J.S.
5 15A:1-1 et seq.) as well as boards, groups, agencies, persons and
6 other public or private entities;

7 c. To administer the provisions of this act;

8 d. To make reports to the federal Department of Health and
9 Human Services as from time to time may be required by such
10 federal department and to the New Jersey Legislature as
11 hereinafter provided;

12 e. To assure that any applicant, qualified applicant or
13 recipient shall be afforded the opportunity for a hearing should
14 his claim for medical assistance be denied, reduced, terminated
15 or not acted upon within a reasonable time;

16 f. To assure that providers shall be afforded the opportunity
17 for an administrative hearing within a reasonable time on any
18 valid complaint arising out of the claim payment process;

19 g. To provide safeguards to restrict the use or disclosure of
20 information concerning applicants and recipients to purposes
21 directly connected with administration of this act;

22 h. To take all necessary action to recover any and all
23 payments incorrectly made to or illegally received by a provider
24 from such provider or his estate or from any other person, firm,
25 corporation, partnership or entity responsible for or receiving
26 the benefit or possession of the incorrect or illegal payments or
27 their estates, successors or assigns, and to assess and collect
28 such penalties as are provided for herein;

29 i. To take all necessary action to recover the cost of benefits
30 incorrectly provided to or illegally obtained by a recipient,
31 including those made after a voluntary divestiture of real or
32 personal property or any interest or estate in property for less
33 than adequate consideration made for the purpose of qualifying
34 for assistance. The division shall take action to recover the cost
35 of benefits from a recipient, legally responsible relative,
36 representative payee, or any other party or parties whose action
37 or inaction resulted in the incorrect or illegal payments or who
38 received the benefit of the divestiture, or from their respective
39 estates, as the case may be and to assess and collect

1 the penalties as are provided for herein, except that no lien shall
2 be imposed against property of the recipient prior to his death
3 except in accordance with section 17 of P.L. 1968, c. 413 (C.
4 30:4D-17). No recovery action shall be initiated more than five
5 years after an incorrect payment has been made to a recipient
6 when the incorrect payment was due solely to an error on the
7 part of the State or any agency, agent or subdivision thereof;

8 j. To take all necessary action to recover the cost of benefits
9 correctly provided to a recipient from the estate of said
10 recipient in accordance with sections 6 through 12 of this
11 amendatory and supplementary act;

12 k. To take all reasonable measures to ascertain the legal or
13 equitable liability of third parties to pay for care and services
14 (available under the plan) arising out of injury, disease, or
15 disability; where it is known that a third party has a liability, to
16 treat such liability as a resource of the individual on whose
17 behalf the care and services are made available for purposes of
18 determining eligibility; and in any case where such a liability is
19 found to exist after medical assistance has been made available
20 on behalf of the individual, to seek reimbursement for such
21 assistance to the extent of such liability;

22 l. To compromise, waive or settle and execute a release of
23 any claim arising under this act including interest or other
24 penalties, or designate another to compromise, waive or settle
25 and execute a release of any claim arising under this act. The
26 commissioner or his designee whose title shall be specified by
27 regulation may compromise, settle or waive any such claim in
28 whole or in part, either in the interest of the Medicaid program
29 or for any other reason which the commissioner by regulation
30 shall establish;

31 m. To pay or credit to a provider any net amount found by
32 final audit as defined by regulation to be owing to the provider.
33 Such payment, if it is not made within 45 days of the final audit,
34 shall include interest on the amount due at the maximum legal
35 rate in effect on the date the payment became due, except that
36 such interest shall not be paid on any obligation for the period
37 preceding September 15, 1976. This subsection shall not apply
38 until federal financial participation is available for such interest
39 payments;

1 n. To issue, or designate another to issue, subpoenas to compel
the attendance of witnesses and the production of books,
3 records, accounts, papers and documents of any party, whether
or not that party is a provider, which directly or indirectly
5 relate to goods or services provided under this act, for the
purpose of assisting in any investigation, examination, or
7 inspection, or in any suspension, debarment, disqualification,
recovery, or other proceeding arising under this act;

9 o. To solicit, receive and review bids pursuant to the
provisions of P.L. 1954, c. 48 (C. 52:34-6 et seq.) and all
11 amendments and supplements thereto, by ¹[authorized insurance
companies and] any corporation doing business in the State of
13 New Jersey, including¹ nonprofit hospital service corporations
[or], medical service corporations, health service corporations or
15 dental service corporations incorporated in New Jersey¹,¹ and
authorized to do business pursuant to P.L. 1938, c. 366 (C.
17 17:48-1 et seq.) [or], P.L. 1940, c. 74 (C. 17:48A-1 et seq.), P.L.
1985, c. 236 (C. 17:48E-1 et seq.), or P.L. 1968, c. 305 (C.
19 17:48C-1 et seq.), and to make recommendations in connection
therewith to the State Medicaid Commission;

21 p. To contract, or otherwise provide as in this act provided,
for the payment of claims in the manner approved by the State
23 Medicaid Commission;

25 q. Where necessary, to advance funds to the underwriter or
fiscal agent to enable such underwriter or fiscal agent, in
accordance with terms of its contract, to make payments to
27 providers;

29 r. To enter into contracts with federal, State, or local
governmental agencies, or other appropriate parties, when
necessary to carry out the provisions of this act;

31 s. To assure that the nature and quality of the medical
assistance provided for under this act shall be uniform and
33 equitable to all recipients;

35 t. To provide for the reimbursement of State and
county-administered skilled nursing and intermediate care
facilities through the use of a governmental peer grouping
37 system, subject to federal approval and the availability of
federal reimbursement.

39 (1) In establishing a governmental peer grouping system, the
State's financial participation is limited to an amount equal to
41 the nonfederal share of the reimbursement which would be due

1 each facility if the governmental peer grouping system was not
established, and each county's financial participation in this
3 reimbursement system is equal to the nonfederal share of the
increase in reimbursement for its facility or facilities which
5 results from the establishment of the governmental peer
grouping system.

7 (2) On or before December 1 of each year, the commissioner
shall estimate and certify to the Director of the Division of
9 Local Government Services in the Department of Community
Affairs the amount of increased federal reimbursement a county
11 may receive under the governmental peer grouping system. On
or before December 15 of each year, the Director of the
13 Division of Local Government Services shall certify the
increased federal reimbursement to the chief financial officer
15 of each county. If the amount of increased federal
reimbursement to a county exceeds or is less than the amount
17 certified, the certification for the next year shall account for
the actual amount of federal reimbursement that the county
19 received during the prior calendar year.

(3) The governing body of each county entitled to receive
21 increased federal reimbursement under the provisions of this
amendatory act shall, by March 31 of each year, submit a report
23 to the commissioner on the intended use of the savings in county
expenditures which result from the increased federal
25 reimbursement. The governing body of each county, with the
advice of agencies providing social and health related services,
27 shall use not less than 10% and no more than 50% of the savings
in county expenditures which result from the increased federal
29 reimbursement for community-based social and health related
programs for elderly and disabled persons who may otherwise
31 require nursing home care. This percentage shall be negotiated
annually between the governing body and the commissioner and
33 shall take into account a county's social, demographic and fiscal
conditions, a county's social and health related expenditures and
35 needs, and estimates of federal revenues to support county
operations in the upcoming year, particularly in the areas of
37 social and health related services.

(4) The commissioner, subject to approval by law, may
39 terminate the governmental peer grouping system if federal
reimbursement is significantly reduced or if the Medicaid

1 program is to significantly altered or changed by the federal
government subsequent to the enactment of this amendatory
3 act. The commissioner, prior to terminating the governmental
peer grouping system, shall submit to the Legislature and to the
5 governing body of each county a report as to the reasons for
terminating the governmental peer grouping system[.];

7 u. The commissioner, in consultation with the Commissioner
of Health, shall:

9 (1) Develop criteria and standards for comprehensive
maternity or pediatric care providers and determine whether a
11 provider who requests to become a comprehensive maternity or
pediatric care provider meets the department's criteria and
13 standards;

(2) Develop a program of comprehensive maternity care
15 services which defines the type of services to be provided, the
level of services to be provided, and the frequency with which
17 qualified applicants are to receive services pursuant to P.L.
1968, c. 413 (C. 30:4D-1 et seq.);

19 (3) Develop a program of comprehensive pediatric care
services which defines the type of services to be provided, the
21 level of services to be provided, and the frequency with which
qualified applicants are to receive services pursuant to P.L.
23 1968, c. 413 (C. 30:4D-1 et seq.);

(4) Develop and implement a system for monitoring the
25 quality and delivery of comprehensive maternity and pediatric
care services and a system for evaluating the effectiveness of
27 the services programs in meeting their objectives;

(5) Establish provider reimbursement rates for the
29 comprehensive maternity and pediatric care services;

v. The commissioner, jointly with the Commissioner of
31 Health, shall report to the Governor and the Legislature no later
than two years following the date of enactment of P.L. 1987, c.
33 115 (C. 30:4D-2.1 et al.) and annually thereafter on the status of
the comprehensive maternity and pediatric care services and
35 their effectiveness in meeting the objectives set forth in section
1 of P.L. 1987, c. 115 (C. 30:4D-2.1) accompanying the report
37 with any recommendations for changes in the law governing the
services that the commissioners deem necessary.

39 (cf: P.L. 1987, c. 115, s. 4)

1 12. Section 8 of P.L. 1968, c. 413 (30:4D-8) is amended to
read as follows:

3 8. The determination of the method of providing payment of
claims under this act shall be made by the State Medicaid
5 Commission on recommendation of the commissioner which
method may be:

7 a. By contract with insurance companies incorporated and
licensed to do business in the State of New Jersey or with
9 nonprofit health service corporations, dental service
corporations, hospital service corporations or medical service
11 corporations, incorporated in New Jersey, and authorized to do
business pursuant to P.L. 1985, c. 236 (C. 17:48E-1 et seq.), P.L.
13 1968, c. 305 (C. 17:48C-1 et seq.), P.L. 1938, c. 366 (C. 17:48-1
et seq.) or P.L. 1940, c. 74 (C. 17:48A-1 et seq.), to underwrite,
15 but not for profit, on an insured premium approach, that portion
of the program covering all cash grant beneficiaries plus all
17 other State certified recipients of medical assistance within the
classes set forth in section 3[(f)(1) through (6)] i. of this act,
19 with the exception of those persons who are confined in
institutions for tuberculosis and mental care or who are required
21 by medical necessity to be confined on a presumably permanent
basis in other medical care institutions by reason of disease or
23 injury, which contract executed pursuant to [section 8a] this
subsection shall provide that for those persons included in the
25 program but not covered on an underwritten basis, the same
carrier selected under [8a] this subsection shall act as fiscal
27 agent for the department, but not for profit, for such medical
assistance benefits as may be available, and any carrier
29 selected pursuant to the provisions of this act is hereby
expressly authorized and empowered to undertake the
31 performance of the requirements of such contract.

33 b. By contract with [an insurance] any [company incorporated
and licensed to do] corporation doing business in the State of
New Jersey [or with] , including nonprofit organizations[,]
35 incorporated in New Jersey[,] and authorized to do business
pursuant to P.L. 1985, c. 236 (C. 17:48E-1 et seq.), P.L. 1968, c.
37 305 (C. 17:48C-1 et seq.), P.L.1938, c. 366 (C. 17:48-1 et seq.)
or P.L. 1940, c. 74 (C. 17:48A-1 et seq.), to act as fiscal agent.

1 c. By direct administration by the Department of [Institutions
and Agencies] Human Services.¹

3 (cf: P.L. 1968, c. 413, s. 8)

¹[2.] 3.¹ This act shall take effect immediately.

5

7 HUMAN SERVICES

Public Assistance

9

11 Permits any corporation doing business in the State to act as a
fiscal intermediary in Medicaid program.

1

STATEMENT

3 This bill provides that nonprofit dental service corporations
established pursuant to the "Dental Service Corporation Act,"
5 P.L. 1968, c. 305 (C. 17:48C-1 et seq.) shall be permitted to
submit a bid to the Commissioner of Human Services to act as a
7 fiscal intermediary in the State Medicaid program. The bill also
conforms the reference to nonprofit hospital and medical
9 service corporations (Blue Cross and Blue Shield, respectively)
to P.L. 1985, c. 236 (C. 17:48E-1 et seq.) which provided for the
11 merger of Blue Cross and Blue Shield into a health service
corporation.

13 Subsection o. of section 7 of P.L. 1968, c. 413 (C. 30:4D-1)
provides that only insurance companies and nonprofit hospital
15 and medical service corporations may submit bids to the
commissioner to serve as fiscal intermediaries for the Medicaid
17 program. The State Medicaid program currently contracts with
Prudential and Blue Cross and Blue Shield of New Jersey, Inc. to
19 serve as fiscal intermediaries to process Medicaid claims and to
make payments to the health care providers for services
21 rendered to Medicaid recipients.

23

HUMAN SERVICES

25

Public Assistance

27 Permits dental service corporations to act as fiscal
intermediaries in Medicaid program.

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO

SENATE, No. 153

with Senate committee amendments

STATE OF NEW JERSEY

DATED: January 21, 1988

The Senate Institutions, Health and Welfare Committee favorably reports Senate Bill No. 153 with committee amendments.

As amended by committee, this bill provides that any corporation doing business in the State, including a nonprofit dental service corporation established pursuant to the "Dental Service Corporation Act," P.L. 1968, c. 305 (C. 17:48C-1 et seq.), shall be permitted to submit a bid to the Commissioner of Human Services to act as a fiscal intermediary in the State Medicaid program. The bill also conforms the reference to nonprofit hospital and medical service corporations (Blue Cross and Blue Shield, respectively) to P.L. 1985, c. 236 (C. 17:48E-1 et seq.) which provided for the merger of Blue Cross and Blue Shield into a health service corporation.

Currently, subsection o. of section 7 of P.L. 1968, c. 413 (C. 30:4D-7) provides that only insurance companies and nonprofit hospital and medical service corporations may submit bids to the commissioner to serve as fiscal intermediaries for the Medicaid program. The State Medicaid program currently contracts with Prudential and Blue Cross and Blue Shield of New Jersey, Inc. to serve as fiscal intermediaries to process Medicaid claims and to make payments to the health care providers for services rendered to Medicaid recipients.

The committee amended the bill to delete the restriction that only certain insurance companies licensed in the State could contract with the Medicaid program to act as fiscal agents, and to provide, instead, that any corporation doing business in the State, including a dental service corporation, is eligible to act as a fiscal agent. This broadening of the types of corporations eligible to serve as fiscal agents is in accordance with federal Medicaid regulations. Other amendments are technical and conform the provisions of section 8 of P.L. 1968, c. 413 (C. 30:4D-8) to recently enacted changes in the Medicaid law.

This bill was pre-filed for introduction in the 1988-89 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.



OFFICE OF THE GOVERNOR NEWS RELEASE

CN-001

Contact: JOHN SAMERJAN
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TRENTON, N.J. 08625

Release: FRI., MARCH 18, 1988

Governor Thomas H. Kean today signed legislation permitting any corporation doing business in New Jersey, including a health service corporation or dental service corporation to act as a fiscal intermediary in the State Medicaid program.

A fiscal intermediary is a corporation that contracts with the Department of Human Services to administer the Medicaid program and is used to process Medicaid claims and make payments to health care providers for services rendered to Medicaid recipients.

S-153, was sponsored by Senator Raymond Lesniak, D-Union and Assemblyman Thomas Deverin, D-Middlesex.

The legislation is effective immediately.

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