

LEGISLATIVE HISTORY CHECKLIST

(continued)

VETO MESSAGE:

No

GOVERNOR'S PRESS RELEASE ON SIGNING:

Yes

FOLLOWING WERE PRINTED:

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REPORTS:

No

HEARINGS:

No

NEWSPAPER ARTICLES:

Yes

"Murphy set to sign bill allocating \$7.5M to women's health," Associated Press State Wire: New Jersey, 2-21-2018

"Murphy reverses Christie, approves \$7.5M for women's health," Associated Press: Cherry Hill Metro Area, 2-21-2018

"New bill would limit governor's clout on tax reciprocity with Pa.," The Times, 2-21-2018

"In his first bill signing, Murphy restores funding for Planned Parenthood," Politico, 2-21-2018

"Gov restores \$7.5M to health clinics," The Jersey Journal, 2-22-2018

"Funding 'signed, sealed, delivered' - Murphy authorizes bill restoring \$7.5M for women's health clinics," The Star-Ledger, 2-22-2018

"Gov restores Planned Parenthood funding - Legislation brings back \$7.5 million in grants to organization, health clinics," The Times, 2-22-2018

"Murphy authorizes bill restoring \$7.5M for women's health clinics," South Jersey Times, 2-22-2018

"Murphy boosts funding for women's health – first bill signing provides \$7.5M," The Record, 2-22-2018

"NJ News," Burlington County Times, February 23, 2018

"Murphy endorses first healthcare legislation," The Daily Targum, 2-23-2018

RWH/JA

P.L. 2018, CHAPTER 1, *approved February 21, 2018*
Senate, No. 105

1 **AN ACT** concerning Medicaid coverage for family planning services
2 and amending P.L.1968, c.413.

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read
8 as follows:

9 3. Definitions. As used in P.L.1968, c.413 (C.30:4D-1 et seq.),
10 and unless the context otherwise requires:

11 a. "Applicant" means any person who has made application for
12 purposes of becoming a "qualified applicant."

13 b. "Commissioner" means the Commissioner of Human
14 Services.

15 c. "Department" means the Department of Human Services,
16 which is herein designated as the single State agency to administer
17 the provisions of this act.

18 d. "Director" means the Director of the Division of Medical
19 Assistance and Health Services.

20 e. "Division" means the Division of Medical Assistance and
21 Health Services.

22 f. "Medicaid" means the New Jersey Medical Assistance and
23 Health Services Program.

24 g. "Medical assistance" means payments on behalf of recipients
25 to providers for medical care and services authorized under
26 P.L.1968, c.413.

27 h. "Provider" means any person, public or private institution,
28 agency, or business concern approved by the division lawfully
29 providing medical care, services, goods, and supplies authorized
30 under P.L.1968, c.413, holding, where applicable, a current valid
31 license to provide such services or to dispense such goods or
32 supplies.

33 i. "Qualified applicant" means a person who is a resident of
34 this State, and either a citizen of the United States or an eligible
35 alien, and is determined to need medical care and services as
36 provided under P.L.1968, c.413, with respect to whom the period
37 for which eligibility to be a recipient is determined shall be the
38 maximum period permitted under federal law, and who:

39 (1) Is a dependent child or parent or caretaker relative of a
40 dependent child who would be, except for resources, eligible for the
41 aid to families with dependent children program under the State

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.

1 Plan for Title IV-A of the federal Social Security Act as of July 16,
2 1996;

3 (2) Is a recipient of Supplemental Security Income for the Aged,
4 Blind and Disabled under Title XVI of the Social Security Act;

5 (3) Is an "ineligible spouse" of a recipient of Supplemental
6 Security Income for the Aged, Blind and Disabled under Title XVI
7 of the Social Security Act, as defined by the federal Social Security
8 Administration;

9 (4) Would be eligible to receive Supplemental Security Income
10 under Title XVI of the federal Social Security Act or, without
11 regard to resources, would be eligible for the aid to families with
12 dependent children program under the State Plan for Title IV-A of
13 the federal Social Security Act as of July 16, 1996, except for
14 failure to meet an eligibility condition or requirement imposed
15 under such State program which is prohibited under Title XIX of
16 the federal Social Security Act such as a durational residency
17 requirement, relative responsibility, consent to imposition of a lien;

18 (5) (Deleted by amendment, P.L.2000, c.71).

19 (6) Is an individual under 21 years of age who, without regard to
20 resources, would be, except for dependent child requirements,
21 eligible for the aid to families with dependent children program
22 under the State Plan for Title IV-A of the federal Social Security
23 Act as of July 16, 1996, or groups of such individuals, including but
24 not limited to, children in resource family placement under
25 supervision of the Division of Child Protection and Permanency in
26 the Department of Children and Families whose maintenance is
27 being paid in whole or in part from public funds, children placed in
28 a resource family home or institution by a private adoption agency
29 in New Jersey or children in intermediate care facilities, including
30 developmental centers for the developmentally disabled, or in
31 psychiatric hospitals;

32 (7) Would be eligible for the Supplemental Security Income
33 program, but is not receiving such assistance and applies for
34 medical assistance only;

35 (8) Is determined to be medically needy and meets all the
36 eligibility requirements described below:

37 (a) The following individuals are eligible for services, if they
38 are determined to be medically needy:

39 (i) Pregnant women;

40 (ii) Dependent children under the age of 21;

41 (iii) Individuals who are 65 years of age and older; and

42 (iv) Individuals who are blind or disabled pursuant to either 42
43 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.

44 (b) The following income standard shall be used to determine
45 medically needy eligibility:

46 (i) For one person and two person households, the income
47 standard shall be the maximum allowable under federal law, but
48 shall not exceed 133 1/3% of the State's payment level to two

1 person households under the aid to families with dependent children
2 program under the State Plan for Title IV-A of the federal Social
3 Security Act in effect as of July 16, 1996; and

4 (ii) For households of three or more persons, the income standard
5 shall be set at 133 1/3% of the State's payment level to similar size
6 households under the aid to families with dependent children
7 program under the State Plan for Title IV-A of the federal Social
8 Security Act in effect as of July 16, 1996.

9 (c) The following resource standard shall be used to determine
10 medically needy eligibility:

11 (i) For one person households, the resource standard shall be
12 200% of the resource standard for recipients of Supplemental
13 Security Income pursuant to 42 U.S.C. s.1382(1)(B);

14 (ii) For two person households, the resource standard shall be
15 200% of the resource standard for recipients of Supplemental
16 Security Income pursuant to 42 U.S.C. s.1382(2)(B);

17 (iii) For households of three or more persons, the resource
18 standard in subparagraph (c)(ii) above shall be increased by
19 \$100.00 for each additional person; and

20 (iv) The resource standards established in (i), (ii), and (iii) are
21 subject to federal approval and the resource standard may be lower
22 if required by the federal Department of Health and Human
23 Services.

24 (d) Individuals whose income exceeds those established in
25 subparagraph (b) of paragraph (8) of this subsection may become
26 medically needy by incurring medical expenses as defined in 42
27 C.F.R.435.831(c) which will reduce their income to the applicable
28 medically needy income established in subparagraph (b) of
29 paragraph (8) of this subsection.

30 (e) A six-month period shall be used to determine whether an
31 individual is medically needy.

32 (f) Eligibility determinations for the medically needy program
33 shall be administered as follows:

34 (i) County welfare agencies and other entities designated by the
35 commissioner are responsible for determining and certifying the
36 eligibility of pregnant women and dependent children. The division
37 shall reimburse county welfare agencies for 100% of the reasonable
38 costs of administration which are not reimbursed by the federal
39 government for the first 12 months of this program's operation.
40 Thereafter, 75% of the administrative costs incurred by county
41 welfare agencies which are not reimbursed by the federal
42 government shall be reimbursed by the division;

43 (ii) The division is responsible for certifying the eligibility of
44 individuals who are 65 years of age and older and individuals who
45 are blind or disabled. The division may enter into contracts with
46 county welfare agencies to determine certain aspects of eligibility.
47 In such instances the division shall provide county welfare agencies

1 with all information the division may have available on the
2 individual.

3 The division shall notify all eligible recipients of the
4 Pharmaceutical Assistance to the Aged and Disabled program,
5 P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the
6 medically needy program and the program's general requirements.
7 The division shall take all reasonable administrative actions to
8 ensure that Pharmaceutical Assistance to the Aged and Disabled
9 recipients, who notify the division that they may be eligible for the
10 program, have their applications processed expeditiously, at times
11 and locations convenient to the recipients; and

12 (iii) The division is responsible for certifying incurred medical
13 expenses for all eligible persons who attempt to qualify for the
14 program pursuant to subparagraph (d) of paragraph (8) of this
15 subsection;

16 (9) (a) Is a child who is at least one year of age and under 19
17 years of age and, if older than six years of age but under 19 years of
18 age, is uninsured; and

19 (b) Is a member of a family whose income does not exceed
20 133% of the poverty level and who meets the federal Medicaid
21 eligibility requirements set forth in section 9401 of Pub.L.99-509
22 (42 U.S.C. s.1396a);

23 (10) Is a pregnant woman who is determined by a provider to be
24 presumptively eligible for medical assistance based on criteria
25 established by the commissioner, pursuant to section 9407 of
26 Pub.L.99-509 (42 U.S.C. s.1396a(a));

27 (11) Is an individual 65 years of age and older, or an individual
28 who is blind or disabled pursuant to section 301 of Pub.L.92-603
29 (42 U.S.C. s.1382c), whose income does not exceed 100% of the
30 poverty level, adjusted for family size, and whose resources do not
31 exceed 100% of the resource standard used to determine medically
32 needy eligibility pursuant to paragraph (8) of this subsection;

33 (12) Is a qualified disabled and working individual pursuant to
34 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
35 does not exceed 200% of the poverty level and whose resources do
36 not exceed 200% of the resource standard used to determine
37 eligibility under the Supplemental Security Income Program,
38 P.L.1973, c.256 (C.44:7-85 et seq.);

39 (13) Is a pregnant woman or is a child who is under one year of
40 age and is a member of a family whose income does not exceed
41 185% of the poverty level and who meets the federal Medicaid
42 eligibility requirements set forth in section 9401 of Pub.L.99-509
43 (42 U.S.C. s.1396a), except that a pregnant woman who is
44 determined to be a qualified applicant shall, notwithstanding any
45 change in the income of the family of which she is a member,
46 continue to be deemed a qualified applicant until the end of the 60-
47 day period beginning on the last day of her pregnancy;

48 (14) (Deleted by amendment, P.L.1997, c.272).

1 (15) (a) Is a specified low-income Medicare beneficiary pursuant
2 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January
3 1, 1993 do not exceed 200% of the resource standard used to
4 determine eligibility under the Supplemental Security Income
5 program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income
6 beginning January 1, 1993 does not exceed 110% of the poverty
7 level, and beginning January 1, 1995 does not exceed 120% of the
8 poverty level.

9 (b) An individual who has, within 36 months, or within 60
10 months in the case of funds transferred into a trust, of applying to
11 be a qualified applicant for Medicaid services in a nursing facility
12 or a medical institution, or for home or community-based services
13 under section 1915(c) of the federal Social Security Act (42 U.S.C.
14 s.1396n(c)), disposed of resources or income for less than fair
15 market value shall be ineligible for assistance for nursing facility
16 services, an equivalent level of services in a medical institution, or
17 home or community-based services under section 1915(c) of the
18 federal Social Security Act (42 U.S.C. s.1396n(c)). The period of
19 the ineligibility shall be the number of months resulting from
20 dividing the uncompensated value of the transferred resources or
21 income by the average monthly private payment rate for nursing
22 facility services in the State as determined annually by the
23 commissioner. In the case of multiple resource or income transfers,
24 the resulting penalty periods shall be imposed sequentially.
25 Application of this requirement shall be governed by 42 U.S.C.
26 s.1396p(c). In accordance with federal law, this provision is
27 effective for all transfers of resources or income made on or after
28 August 11, 1993. Notwithstanding the provisions of this subsection
29 to the contrary, the State eligibility requirements concerning
30 resource or income transfers shall not be more restrictive than those
31 enacted pursuant to 42 U.S.C. s.1396p(c).

32 (c) An individual seeking nursing facility services or home or
33 community-based services and who has a community spouse shall
34 be required to expend those resources which are not protected for
35 the needs of the community spouse in accordance with section
36 1924(c) of the federal Social Security Act (42 U.S.C. s.1396r-5(c))
37 on the costs of long-term care, burial arrangements, and any other
38 expense deemed appropriate and authorized by the commissioner.
39 An individual shall be ineligible for Medicaid services in a nursing
40 facility or for home or community-based services under section
41 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)) if
42 the individual expends funds in violation of this subparagraph. The
43 period of ineligibility shall be the number of months resulting from
44 dividing the uncompensated value of transferred resources and
45 income by the average monthly private payment rate for nursing
46 facility services in the State as determined by the commissioner.
47 The period of ineligibility shall begin with the month that the

1 individual would otherwise be eligible for Medicaid coverage for
2 nursing facility services or home or community-based services.

3 This subparagraph shall be operative only if all necessary
4 approvals are received from the federal government including, but
5 not limited to, approval of necessary State plan amendments and
6 approval of any waivers;

7 (16) Subject to federal approval under Title XIX of the federal
8 Social Security Act, is a dependent child, parent or specified
9 caretaker relative of a child who is a qualified applicant, who would
10 be eligible, without regard to resources, for the aid to families with
11 dependent children program under the State Plan for Title IV-A of
12 the federal Social Security Act as of July 16, 1996, except for the
13 income eligibility requirements of that program, and whose family
14 earned income,

15 (a) if a dependent child, does not exceed 133% of the poverty
16 level; and

17 (b) if a parent or specified caretaker relative, beginning
18 September 1, 2005 does not exceed 100% of the poverty level,
19 beginning September 1, 2006 does not exceed 115% of the poverty
20 level and beginning September 1, 2007 does not exceed 133% of
21 the poverty level,

22 plus such earned income disregards as shall be determined
23 according to a methodology to be established by regulation of the
24 commissioner;

25 The commissioner may increase the income eligibility limits for
26 children and parents and specified caretaker relatives, as funding
27 permits;

28 (17) Is an individual from 18 through 20 years of age who is not
29 a dependent child and would be eligible for medical assistance
30 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
31 income or resources, who, on the individual's 18th birthday was in
32 resource family care under the care and custody of the Division of
33 Child Protection and Permanency in the Department of Children
34 and Families and whose maintenance was being paid in whole or in
35 part from public funds;

36 (18) Is a person between the ages of 16 and 65 who is
37 permanently disabled and working, and:

38 (a) whose income is at or below 250% of the poverty level, plus
39 other established disregards;

40 (b) who pays the premium contribution and other cost sharing as
41 established by the commissioner, subject to the limits and
42 conditions of federal law; and

43 (c) whose assets, resources and unearned income do not exceed
44 limitations as established by the commissioner;

45 (19) Is an uninsured individual under 65 years of age who:

46 (a) has been screened for breast or cervical cancer under the
47 federal Centers for Disease Control and Prevention breast and
48 cervical cancer early detection program;

- 1 (b) requires treatment for breast or cervical cancer based upon
2 criteria established by the commissioner;
- 3 (c) has an income that does not exceed the income standard
4 established by the commissioner pursuant to federal guidelines;
- 5 (d) meets all other Medicaid eligibility requirements; and
- 6 (e) in accordance with Pub.L.106-354, is determined by a
7 qualified entity to be presumptively eligible for medical assistance
8 pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established
9 by the commissioner pursuant to section 1920B of the federal Social
10 Security Act (42 U.S.C. s.1396r-1b); **【or】**
- 11 (20) Subject to federal approval under Title XIX of the federal
12 Social Security Act, is a single adult or couple, without dependent
13 children, whose income in 2006 does not exceed 50% of the poverty
14 level, in 2007 does not exceed 75% of the poverty level and in 2008
15 and each year thereafter does not exceed 100% of the poverty level;
16 except that a person who is a recipient of Work First New Jersey
17 general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107
18 et seq.), shall not be a qualified applicant; or
- 19 (21) is an individual who:
- 20 (a) has an income that does not exceed the highest income
21 eligibility level for pregnant women established under the State
22 plan under Title XIX or Title XXI of the federal Social Security
23 Act;
- 24 (b) is not pregnant; and
- 25 (c) is eligible to receive family planning services provided
26 under the Medicaid program pursuant to subsection k. of section 6
27 of P.L.1968, c.413 (C.30:4D-6) and in accordance with 42 U.S.C.
28 s.1396a(ii).
- 29 j. "Recipient" means any qualified applicant receiving benefits
30 under this act.
- 31 k. "Resident" means a person who is living in the State
32 voluntarily with the intention of making his home here and not for a
33 temporary purpose. Temporary absences from the State, with
34 subsequent returns to the State or intent to return when the purposes
35 of the absences have been accomplished, do not interrupt continuity
36 of residence.
- 37 l. "State Medicaid Commission" means the Governor, the
38 Commissioner of Human Services, the President of the Senate and
39 the Speaker of the General Assembly, hereby constituted a
40 commission to approve and direct the means and method for the
41 payment of claims pursuant to P.L.1968, c.413.
- 42 m. "Third party" means any person, institution, corporation,
43 insurance company, group health plan as defined in section 607(1)
44 of the federal "Employee Retirement and Income Security Act of
45 1974," 29 U.S.C. s.1167(1), service benefit plan, health
46 maintenance organization, or other prepaid health plan, or public,
47 private or governmental entity who is or may be liable in contract,
48 tort, or otherwise by law or equity to pay all or part of the medical

- 1 cost of injury, disease or disability of an applicant for or recipient
2 of medical assistance payable under P.L.1968, c.413.
- 3 n. "Governmental peer grouping system" means a separate
4 class of skilled nursing and intermediate care facilities administered
5 by the State or county governments, established for the purpose of
6 screening their reported costs and setting reimbursement rates under
7 the Medicaid program that are reasonable and adequate to meet the
8 costs that must be incurred by efficiently and economically operated
9 State or county skilled nursing and intermediate care facilities.
- 10 o. "Comprehensive maternity or pediatric care provider" means
11 any person or public or private health care facility that is a provider
12 and that is approved by the commissioner to provide comprehensive
13 maternity care or comprehensive pediatric care as defined in
14 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
15 (C.30:4D-6).
- 16 p. "Poverty level" means the official poverty level based on
17 family size established and adjusted under Section 673(2) of
18 Subtitle B, the "Community Services Block Grant Act," of
19 Pub.L.97-35 (42 U.S.C. s.9902(2)).
- 20 q. "Eligible alien" means one of the following:
- 21 (1) an alien present in the United States prior to August 22,
22 1996, who is:
- 23 (a) a lawful permanent resident;
- 24 (b) a refugee pursuant to section 207 of the federal "Immigration
25 and Nationality Act" (8 U.S.C. s.1157);
- 26 (c) an asylee pursuant to section 208 of the federal
27 "Immigration and Nationality Act" (8 U.S.C. s.1158);
- 28 (d) an alien who has had deportation withheld pursuant to
29 section 243(h) of the federal "Immigration and Nationality Act" (8
30 U.S.C. s.1253 (h));
- 31 (e) an alien who has been granted parole for less than one year
32 by the U.S. Citizenship and Immigration Services pursuant to
33 section 212(d)(5) of the federal "Immigration and Nationality Act"
34 (8 U.S.C. s.1182(d)(5));
- 35 (f) an alien granted conditional entry pursuant to section
36 203(a)(7) of the federal "Immigration and Nationality Act" (8
37 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or
- 38 (g) an alien who is honorably discharged from or on active duty
39 in the United States armed forces and the alien's spouse and
40 unmarried dependent child.
- 41 (2) An alien who entered the United States on or after August
42 22, 1996, who is:
- 43 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of
44 this subsection; or
- 45 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
46 subsection who entered the United States at least five years ago.
- 47 (3) A legal alien who is a victim of domestic violence in
48 accordance with criteria specified for eligibility for public benefits

1 as provided in Title V of the federal "Illegal Immigration Reform
2 and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
3 (cf: P.L.2012, c.16, s.114)
4

5 2. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
6 as follows:

7 6. a. Subject to the requirements of Title XIX of the federal
8 Social Security Act, the limitations imposed by this act and by the
9 rules and regulations promulgated pursuant thereto, the department
10 shall provide medical assistance to qualified applicants, including
11 authorized services within each of the following classifications:

12 (1) Inpatient hospital services;

13 (2) Outpatient hospital services;

14 (3) Other laboratory and X-ray services;

15 (4) (a) Skilled nursing or intermediate care facility services;

16 (b) Early and periodic screening and diagnosis of individuals
17 who are eligible under the program and are under age 21, to
18 ascertain their physical or mental health status and the health care,
19 treatment, and other measures to correct or ameliorate defects and
20 chronic conditions discovered thereby, as may be provided in
21 regulations of the Secretary of the federal Department of Health and
22 Human Services and approved by the commissioner;

23 (5) Physician's services furnished in the office, the patient's
24 home, a hospital, a skilled nursing, or intermediate care facility or
25 elsewhere.

26 As used in this subsection, "laboratory and X-ray services"
27 includes HIV drug resistance testing, including, but not limited to,
28 genotype assays that have been cleared or approved by the federal
29 Food and Drug Administration, laboratory developed genotype
30 assays, phenotype assays, and other assays using phenotype
31 prediction with genotype comparison, for persons diagnosed with
32 HIV infection or AIDS.

33 b. Subject to the limitations imposed by federal law, by this
34 act, and by the rules and regulations promulgated pursuant thereto,
35 the medical assistance program may be expanded to include
36 authorized services within each of the following classifications:

37 (1) Medical care not included in subsection a.(5) above, or any
38 other type of remedial care recognized under State law, furnished
39 by licensed practitioners within the scope of their practice, as
40 defined by State law;

41 (2) Home health care services;

42 (3) Clinic services;

43 (4) Dental services;

44 (5) Physical therapy and related services;

45 (6) Prescribed drugs, dentures, and prosthetic devices; and
46 eyeglasses prescribed by a physician skilled in diseases of the eye
47 or by an optometrist, whichever the individual may select;

48 (7) Optometric services;

- 1 (8) Podiatric services;
- 2 (9) Chiropractic services;
- 3 (10) Psychological services;
- 4 (11) Inpatient psychiatric hospital services for individuals under
- 5 21 years of age, or under age 22 if they are receiving such services
- 6 immediately before attaining age 21;
- 7 (12) Other diagnostic, screening, preventive, and rehabilitative
- 8 services, and other remedial care;
- 9 (13) Inpatient hospital services, nursing facility services, and
- 10 intermediate care facility services for individuals 65 years of age or
- 11 over in an institution for mental diseases;
- 12 (14) Intermediate care facility services;
- 13 (15) Transportation services;
- 14 (16) Services in connection with the inpatient or outpatient
- 15 treatment or care of substance use disorder, when the treatment is
- 16 prescribed by a physician and provided in a licensed hospital or in a
- 17 narcotic and substance use disorder treatment center approved by
- 18 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
- 19 et seq.) and whose staff includes a medical director, and limited to
- 20 those services eligible for federal financial participation under Title
- 21 XIX of the federal Social Security Act;
- 22 (17) Any other medical care and any other type of remedial care
- 23 recognized under State law, specified by the Secretary of the federal
- 24 Department of Health and Human Services, and approved by the
- 25 commissioner;
- 26 (18) Comprehensive maternity care, which may include: the
- 27 basic number of prenatal and postpartum visits recommended by the
- 28 American College of Obstetrics and Gynecology; additional
- 29 prenatal and postpartum visits that are medically necessary;
- 30 necessary laboratory, nutritional assessment and counseling, health
- 31 education, personal counseling, managed care, outreach, and
- 32 follow-up services; treatment of conditions which may complicate
- 33 pregnancy; and physician or certified nurse-midwife delivery
- 34 services;
- 35 (19) Comprehensive pediatric care, which may include:
- 36 ambulatory, preventive, and primary care health services. The
- 37 preventive services shall include, at a minimum, the basic number
- 38 of preventive visits recommended by the American Academy of
- 39 Pediatrics;
- 40 (20) Services provided by a hospice which is participating in the
- 41 Medicare program established pursuant to Title XVIII of the Social
- 42 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
- 43 services shall be provided subject to approval of the Secretary of
- 44 the federal Department of Health and Human Services for federal
- 45 reimbursement;
- 46 (21) Mammograms, subject to approval of the Secretary of the
- 47 federal Department of Health and Human Services for federal
- 48 reimbursement, including one baseline mammogram for women

- 1 who are at least 35 but less than 40 years of age; one mammogram
2 examination every two years or more frequently, if recommended
3 by a physician, for women who are at least 40 but less than 50 years
4 of age; and one mammogram examination every year for women
5 age 50 and over;
- 6 (22) Upon referral by a physician, advanced practice nurse, or
7 physician assistant of a person who has been diagnosed with
8 diabetes, gestational diabetes, or pre-diabetes, in accordance with
9 standards adopted by the American Diabetes Association :
- 10 (a) Expenses for diabetes self-management education or training
11 to ensure that a person with diabetes, gestational diabetes, or pre-
12 diabetes can optimize metabolic control, prevent and manage
13 complications, and maximize quality of life. Diabetes self-
14 management education shall be provided by an in-State provider
15 who is:
- 16 (i) a licensed, registered, or certified health care professional
17 who is certified by the National Certification Board of Diabetes
18 Educators as a Certified Diabetes Educator, or certified by the
19 American Association of Diabetes Educators with a Board
20 Certified-Advanced Diabetes Management credential, including, but
21 not limited to: a physician, an advanced practice or registered nurse,
22 a physician assistant, a pharmacist, a chiropractor, a dietitian
23 registered by a nationally recognized professional association of
24 dietitians, or a nutritionist holding a certified nutritionist specialist
25 (CNS) credential from the Board for Certification of Nutrition
26 Specialists ; or
- 27 (ii) an entity meeting the National Standards for Diabetes Self-
28 Management Education and Support, as evidenced by a recognition
29 by the American Diabetes Association or accreditation by the
30 American Association of Diabetes Educators;
- 31 (b) Expenses for medical nutrition therapy as an effective
32 component of the person's overall treatment plan upon a: diagnosis
33 of diabetes, gestational diabetes, or pre-diabetes; change in the
34 beneficiary's medical condition, treatment, or diagnosis; or
35 determination of a physician, advanced practice nurse, or physician
36 assistant that reeducation or refresher education is necessary.
37 Medical nutrition therapy shall be provided by an in-State provider
38 who is a dietitian registered by a nationally-recognized professional
39 association of dietitians, or a nutritionist holding a certified
40 nutritionist specialist (CNS) credential from the Board for
41 Certification of Nutrition Specialists, who is familiar with the
42 components of diabetes medical nutrition therapy;
- 43 (c) For a person diagnosed with pre-diabetes, items and services
44 furnished under an in-State diabetes prevention program that meets
45 the standards of the National Diabetes Prevention Program, as
46 established by the federal Centers for Disease Control and
47 Prevention; and

1 (d) Expenses for any medically appropriate and necessary
2 supplies and equipment recommended or prescribed by a physician,
3 advanced practice nurse, or physician assistant for the management
4 and treatment of diabetes, gestational diabetes, or pre-diabetes,
5 including, but not limited to: equipment and supplies for self-
6 management of blood glucose; insulin pens; insulin pumps and
7 related supplies; and other insulin delivery devices.

8 c. Payments for the foregoing services, goods, and supplies
9 furnished pursuant to this act shall be made to the extent authorized
10 by this act, the rules and regulations promulgated pursuant thereto
11 and, where applicable, subject to the agreement of insurance
12 provided for under this act. The payments shall constitute payment
13 in full to the provider on behalf of the recipient. Every provider
14 making a claim for payment pursuant to this act shall certify in
15 writing on the claim submitted that no additional amount will be
16 charged to the recipient, the recipient's family, the recipient's
17 representative or others on the recipient's behalf for the services,
18 goods, and supplies furnished pursuant to this act.

19 No provider whose claim for payment pursuant to this act has
20 been denied because the services, goods, or supplies were
21 determined to be medically unnecessary shall seek reimbursement
22 from the recipient, his family, his representative or others on his
23 behalf for such services, goods, and supplies provided pursuant to
24 this act; provided, however, a provider may seek reimbursement
25 from a recipient for services, goods, or supplies not authorized by
26 this act, if the recipient elected to receive the services, goods or
27 supplies with the knowledge that they were not authorized.

28 d. Any individual eligible for medical assistance (including
29 drugs) may obtain such assistance from any person qualified to
30 perform the service or services required (including an organization
31 which provides such services, or arranges for their availability on a
32 prepayment basis), who undertakes to provide the individual such
33 services.

34 No copayment or other form of cost-sharing shall be imposed on
35 any individual eligible for medical assistance, except as mandated
36 by federal law as a condition of federal financial participation.

37 e. Anything in this act to the contrary notwithstanding, no
38 payments for medical assistance shall be made under this act with
39 respect to care or services for any individual who:

40 (1) Is an inmate of a public institution (except as a patient in a
41 medical institution); provided, however, that an individual who is
42 otherwise eligible may continue to receive services for the month in
43 which he becomes an inmate, should the commissioner determine to
44 expand the scope of Medicaid eligibility to include such an
45 individual, subject to the limitations imposed by federal law and
46 regulations, or

47 (2) Has not attained 65 years of age and who is a patient in an
48 institution for mental diseases, or

1 (3) Is over 21 years of age and who is receiving inpatient
2 psychiatric hospital services in a psychiatric facility; provided,
3 however, that an individual who was receiving such services
4 immediately prior to attaining age 21 may continue to receive such
5 services until the individual reaches age 22. Nothing in this
6 subsection shall prohibit the commissioner from extending medical
7 assistance to all eligible persons receiving inpatient psychiatric
8 services; provided that there is federal financial participation
9 available.

10 f. (1) A third party as defined in section 3 of P.L.1968, c.413
11 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
12 this or another state when determining the person's eligibility for
13 enrollment or the provision of benefits by that third party.

14 (2) In addition, any provision in a contract of insurance, health
15 benefits plan, or other health care coverage document, will, trust,
16 agreement, court order, or other instrument which reduces or
17 excludes coverage or payment for health care-related goods and
18 services to or for an individual because of that individual's actual or
19 potential eligibility for or receipt of Medicaid benefits shall be null
20 and void, and no payments shall be made under this act as a result
21 of any such provision.

22 (3) Notwithstanding any provision of law to the contrary, the
23 provisions of paragraph (2) of this subsection shall not apply to a
24 trust agreement that is established pursuant to 42 U.S.C.
25 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
26 provided by government entities to a person who is disabled as
27 defined in section 1614(a)(3) of the federal Social Security Act (42
28 U.S.C. s.1382c (a)(3)).

29 g. The following services shall be provided to eligible
30 medically needy individuals as follows:

31 (1) Pregnant women shall be provided prenatal care and delivery
32 services and postpartum care, including the services cited in
33 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
34 (10), (12), (15), and (17) of this section, and nursing facility
35 services cited in subsection b.(13) of this section.

36 (2) Dependent children shall be provided with services cited in
37 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
38 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
39 nursing facility services cited in subsection b.(13) of this section.

40 (3) Individuals who are 65 years of age or older shall be
41 provided with services cited in subsection a.(3) and (5) of this
42 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
43 (8), (10), (12), (15), and (17) of this section, and nursing facility
44 services cited in subsection b.(13) of this section.

45 (4) Individuals who are blind or disabled shall be provided with
46 services cited in subsection a.(3) and (5) of this section and
47 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),

1 (12), (15), and (17) of this section, and nursing facility services
2 cited in subsection b.(13) of this section.

3 (5) (a) Inpatient hospital services, subsection a.(1) of this
4 section, shall only be provided to eligible medically needy
5 individuals, other than pregnant women, if the federal Department
6 of Health and Human Services discontinues the State's waiver to
7 establish inpatient hospital reimbursement rates for the Medicare
8 and Medicaid programs under the authority of section 601(c)(3) of
9 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
10 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
11 extended to other eligible medically needy individuals if the federal
12 Department of Health and Human Services directs that these
13 services be included.

14 (b) Outpatient hospital services, subsection a.(2) of this section,
15 shall only be provided to eligible medically needy individuals if the
16 federal Department of Health and Human Services discontinues the
17 State's waiver to establish outpatient hospital reimbursement rates
18 for the Medicare and Medicaid programs under the authority of
19 section 601(c)(3) of the Social Security Amendments of 1983,
20 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
21 services may be extended to all or to certain medically needy
22 individuals if the federal Department of Health and Human Services
23 directs that these services be included. However, the use of
24 outpatient hospital services shall be limited to clinic services and to
25 emergency room services for injuries and significant acute medical
26 conditions.

27 (c) The division shall monitor the use of inpatient and outpatient
28 hospital services by medically needy persons.

29 h. In the case of a qualified disabled and working individual
30 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
31 only medical assistance provided under this act shall be the
32 payment of premiums for Medicare part A under 42 U.S.C.
33 ss.1395i-2 and 1395r.

34 i. In the case of a specified low-income Medicare beneficiary
35 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical
36 assistance provided under this act shall be the payment of premiums
37 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
38 U.S.C. s.1396d(p)(3)(A)(ii).

39 j. In the case of a qualified individual pursuant to 42 U.S.C.
40 s.1396a(aa), the only medical assistance provided under this act
41 shall be payment for authorized services provided during the period
42 in which the individual requires treatment for breast or cervical
43 cancer, in accordance with criteria established by the commissioner.

44 k. In the case of a qualified individual pursuant to 42 U.S.C.
45 s.1396a(ii), the only medical assistance provided under this act shall
46 be payment for family planning services and supplies as described
47 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and

1 treatment services that are provided pursuant to a family planning
2 service in a family planning setting.

3 (cf: P.L.2017, c.161, s.1)

4
5 3. The Commissioner of Human Services, pursuant to the
6 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
7 seq.), shall adopt rules and regulations necessary to implement the
8 provisions of this act.

9
10 4. This act shall take effect on the first day of the fourth month
11 next following the date of enactment, but the Commissioner of
12 Human Services may take such anticipatory administrative action in
13 advance thereof, including, but not limited to, the submission of a
14 State plan amendment to the federal Centers for Medicare &
15 Medicaid Services, as may be necessary for the implementation of
16 this act.

17
18
19 _____
20
21 Provides Medicaid coverage for family planning services to
22 individuals with incomes up to 200 percent of the federal poverty
23 level.

SENATE, No. 105

STATE OF NEW JERSEY 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Senator LORETTA WEINBERG

District 37 (Bergen)

Senator LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Co-Sponsored by:

Senators Cunningham, Pou, Ruiz and Codey

SYNOPSIS

Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



(Sponsorship Updated As Of: 1/23/2018)

1 **AN ACT** concerning Medicaid coverage for family planning services
2 and amending P.L.1968, c.413.

3

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

6

7 1. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read
8 as follows:

9 3. Definitions. As used in P.L.1968, c.413 (C.30:4D-1 et seq.),
10 and unless the context otherwise requires:

11 a. "Applicant" means any person who has made application for
12 purposes of becoming a "qualified applicant."

13 b. "Commissioner" means the Commissioner of Human
14 Services.

15 c. "Department" means the Department of Human Services,
16 which is herein designated as the single State agency to administer
17 the provisions of this act.

18 d. "Director" means the Director of the Division of Medical
19 Assistance and Health Services.

20 e. "Division" means the Division of Medical Assistance and
21 Health Services.

22 f. "Medicaid" means the New Jersey Medical Assistance and
23 Health Services Program.

24 g. "Medical assistance" means payments on behalf of recipients
25 to providers for medical care and services authorized under
26 P.L.1968, c.413.

27 h. "Provider" means any person, public or private institution,
28 agency, or business concern approved by the division lawfully
29 providing medical care, services, goods, and supplies authorized
30 under P.L.1968, c.413, holding, where applicable, a current valid
31 license to provide such services or to dispense such goods or
32 supplies.

33 i. "Qualified applicant" means a person who is a resident of
34 this State, and either a citizen of the United States or an eligible
35 alien, and is determined to need medical care and services as
36 provided under P.L.1968, c.413, with respect to whom the period
37 for which eligibility to be a recipient is determined shall be the
38 maximum period permitted under federal law, and who:

39 (1) Is a dependent child or parent or caretaker relative of a
40 dependent child who would be, except for resources, eligible for the
41 aid to families with dependent children program under the State
42 Plan for Title IV-A of the federal Social Security Act as of July 16,
43 1996;

44 (2) Is a recipient of Supplemental Security Income for the Aged,
45 Blind and Disabled under Title XVI of the Social Security Act;

**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.

- 1 (3) Is an "ineligible spouse" of a recipient of Supplemental
2 Security Income for the Aged, Blind and Disabled under Title XVI
3 of the Social Security Act, as defined by the federal Social Security
4 Administration;
- 5 (4) Would be eligible to receive Supplemental Security Income
6 under Title XVI of the federal Social Security Act or, without
7 regard to resources, would be eligible for the aid to families with
8 dependent children program under the State Plan for Title IV-A of
9 the federal Social Security Act as of July 16, 1996, except for
10 failure to meet an eligibility condition or requirement imposed
11 under such State program which is prohibited under Title XIX of
12 the federal Social Security Act such as a durational residency
13 requirement, relative responsibility, consent to imposition of a lien;
- 14 (5) (Deleted by amendment, P.L.2000, c.71).
- 15 (6) Is an individual under 21 years of age who, without regard to
16 resources, would be, except for dependent child requirements,
17 eligible for the aid to families with dependent children program
18 under the State Plan for Title IV-A of the federal Social Security
19 Act as of July 16, 1996, or groups of such individuals, including but
20 not limited to, children in resource family placement under
21 supervision of the Division of Child Protection and Permanency in
22 the Department of Children and Families whose maintenance is
23 being paid in whole or in part from public funds, children placed in
24 a resource family home or institution by a private adoption agency
25 in New Jersey or children in intermediate care facilities, including
26 developmental centers for the developmentally disabled, or in
27 psychiatric hospitals;
- 28 (7) Would be eligible for the Supplemental Security Income
29 program, but is not receiving such assistance and applies for
30 medical assistance only;
- 31 (8) Is determined to be medically needy and meets all the
32 eligibility requirements described below:
- 33 (a) The following individuals are eligible for services, if they
34 are determined to be medically needy:
- 35 (i) Pregnant women;
- 36 (ii) Dependent children under the age of 21;
- 37 (iii) Individuals who are 65 years of age and older; and
- 38 (iv) Individuals who are blind or disabled pursuant to either 42
39 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
- 40 (b) The following income standard shall be used to determine
41 medically needy eligibility:
- 42 (i) For one person and two person households, the income
43 standard shall be the maximum allowable under federal law, but
44 shall not exceed 133 1/3% of the State's payment level to two
45 person households under the aid to families with dependent children
46 program under the State Plan for Title IV-A of the federal Social
47 Security Act in effect as of July 16, 1996; and

1 (ii) For households of three or more persons, the income standard
2 shall be set at 133 1/3% of the State's payment level to similar size
3 households under the aid to families with dependent children
4 program under the State Plan for Title IV-A of the federal Social
5 Security Act in effect as of July 16, 1996.

6 (c) The following resource standard shall be used to determine
7 medically needy eligibility:

8 (i) For one person households, the resource standard shall be
9 200% of the resource standard for recipients of Supplemental
10 Security Income pursuant to 42 U.S.C. s.1382(1)(B);

11 (ii) For two person households, the resource standard shall be
12 200% of the resource standard for recipients of Supplemental
13 Security Income pursuant to 42 U.S.C. s.1382(2)(B);

14 (iii) For households of three or more persons, the resource
15 standard in subparagraph (c)(ii) above shall be increased by
16 \$100.00 for each additional person; and

17 (iv) The resource standards established in (i), (ii), and (iii) are
18 subject to federal approval and the resource standard may be lower
19 if required by the federal Department of Health and Human
20 Services.

21 (d) Individuals whose income exceeds those established in
22 subparagraph (b) of paragraph (8) of this subsection may become
23 medically needy by incurring medical expenses as defined in 42
24 C.F.R.435.831(c) which will reduce their income to the applicable
25 medically needy income established in subparagraph (b) of
26 paragraph (8) of this subsection.

27 (e) A six-month period shall be used to determine whether an
28 individual is medically needy.

29 (f) Eligibility determinations for the medically needy program
30 shall be administered as follows:

31 (i) County welfare agencies and other entities designated by the
32 commissioner are responsible for determining and certifying the
33 eligibility of pregnant women and dependent children. The division
34 shall reimburse county welfare agencies for 100% of the reasonable
35 costs of administration which are not reimbursed by the federal
36 government for the first 12 months of this program's operation.
37 Thereafter, 75% of the administrative costs incurred by county
38 welfare agencies which are not reimbursed by the federal
39 government shall be reimbursed by the division;

40 (ii) The division is responsible for certifying the eligibility of
41 individuals who are 65 years of age and older and individuals who
42 are blind or disabled. The division may enter into contracts with
43 county welfare agencies to determine certain aspects of eligibility.
44 In such instances the division shall provide county welfare agencies
45 with all information the division may have available on the
46 individual.

47 The division shall notify all eligible recipients of the
48 Pharmaceutical Assistance to the Aged and Disabled program,

1 P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the
2 medically needy program and the program's general requirements.
3 The division shall take all reasonable administrative actions to
4 ensure that Pharmaceutical Assistance to the Aged and Disabled
5 recipients, who notify the division that they may be eligible for the
6 program, have their applications processed expeditiously, at times
7 and locations convenient to the recipients; and

8 (iii) The division is responsible for certifying incurred medical
9 expenses for all eligible persons who attempt to qualify for the
10 program pursuant to subparagraph (d) of paragraph (8) of this
11 subsection;

12 (9) (a) Is a child who is at least one year of age and under 19
13 years of age and, if older than six years of age but under 19 years of
14 age, is uninsured; and

15 (b) Is a member of a family whose income does not exceed
16 133% of the poverty level and who meets the federal Medicaid
17 eligibility requirements set forth in section 9401 of Pub.L.99-509
18 (42 U.S.C. s.1396a);

19 (10) Is a pregnant woman who is determined by a provider to be
20 presumptively eligible for medical assistance based on criteria
21 established by the commissioner, pursuant to section 9407 of
22 Pub.L.99-509 (42 U.S.C. s.1396a(a));

23 (11) Is an individual 65 years of age and older, or an individual
24 who is blind or disabled pursuant to section 301 of Pub.L.92-603
25 (42 U.S.C. s.1382c), whose income does not exceed 100% of the
26 poverty level, adjusted for family size, and whose resources do not
27 exceed 100% of the resource standard used to determine medically
28 needy eligibility pursuant to paragraph (8) of this subsection;

29 (12) Is a qualified disabled and working individual pursuant to
30 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
31 does not exceed 200% of the poverty level and whose resources do
32 not exceed 200% of the resource standard used to determine
33 eligibility under the Supplemental Security Income Program,
34 P.L.1973, c.256 (C.44:7-85 et seq.);

35 (13) Is a pregnant woman or is a child who is under one year of
36 age and is a member of a family whose income does not exceed
37 185% of the poverty level and who meets the federal Medicaid
38 eligibility requirements set forth in section 9401 of Pub.L.99-509
39 (42 U.S.C. s.1396a), except that a pregnant woman who is
40 determined to be a qualified applicant shall, notwithstanding any
41 change in the income of the family of which she is a member,
42 continue to be deemed a qualified applicant until the end of the 60-
43 day period beginning on the last day of her pregnancy;

44 (14) (Deleted by amendment, P.L.1997, c.272).

45 (15) (a) Is a specified low-income Medicare beneficiary pursuant
46 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January
47 1, 1993 do not exceed 200% of the resource standard used to
48 determine eligibility under the Supplemental Security Income

1 program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income
2 beginning January 1, 1993 does not exceed 110% of the poverty
3 level, and beginning January 1, 1995 does not exceed 120% of the
4 poverty level.

5 (b) An individual who has, within 36 months, or within 60
6 months in the case of funds transferred into a trust, of applying to
7 be a qualified applicant for Medicaid services in a nursing facility
8 or a medical institution, or for home or community-based services
9 under section 1915(c) of the federal Social Security Act (42 U.S.C.
10 s.1396n(c)), disposed of resources or income for less than fair
11 market value shall be ineligible for assistance for nursing facility
12 services, an equivalent level of services in a medical institution, or
13 home or community-based services under section 1915(c) of the
14 federal Social Security Act (42 U.S.C. s.1396n(c)). The period of
15 the ineligibility shall be the number of months resulting from
16 dividing the uncompensated value of the transferred resources or
17 income by the average monthly private payment rate for nursing
18 facility services in the State as determined annually by the
19 commissioner. In the case of multiple resource or income transfers,
20 the resulting penalty periods shall be imposed sequentially.
21 Application of this requirement shall be governed by 42 U.S.C.
22 s.1396p(c). In accordance with federal law, this provision is
23 effective for all transfers of resources or income made on or after
24 August 11, 1993. Notwithstanding the provisions of this subsection
25 to the contrary, the State eligibility requirements concerning
26 resource or income transfers shall not be more restrictive than those
27 enacted pursuant to 42 U.S.C. s.1396p(c).

28 (c) An individual seeking nursing facility services or home or
29 community-based services and who has a community spouse shall
30 be required to expend those resources which are not protected for
31 the needs of the community spouse in accordance with section
32 1924(c) of the federal Social Security Act (42 U.S.C. s.1396r-5(c))
33 on the costs of long-term care, burial arrangements, and any other
34 expense deemed appropriate and authorized by the commissioner.
35 An individual shall be ineligible for Medicaid services in a nursing
36 facility or for home or community-based services under section
37 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)) if
38 the individual expends funds in violation of this subparagraph. The
39 period of ineligibility shall be the number of months resulting from
40 dividing the uncompensated value of transferred resources and
41 income by the average monthly private payment rate for nursing
42 facility services in the State as determined by the commissioner.
43 The period of ineligibility shall begin with the month that the
44 individual would otherwise be eligible for Medicaid coverage for
45 nursing facility services or home or community-based services.

46 This subparagraph shall be operative only if all necessary
47 approvals are received from the federal government including, but

1 not limited to, approval of necessary State plan amendments and
2 approval of any waivers;

3 (16) Subject to federal approval under Title XIX of the federal
4 Social Security Act, is a dependent child, parent or specified
5 caretaker relative of a child who is a qualified applicant, who would
6 be eligible, without regard to resources, for the aid to families with
7 dependent children program under the State Plan for Title IV-A of
8 the federal Social Security Act as of July 16, 1996, except for the
9 income eligibility requirements of that program, and whose family
10 earned income,

11 (a) if a dependent child, does not exceed 133% of the poverty
12 level; and

13 (b) if a parent or specified caretaker relative, beginning
14 September 1, 2005 does not exceed 100% of the poverty level,
15 beginning September 1, 2006 does not exceed 115% of the poverty
16 level and beginning September 1, 2007 does not exceed 133% of
17 the poverty level,

18 plus such earned income disregards as shall be determined
19 according to a methodology to be established by regulation of the
20 commissioner;

21 The commissioner may increase the income eligibility limits for
22 children and parents and specified caretaker relatives, as funding
23 permits;

24 (17) Is an individual from 18 through 20 years of age who is not
25 a dependent child and would be eligible for medical assistance
26 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
27 income or resources, who, on the individual's 18th birthday was in
28 resource family care under the care and custody of the Division of
29 Child Protection and Permanency in the Department of Children
30 and Families and whose maintenance was being paid in whole or in
31 part from public funds;

32 (18) Is a person between the ages of 16 and 65 who is
33 permanently disabled and working, and:

34 (a) whose income is at or below 250% of the poverty level, plus
35 other established disregards;

36 (b) who pays the premium contribution and other cost sharing as
37 established by the commissioner, subject to the limits and
38 conditions of federal law; and

39 (c) whose assets, resources and unearned income do not exceed
40 limitations as established by the commissioner;

41 (19) Is an uninsured individual under 65 years of age who:

42 (a) has been screened for breast or cervical cancer under the
43 federal Centers for Disease Control and Prevention breast and
44 cervical cancer early detection program;

45 (b) requires treatment for breast or cervical cancer based upon
46 criteria established by the commissioner;

47 (c) has an income that does not exceed the income standard
48 established by the commissioner pursuant to federal guidelines;

1 (d) meets all other Medicaid eligibility requirements; and

2 (e) in accordance with Pub.L.106-354, is determined by a
3 qualified entity to be presumptively eligible for medical assistance
4 pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established
5 by the commissioner pursuant to section 1920B of the federal Social
6 Security Act (42 U.S.C. s.1396r-1b); **【or】**

7 (20) Subject to federal approval under Title XIX of the federal
8 Social Security Act, is a single adult or couple, without dependent
9 children, whose income in 2006 does not exceed 50% of the poverty
10 level, in 2007 does not exceed 75% of the poverty level and in 2008
11 and each year thereafter does not exceed 100% of the poverty level;
12 except that a person who is a recipient of Work First New Jersey
13 general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107
14 et seq.), shall not be a qualified applicant; or

15 (21) is an individual who:

16 (a) has an income that does not exceed the highest income
17 eligibility level for pregnant women established under the State
18 plan under Title XIX or Title XXI of the federal Social Security
19 Act;

20 (b) is not pregnant; and

21 (c) is eligible to receive family planning services provided
22 under the Medicaid program pursuant to subsection k. of section 6
23 of P.L.1968, c.413 (C.30:4D-6) and in accordance with 42 U.S.C.
24 s.1396a(ii).

25 j. "Recipient" means any qualified applicant receiving benefits
26 under this act.

27 k. "Resident" means a person who is living in the State
28 voluntarily with the intention of making his home here and not for a
29 temporary purpose. Temporary absences from the State, with
30 subsequent returns to the State or intent to return when the purposes
31 of the absences have been accomplished, do not interrupt continuity
32 of residence.

33 l. "State Medicaid Commission" means the Governor, the
34 Commissioner of Human Services, the President of the Senate and
35 the Speaker of the General Assembly, hereby constituted a
36 commission to approve and direct the means and method for the
37 payment of claims pursuant to P.L.1968, c.413.

38 m. "Third party" means any person, institution, corporation,
39 insurance company, group health plan as defined in section 607(1)
40 of the federal "Employee Retirement and Income Security Act of
41 1974," 29 U.S.C. s.1167(1), service benefit plan, health
42 maintenance organization, or other prepaid health plan, or public,
43 private or governmental entity who is or may be liable in contract,
44 tort, or otherwise by law or equity to pay all or part of the medical
45 cost of injury, disease or disability of an applicant for or recipient
46 of medical assistance payable under P.L.1968, c.413.

47 n. "Governmental peer grouping system" means a separate
48 class of skilled nursing and intermediate care facilities administered

1 by the State or county governments, established for the purpose of
2 screening their reported costs and setting reimbursement rates under
3 the Medicaid program that are reasonable and adequate to meet the
4 costs that must be incurred by efficiently and economically operated
5 State or county skilled nursing and intermediate care facilities.

6 o. "Comprehensive maternity or pediatric care provider" means
7 any person or public or private health care facility that is a provider
8 and that is approved by the commissioner to provide comprehensive
9 maternity care or comprehensive pediatric care as defined in
10 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
11 (C.30:4D-6).

12 p. "Poverty level" means the official poverty level based on
13 family size established and adjusted under Section 673(2) of
14 Subtitle B, the "Community Services Block Grant Act," of
15 Pub.L.97-35 (42 U.S.C. s.9902(2)).

16 q. "Eligible alien" means one of the following:

17 (1) an alien present in the United States prior to August 22,
18 1996, who is:

19 (a) a lawful permanent resident;

20 (b) a refugee pursuant to section 207 of the federal "Immigration
21 and Nationality Act" (8 U.S.C. s.1157);

22 (c) an asylee pursuant to section 208 of the federal
23 "Immigration and Nationality Act" (8 U.S.C. s.1158);

24 (d) an alien who has had deportation withheld pursuant to
25 section 243(h) of the federal "Immigration and Nationality Act" (8
26 U.S.C. s.1253 (h));

27 (e) an alien who has been granted parole for less than one year
28 by the U.S. Citizenship and Immigration Services pursuant to
29 section 212(d)(5) of the federal "Immigration and Nationality Act"
30 (8 U.S.C. s.1182(d)(5));

31 (f) an alien granted conditional entry pursuant to section
32 203(a)(7) of the federal "Immigration and Nationality Act" (8
33 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or

34 (g) an alien who is honorably discharged from or on active duty
35 in the United States armed forces and the alien's spouse and
36 unmarried dependent child.

37 (2) An alien who entered the United States on or after August
38 22, 1996, who is:

39 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of
40 this subsection; or

41 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
42 subsection who entered the United States at least five years ago.

43 (3) A legal alien who is a victim of domestic violence in
44 accordance with criteria specified for eligibility for public benefits
45 as provided in Title V of the federal "Illegal Immigration Reform
46 and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).

47 (cf: P.L.2012, c.16, s.114)

1 2. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
2 as follows:

3 6. a. Subject to the requirements of Title XIX of the federal
4 Social Security Act, the limitations imposed by this act and by the
5 rules and regulations promulgated pursuant thereto, the department
6 shall provide medical assistance to qualified applicants, including
7 authorized services within each of the following classifications:

- 8 (1) Inpatient hospital services;
- 9 (2) Outpatient hospital services;
- 10 (3) Other laboratory and X-ray services;
- 11 (4) (a) Skilled nursing or intermediate care facility services;
- 12 (b) Early and periodic screening and diagnosis of individuals
13 who are eligible under the program and are under age 21, to
14 ascertain their physical or mental defects and the health care,
15 treatment, and other measures to correct or ameliorate defects and
16 chronic conditions discovered thereby, as may be provided in
17 regulations of the Secretary of the federal Department of Health and
18 Human Services and approved by the commissioner;
- 19 (5) Physician's services furnished in the office, the patient's
20 home, a hospital, a skilled nursing, or intermediate care facility or
21 elsewhere.

22 As used in this subsection, "laboratory and X-ray services"
23 includes HIV drug resistance testing, including, but not limited to,
24 genotype assays that have been cleared or approved by the federal
25 Food and Drug Administration, laboratory developed genotype
26 assays, phenotype assays, and other assays using phenotype
27 prediction with genotype comparison, for persons diagnosed with
28 HIV infection or AIDS.

29 b. Subject to the limitations imposed by federal law, by this
30 act, and by the rules and regulations promulgated pursuant thereto,
31 the medical assistance program may be expanded to include
32 authorized services within each of the following classifications:

- 33 (1) Medical care not included in subsection a.(5) above, or any
34 other type of remedial care recognized under State law, furnished
35 by licensed practitioners within the scope of their practice, as
36 defined by State law;
- 37 (2) Home health care services;
- 38 (3) Clinic services;
- 39 (4) Dental services;
- 40 (5) Physical therapy and related services;
- 41 (6) Prescribed drugs, dentures, and prosthetic devices; and
42 eyeglasses prescribed by a physician skilled in diseases of the eye
43 or by an optometrist, whichever the individual may select;
- 44 (7) Optometric services;
- 45 (8) Podiatric services;
- 46 (9) Chiropractic services;
- 47 (10) Psychological services;

- 1 (11) Inpatient psychiatric hospital services for individuals under
- 2 21 years of age, or under age 22 if they are receiving such services
- 3 immediately before attaining age 21;
- 4 (12) Other diagnostic, screening, preventive, and rehabilitative
- 5 services, and other remedial care;
- 6 (13) Inpatient hospital services, nursing facility services, and
- 7 intermediate care facility services for individuals 65 years of age or
- 8 over in an institution for mental diseases;
- 9 (14) Intermediate care facility services;
- 10 (15) Transportation services;
- 11 (16) Services in connection with the inpatient or outpatient
- 12 treatment or care of drug abuse, when the treatment is prescribed by
- 13 a physician and provided in a licensed hospital or in a narcotic and
- 14 drug abuse treatment center approved by the Department of Health
- 15 pursuant to P.L.1970, c.334 (C.26:2G-21 et seq.) and whose staff
- 16 includes a medical director, and limited to those services eligible
- 17 for federal financial participation under Title XIX of the federal
- 18 Social Security Act;
- 19 (17) Any other medical care and any other type of remedial care
- 20 recognized under State law, specified by the Secretary of the federal
- 21 Department of Health and Human Services, and approved by the
- 22 commissioner;
- 23 (18) Comprehensive maternity care, which may include: the
- 24 basic number of prenatal and postpartum visits recommended by the
- 25 American College of Obstetrics and Gynecology; additional
- 26 prenatal and postpartum visits that are medically necessary;
- 27 necessary laboratory, nutritional assessment and counseling, health
- 28 education, personal counseling, managed care, outreach, and
- 29 follow-up services; treatment of conditions which may complicate
- 30 pregnancy; and physician or certified nurse-midwife delivery
- 31 services;
- 32 (19) Comprehensive pediatric care, which may include:
- 33 ambulatory, preventive, and primary care health services. The
- 34 preventive services shall include, at a minimum, the basic number
- 35 of preventive visits recommended by the American Academy of
- 36 Pediatrics;
- 37 (20) Services provided by a hospice which is participating in the
- 38 Medicare program established pursuant to Title XVIII of the Social
- 39 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
- 40 services shall be provided subject to approval of the Secretary of
- 41 the federal Department of Health and Human Services for federal
- 42 reimbursement;
- 43 (21) Mammograms, subject to approval of the Secretary of the
- 44 federal Department of Health and Human Services for federal
- 45 reimbursement, including one baseline mammogram for women
- 46 who are at least 35 but less than 40 years of age; one mammogram
- 47 examination every two years or more frequently, if recommended
- 48 by a physician, for women who are at least 40 but less than 50 years

1 of age; and one mammogram examination every year for women
2 age 50 and over.

3 c. Payments for the foregoing services, goods, and supplies
4 furnished pursuant to this act shall be made to the extent authorized
5 by this act, the rules and regulations promulgated pursuant thereto
6 and, where applicable, subject to the agreement of insurance
7 provided for under this act. The payments shall constitute payment
8 in full to the provider on behalf of the recipient. Every provider
9 making a claim for payment pursuant to this act shall certify in
10 writing on the claim submitted that no additional amount will be
11 charged to the recipient, the recipient's family, the recipient's
12 representative or others on the recipient's behalf for the services,
13 goods, and supplies furnished pursuant to this act.

14 No provider whose claim for payment pursuant to this act has
15 been denied because the services, goods, or supplies were
16 determined to be medically unnecessary shall seek reimbursement
17 from the recipient, his family, his representative or others on his
18 behalf for such services, goods, and supplies provided pursuant to
19 this act; provided, however, a provider may seek reimbursement
20 from a recipient for services, goods, or supplies not authorized by
21 this act, if the recipient elected to receive the services, goods or
22 supplies with the knowledge that they were not authorized.

23 d. Any individual eligible for medical assistance (including
24 drugs) may obtain such assistance from any person qualified to
25 perform the service or services required (including an organization
26 which provides such services, or arranges for their availability on a
27 prepayment basis), who undertakes to provide the individual such
28 services.

29 No copayment or other form of cost-sharing shall be imposed on
30 any individual eligible for medical assistance, except as mandated
31 by federal law as a condition of federal financial participation.

32 e. Anything in this act to the contrary notwithstanding, no
33 payments for medical assistance shall be made under this act with
34 respect to care or services for any individual who:

35 (1) Is an inmate of a public institution (except as a patient in a
36 medical institution); provided, however, that an individual who is
37 otherwise eligible may continue to receive services for the month in
38 which he becomes an inmate, should the commissioner determine to
39 expand the scope of Medicaid eligibility to include such an
40 individual, subject to the limitations imposed by federal law and
41 regulations, or

42 (2) Has not attained 65 years of age and who is a patient in an
43 institution for mental diseases, or

44 (3) Is over 21 years of age and who is receiving inpatient
45 psychiatric hospital services in a psychiatric facility; provided,
46 however, that an individual who was receiving such services
47 immediately prior to attaining age 21 may continue to receive such
48 services until the individual reaches age 22. Nothing in this

1 subsection shall prohibit the commissioner from extending medical
2 assistance to all eligible persons receiving inpatient psychiatric
3 services; provided that there is federal financial participation
4 available.

5 f. (1) A third party as defined in section 3 of P.L.1968, c.413
6 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
7 this or another state when determining the person's eligibility for
8 enrollment or the provision of benefits by that third party.

9 (2) In addition, any provision in a contract of insurance, health
10 benefits plan, or other health care coverage document, will, trust,
11 agreement, court order, or other instrument which reduces or
12 excludes coverage or payment for health care-related goods and
13 services to or for an individual because of that individual's actual or
14 potential eligibility for or receipt of Medicaid benefits shall be null
15 and void, and no payments shall be made under this act as a result
16 of any such provision.

17 (3) Notwithstanding any provision of law to the contrary, the
18 provisions of paragraph (2) of this subsection shall not apply to a
19 trust agreement that is established pursuant to 42 U.S.C.
20 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
21 provided by government entities to a person who is disabled as
22 defined in section 1614(a)(3) of the federal Social Security Act (42
23 U.S.C. s.1382c (a)(3)).

24 g. The following services shall be provided to eligible
25 medically needy individuals as follows:

26 (1) Pregnant women shall be provided prenatal care and delivery
27 services and postpartum care, including the services cited in
28 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
29 (10), (12), (15), and (17) of this section, and nursing facility
30 services cited in subsection b.(13) of this section.

31 (2) Dependent children shall be provided with services cited in
32 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
33 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
34 nursing facility services cited in subsection b.(13) of this section.

35 (3) Individuals who are 65 years of age or older shall be
36 provided with services cited in subsection a.(3) and (5) of this
37 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
38 (8), (10), (12), (15), and (17) of this section, and nursing facility
39 services cited in subsection b.(13) of this section.

40 (4) Individuals who are blind or disabled shall be provided with
41 services cited in subsection a.(3) and (5) of this section and
42 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
43 (12), (15), and (17) of this section, and nursing facility services
44 cited in subsection b.(13) of this section.

45 (5) (a) Inpatient hospital services, subsection a.(1) of this
46 section, shall only be provided to eligible medically needy
47 individuals, other than pregnant women, if the federal Department
48 of Health and Human Services discontinues the State's waiver to

1 establish inpatient hospital reimbursement rates for the Medicare
2 and Medicaid programs under the authority of section 601(c)(3) of
3 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
4 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
5 extended to other eligible medically needy individuals if the federal
6 Department of Health and Human Services directs that these
7 services be included.

8 (b) Outpatient hospital services, subsection a.(2) of this section,
9 shall only be provided to eligible medically needy individuals if the
10 federal Department of Health and Human Services discontinues the
11 State's waiver to establish outpatient hospital reimbursement rates
12 for the Medicare and Medicaid programs under the authority of
13 section 601(c)(3) of the Social Security Amendments of 1983,
14 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
15 services may be extended to all or to certain medically needy
16 individuals if the federal Department of Health and Human Services
17 directs that these services be included. However, the use of
18 outpatient hospital services shall be limited to clinic services and to
19 emergency room services for injuries and significant acute medical
20 conditions.

21 (c) The division shall monitor the use of inpatient and outpatient
22 hospital services by medically needy persons.

23 h. In the case of a qualified disabled and working individual
24 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
25 only medical assistance provided under this act shall be the
26 payment of premiums for Medicare part A under 42 U.S.C.
27 ss.1395i-2 and 1395r.

28 i. In the case of a specified low-income Medicare beneficiary
29 pursuant to 42 U.S.C. s.1396a(a)(10)(E)iii, the only medical
30 assistance provided under this act shall be the payment of premiums
31 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
32 U.S.C. s.1396d(p)(3)(A)(ii).

33 j. In the case of a qualified individual pursuant to 42 U.S.C.
34 s.1396a(aa), the only medical assistance provided under this act
35 shall be payment for authorized services provided during the period
36 in which the individual requires treatment for breast or cervical
37 cancer, in accordance with criteria established by the commissioner.

38 k. In the case of a qualified individual pursuant to 42 U.S.C.
39 s.1396a(ii), the only medical assistance provided under this act shall
40 be payment for family planning services and supplies as described
41 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
42 treatment services that are provided pursuant to a family planning
43 service in a family planning setting.

44 (cf: P.L.2012, c.17, s.359)

45
46 3. The Commissioner of Human Services, pursuant to the
47 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et

1 seq.), shall adopt rules and regulations necessary to implement the
2 provisions of this act.

3
4 4. This act shall take effect on the first day of the fourth month
5 next following the date of enactment, but the Commissioner of
6 Human Services may take such anticipatory administrative action in
7 advance thereof, including, but not limited to, the submission of a
8 State plan amendment to the federal Centers for Medicare &
9 Medicaid Services, as may be necessary for the implementation of
10 this act.

11

12

13

STATEMENT

14

15 This bill would provide Medicaid coverage for family planning
16 services to individuals whose income does not exceed 200 percent
17 of the federal poverty level.

18 Specifically, the bill expands coverage of family planning
19 services to non-pregnant individuals whose income does not exceed
20 the highest income eligibility level established for pregnant women
21 under the State plan under Title XIX or Title XXI of the federal
22 Social Security Act (Medicaid and the Children's Health Insurance
23 Program, respectively), which is currently 200 percent of the
24 federal poverty level in New Jersey.

25 This bill would exercise a new State option provided under the
26 federal "Patient Protection and Affordable Care Act," Pub.L.111-
27 148, as amended by the "Health Care and Education Reconciliation
28 Act of 2010," Pub.L.111-152, which permits states to expand
29 family planning services through a State plan amendment, rather
30 than through a demonstration waiver under section 1115 of the
31 Social Security Act. Under federal law, the federal government
32 would pay 90 percent of the costs for these services.

33 The bill takes effect on the first day of the fourth month
34 following its enactment, but authorizes the Commissioner of Human
35 Services to take such prior administrative action as may be
36 necessary for implementation.

SENATE HEALTH, HUMAN SERVICES AND SENIOR
CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 105

STATE OF NEW JERSEY

DATED: JANUARY 22, 2018

The Senate Health, Human Services and Senior Citizens Committee reports favorably Senate Bill No. 105.

This bill would provide Medicaid coverage for family planning services to individuals whose income does not exceed 200 percent of the federal poverty level.

Specifically, the bill expands coverage for family planning services provided to non-pregnant individuals whose income does not exceed the highest income eligibility level established for pregnant women under the State plan under Title XIX or Title XXI of the federal Social Security Act (Medicaid and the Children's Health Insurance Program, respectively), which is currently 200 percent of the federal poverty level in New Jersey.

This bill would exercise a new State option provided under the federal "Patient Protection and Affordable Care Act," Pub.L.111- 148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, which permits states to expand family planning services through a State plan amendment, rather than through a demonstration waiver under section 1115 of the Social Security Act. Under federal law, the federal government would pay 90 percent of the costs for these services.

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

LEGISLATIVE FISCAL ESTIMATE
SENATE, No. 105
STATE OF NEW JERSEY
218th LEGISLATURE

DATED: FEBRUARY 8, 2018

SUMMARY

Synopsis: Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

Type of Impact: Annual expenditure increase to the State General Fund; partially offset by enhanced federal Medicaid funds.

Agencies Affected: Department of Human Services.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
Annual State Expenditure Increase	Indeterminate – See comments below
Annual State Revenue Increase	Indeterminate – See comments below

- The Office of Legislative Services (OLS) estimates that the State may incur annual net costs to provide family planning services to individuals who enroll in the Medicaid family planning expansion established by the bill. However, due to the fairly narrow target population and the 90 percent federal matching rate, total annual net State costs are likely to be insignificant.

BILL DESCRIPTION

This bill would provide Medicaid coverage for family planning services to individuals whose income does not exceed 200 percent of the federal poverty level.

Specifically, the bill would expand coverage of family planning services to non-pregnant individuals whose income does not exceed the highest income eligibility level established for pregnant women under the State plan under Title XIX or Title XXI of the federal Social Security Act (Medicaid and the Children’s Health Insurance Program, respectively), which is currently 200 percent of the federal poverty level in New Jersey.

This bill would exercise a State option provided under the federal Affordable Care Act, which permits states to expand family planning services through a State plan amendment, rather than through a demonstration waiver under section 1115 of the Social Security Act. The federal government would pay 90 percent of the costs for these services.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates that the State may incur annual net costs to provide family planning services to individuals who enroll in the Medicaid family planning expansion established by the bill. It is not possible to quantify the total annual net State costs for this expansion, but they are likely to be insignificant because the federal Affordable Care Act provides that 90 percent of the total costs would be covered by the federal government and because it is likely that only a fairly small number of individuals would be eligible and apply for the program.

Due to the Affordable Care Act, individuals who earn less than 138 percent of the federal poverty level are eligible for Medicaid, which covers family planning services. Therefore, the bill's program would be targeted to people who earn between 138 percent and 200 percent of the federal poverty level. Many of the individuals who have this earnings level may also qualify for heavily subsidized health insurance through the Affordable Care Act and thus may also already have access to family planning services. It is not possible for the OLS to determine the number of individuals who meet the financial eligibility criteria but do not purchase insurance and need access to family planning services, but it is likely to be marginal. Without information on the number of likely recipients, the OLS cannot quantify the cost of this legislation, but it is likely to be insignificant.

Section: *Human Services*

Analyst: *David Drescher*
 Senior Fiscal Analyst

Approved: *Frank W. Haines III*
 Legislative Budget and Finance Officer

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

ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

SENATE, No. 105

STATE OF NEW JERSEY

DATED: FEBRUARY 12, 2018

The Assembly Budget Committee reports favorably Senate Bill No. 105.

This bill provides Medicaid coverage for family planning services to individuals whose income does not exceed 200 percent of the federal poverty level.

Specifically, the bill expands coverage of family planning services to non-pregnant individuals whose income does not exceed the highest income eligibility level established for pregnant women under the State plan under Title XIX or Title XXI of the federal Social Security Act (Medicaid and the Children's Health Insurance Program, respectively), which is currently 200 percent of the federal poverty level in New Jersey.

This bill exercises a new State option provided under the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, which permits states to expand family planning services through a State plan amendment, rather than through a demonstration waiver under section 1115 of the Social Security Act. Under federal law, the federal government would pay 90 percent of the costs for these services.

The bill takes effect on the first day of the fourth month following its enactment, but authorizes the Commissioner of Human Services to take such prior administrative action as may be necessary for its implementation.

As reported, this bill is identical to Assembly Bill No. 1656, as also reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services (OLS) estimates that this bill may cause the State to incur costs to provide family planning services to individuals who enroll in the Medicaid family planning expansion established by the bill. However, due to the fairly narrow target population and the 90 percent federal matching rate, total State costs are likely to be minimal.

SENATE, No. 105

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Senator LORETTA WEINBERG

District 37 (Bergen)

Senator LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Assemblywoman ELIANA PINTOR MARIN

District 29 (Essex)

Assemblyman JOSEPH A. LAGANA

District 38 (Bergen and Passaic)

Assemblywoman MILA M. JASEY

District 27 (Essex and Morris)

Assemblyman RAJ MUKHERJI

District 33 (Hudson)

Assemblywoman JOANN DOWNEY

District 11 (Monmouth)

Co-Sponsored by:

Senators Cunningham, Pou, Ruiz, Codey, Gopal, Sarlo, Assemblyman McKeon, Assemblywomen Mosquera, Muoio, Caride, Assemblymen Houghtaling, Johnson, Kennedy, Assemblywomen Tucker, Pinkin, Assemblymen Coughlin, Benson, Wimberly, Assemblywoman Vainieri Huttel, Assemblyman Holley, Assemblywomen Reynolds-Jackson, Murphy, McKnight and Quijano

SYNOPSIS

Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

CURRENT VERSION OF TEXT

As reported by the Senate Health, Human Services and Senior Citizens Committee with technical review.

(Sponsorship Updated As Of: 2/16/2018)

1 **AN ACT** concerning Medicaid coverage for family planning services
2 and amending P.L.1968, c.413.

3

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

6

7 1. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read
8 as follows:

9 3. Definitions. As used in P.L.1968, c.413 (C.30:4D-1 et seq.),
10 and unless the context otherwise requires:

11 a. "Applicant" means any person who has made application for
12 purposes of becoming a "qualified applicant."

13 b. "Commissioner" means the Commissioner of Human
14 Services.

15 c. "Department" means the Department of Human Services,
16 which is herein designated as the single State agency to administer
17 the provisions of this act.

18 d. "Director" means the Director of the Division of Medical
19 Assistance and Health Services.

20 e. "Division" means the Division of Medical Assistance and
21 Health Services.

22 f. "Medicaid" means the New Jersey Medical Assistance and
23 Health Services Program.

24 g. "Medical assistance" means payments on behalf of recipients
25 to providers for medical care and services authorized under
26 P.L.1968, c.413.

27 h. "Provider" means any person, public or private institution,
28 agency, or business concern approved by the division lawfully
29 providing medical care, services, goods, and supplies authorized
30 under P.L.1968, c.413, holding, where applicable, a current valid
31 license to provide such services or to dispense such goods or
32 supplies.

33 i. "Qualified applicant" means a person who is a resident of
34 this State, and either a citizen of the United States or an eligible
35 alien, and is determined to need medical care and services as
36 provided under P.L.1968, c.413, with respect to whom the period
37 for which eligibility to be a recipient is determined shall be the
38 maximum period permitted under federal law, and who:

39 (1) Is a dependent child or parent or caretaker relative of a
40 dependent child who would be, except for resources, eligible for the
41 aid to families with dependent children program under the State
42 Plan for Title IV-A of the federal Social Security Act as of July 16,
43 1996;

44 (2) Is a recipient of Supplemental Security Income for the Aged,
45 Blind and Disabled under Title XVI of the Social Security Act;

**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.

1 (3) Is an "ineligible spouse" of a recipient of Supplemental
2 Security Income for the Aged, Blind and Disabled under Title XVI
3 of the Social Security Act, as defined by the federal Social Security
4 Administration;

5 (4) Would be eligible to receive Supplemental Security Income
6 under Title XVI of the federal Social Security Act or, without
7 regard to resources, would be eligible for the aid to families with
8 dependent children program under the State Plan for Title IV-A of
9 the federal Social Security Act as of July 16, 1996, except for
10 failure to meet an eligibility condition or requirement imposed
11 under such State program which is prohibited under Title XIX of
12 the federal Social Security Act such as a durational residency
13 requirement, relative responsibility, consent to imposition of a lien;

14 (5) (Deleted by amendment, P.L.2000, c.71).

15 (6) Is an individual under 21 years of age who, without regard to
16 resources, would be, except for dependent child requirements,
17 eligible for the aid to families with dependent children program
18 under the State Plan for Title IV-A of the federal Social Security
19 Act as of July 16, 1996, or groups of such individuals, including but
20 not limited to, children in resource family placement under
21 supervision of the Division of Child Protection and Permanency in
22 the Department of Children and Families whose maintenance is
23 being paid in whole or in part from public funds, children placed in
24 a resource family home or institution by a private adoption agency
25 in New Jersey or children in intermediate care facilities, including
26 developmental centers for the developmentally disabled, or in
27 psychiatric hospitals;

28 (7) Would be eligible for the Supplemental Security Income
29 program, but is not receiving such assistance and applies for
30 medical assistance only;

31 (8) Is determined to be medically needy and meets all the
32 eligibility requirements described below:

33 (a) The following individuals are eligible for services, if they
34 are determined to be medically needy:

35 (i) Pregnant women;

36 (ii) Dependent children under the age of 21;

37 (iii) Individuals who are 65 years of age and older; and

38 (iv) Individuals who are blind or disabled pursuant to either 42
39 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.

40 (b) The following income standard shall be used to determine
41 medically needy eligibility:

42 (i) For one person and two person households, the income
43 standard shall be the maximum allowable under federal law, but
44 shall not exceed 133 1/3% of the State's payment level to two
45 person households under the aid to families with dependent children
46 program under the State Plan for Title IV-A of the federal Social
47 Security Act in effect as of July 16, 1996; and

- 1 (ii) For households of three or more persons, the income standard
2 shall be set at 133 1/3% of the State's payment level to similar size
3 households under the aid to families with dependent children
4 program under the State Plan for Title IV-A of the federal Social
5 Security Act in effect as of July 16, 1996.
- 6 (c) The following resource standard shall be used to determine
7 medically needy eligibility:
- 8 (i) For one person households, the resource standard shall be
9 200% of the resource standard for recipients of Supplemental
10 Security Income pursuant to 42 U.S.C. s.1382(1)(B);
- 11 (ii) For two person households, the resource standard shall be
12 200% of the resource standard for recipients of Supplemental
13 Security Income pursuant to 42 U.S.C. s.1382(2)(B);
- 14 (iii) For households of three or more persons, the resource
15 standard in subparagraph (c)(ii) above shall be increased by
16 \$100.00 for each additional person; and
- 17 (iv) The resource standards established in (i), (ii), and (iii) are
18 subject to federal approval and the resource standard may be lower
19 if required by the federal Department of Health and Human
20 Services.
- 21 (d) Individuals whose income exceeds those established in
22 subparagraph (b) of paragraph (8) of this subsection may become
23 medically needy by incurring medical expenses as defined in 42
24 C.F.R.435.831(c) which will reduce their income to the applicable
25 medically needy income established in subparagraph (b) of
26 paragraph (8) of this subsection.
- 27 (e) A six-month period shall be used to determine whether an
28 individual is medically needy.
- 29 (f) Eligibility determinations for the medically needy program
30 shall be administered as follows:
- 31 (i) County welfare agencies and other entities designated by the
32 commissioner are responsible for determining and certifying the
33 eligibility of pregnant women and dependent children. The division
34 shall reimburse county welfare agencies for 100% of the reasonable
35 costs of administration which are not reimbursed by the federal
36 government for the first 12 months of this program's operation.
37 Thereafter, 75% of the administrative costs incurred by county
38 welfare agencies which are not reimbursed by the federal
39 government shall be reimbursed by the division;
- 40 (ii) The division is responsible for certifying the eligibility of
41 individuals who are 65 years of age and older and individuals who
42 are blind or disabled. The division may enter into contracts with
43 county welfare agencies to determine certain aspects of eligibility.
44 In such instances the division shall provide county welfare agencies
45 with all information the division may have available on the
46 individual.
- 47 The division shall notify all eligible recipients of the
48 Pharmaceutical Assistance to the Aged and Disabled program,

1 P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the
2 medically needy program and the program's general requirements.
3 The division shall take all reasonable administrative actions to
4 ensure that Pharmaceutical Assistance to the Aged and Disabled
5 recipients, who notify the division that they may be eligible for the
6 program, have their applications processed expeditiously, at times
7 and locations convenient to the recipients; and

8 (iii) The division is responsible for certifying incurred medical
9 expenses for all eligible persons who attempt to qualify for the
10 program pursuant to subparagraph (d) of paragraph (8) of this
11 subsection;

12 (9) (a) Is a child who is at least one year of age and under 19
13 years of age and, if older than six years of age but under 19 years of
14 age, is uninsured; and

15 (b) Is a member of a family whose income does not exceed
16 133% of the poverty level and who meets the federal Medicaid
17 eligibility requirements set forth in section 9401 of Pub.L.99-509
18 (42 U.S.C. s.1396a);

19 (10) Is a pregnant woman who is determined by a provider to be
20 presumptively eligible for medical assistance based on criteria
21 established by the commissioner, pursuant to section 9407 of
22 Pub.L.99-509 (42 U.S.C. s.1396a(a));

23 (11) Is an individual 65 years of age and older, or an individual
24 who is blind or disabled pursuant to section 301 of Pub.L.92-603
25 (42 U.S.C. s.1382c), whose income does not exceed 100% of the
26 poverty level, adjusted for family size, and whose resources do not
27 exceed 100% of the resource standard used to determine medically
28 needy eligibility pursuant to paragraph (8) of this subsection;

29 (12) Is a qualified disabled and working individual pursuant to
30 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
31 does not exceed 200% of the poverty level and whose resources do
32 not exceed 200% of the resource standard used to determine
33 eligibility under the Supplemental Security Income Program,
34 P.L.1973, c.256 (C.44:7-85 et seq.);

35 (13) Is a pregnant woman or is a child who is under one year of
36 age and is a member of a family whose income does not exceed
37 185% of the poverty level and who meets the federal Medicaid
38 eligibility requirements set forth in section 9401 of Pub.L.99-509
39 (42 U.S.C. s.1396a), except that a pregnant woman who is
40 determined to be a qualified applicant shall, notwithstanding any
41 change in the income of the family of which she is a member,
42 continue to be deemed a qualified applicant until the end of the 60-
43 day period beginning on the last day of her pregnancy;

44 (14) (Deleted by amendment, P.L.1997, c.272).

45 (15) (a) Is a specified low-income Medicare beneficiary pursuant
46 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January
47 1, 1993 do not exceed 200% of the resource standard used to
48 determine eligibility under the Supplemental Security Income

1 program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income
2 beginning January 1, 1993 does not exceed 110% of the poverty
3 level, and beginning January 1, 1995 does not exceed 120% of the
4 poverty level.

5 (b) An individual who has, within 36 months, or within 60
6 months in the case of funds transferred into a trust, of applying to
7 be a qualified applicant for Medicaid services in a nursing facility
8 or a medical institution, or for home or community-based services
9 under section 1915(c) of the federal Social Security Act (42 U.S.C.
10 s.1396n(c)), disposed of resources or income for less than fair
11 market value shall be ineligible for assistance for nursing facility
12 services, an equivalent level of services in a medical institution, or
13 home or community-based services under section 1915(c) of the
14 federal Social Security Act (42 U.S.C. s.1396n(c)). The period of
15 the ineligibility shall be the number of months resulting from
16 dividing the uncompensated value of the transferred resources or
17 income by the average monthly private payment rate for nursing
18 facility services in the State as determined annually by the
19 commissioner. In the case of multiple resource or income transfers,
20 the resulting penalty periods shall be imposed sequentially.
21 Application of this requirement shall be governed by 42 U.S.C.
22 s.1396p(c). In accordance with federal law, this provision is
23 effective for all transfers of resources or income made on or after
24 August 11, 1993. Notwithstanding the provisions of this subsection
25 to the contrary, the State eligibility requirements concerning
26 resource or income transfers shall not be more restrictive than those
27 enacted pursuant to 42 U.S.C. s.1396p(c).

28 (c) An individual seeking nursing facility services or home or
29 community-based services and who has a community spouse shall
30 be required to expend those resources which are not protected for
31 the needs of the community spouse in accordance with section
32 1924(c) of the federal Social Security Act (42 U.S.C. s.1396r-5(c))
33 on the costs of long-term care, burial arrangements, and any other
34 expense deemed appropriate and authorized by the commissioner.
35 An individual shall be ineligible for Medicaid services in a nursing
36 facility or for home or community-based services under section
37 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)) if
38 the individual expends funds in violation of this subparagraph. The
39 period of ineligibility shall be the number of months resulting from
40 dividing the uncompensated value of transferred resources and
41 income by the average monthly private payment rate for nursing
42 facility services in the State as determined by the commissioner.
43 The period of ineligibility shall begin with the month that the
44 individual would otherwise be eligible for Medicaid coverage for
45 nursing facility services or home or community-based services.

46 This subparagraph shall be operative only if all necessary
47 approvals are received from the federal government including, but

1 not limited to, approval of necessary State plan amendments and
2 approval of any waivers;

3 (16) Subject to federal approval under Title XIX of the federal
4 Social Security Act, is a dependent child, parent or specified
5 caretaker relative of a child who is a qualified applicant, who would
6 be eligible, without regard to resources, for the aid to families with
7 dependent children program under the State Plan for Title IV-A of
8 the federal Social Security Act as of July 16, 1996, except for the
9 income eligibility requirements of that program, and whose family
10 earned income,

11 (a) if a dependent child, does not exceed 133% of the poverty
12 level; and

13 (b) if a parent or specified caretaker relative, beginning
14 September 1, 2005 does not exceed 100% of the poverty level,
15 beginning September 1, 2006 does not exceed 115% of the poverty
16 level and beginning September 1, 2007 does not exceed 133% of
17 the poverty level,

18 plus such earned income disregards as shall be determined
19 according to a methodology to be established by regulation of the
20 commissioner;

21 The commissioner may increase the income eligibility limits for
22 children and parents and specified caretaker relatives, as funding
23 permits;

24 (17) Is an individual from 18 through 20 years of age who is not
25 a dependent child and would be eligible for medical assistance
26 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
27 income or resources, who, on the individual's 18th birthday was in
28 resource family care under the care and custody of the Division of
29 Child Protection and Permanency in the Department of Children
30 and Families and whose maintenance was being paid in whole or in
31 part from public funds;

32 (18) Is a person between the ages of 16 and 65 who is
33 permanently disabled and working, and:

34 (a) whose income is at or below 250% of the poverty level, plus
35 other established disregards;

36 (b) who pays the premium contribution and other cost sharing as
37 established by the commissioner, subject to the limits and
38 conditions of federal law; and

39 (c) whose assets, resources and unearned income do not exceed
40 limitations as established by the commissioner;

41 (19) Is an uninsured individual under 65 years of age who:

42 (a) has been screened for breast or cervical cancer under the
43 federal Centers for Disease Control and Prevention breast and
44 cervical cancer early detection program;

45 (b) requires treatment for breast or cervical cancer based upon
46 criteria established by the commissioner;

47 (c) has an income that does not exceed the income standard
48 established by the commissioner pursuant to federal guidelines;

1 (d) meets all other Medicaid eligibility requirements; and

2 (e) in accordance with Pub.L.106-354, is determined by a
3 qualified entity to be presumptively eligible for medical assistance
4 pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established
5 by the commissioner pursuant to section 1920B of the federal Social
6 Security Act (42 U.S.C. s.1396r-1b); **or**

7 (20) Subject to federal approval under Title XIX of the federal
8 Social Security Act, is a single adult or couple, without dependent
9 children, whose income in 2006 does not exceed 50% of the poverty
10 level, in 2007 does not exceed 75% of the poverty level and in 2008
11 and each year thereafter does not exceed 100% of the poverty level;
12 except that a person who is a recipient of Work First New Jersey
13 general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107
14 et seq.), shall not be a qualified applicant; or

15 (21) is an individual who:

16 (a) has an income that does not exceed the highest income
17 eligibility level for pregnant women established under the State
18 plan under Title XIX or Title XXI of the federal Social Security
19 Act;

20 (b) is not pregnant; and

21 (c) is eligible to receive family planning services provided
22 under the Medicaid program pursuant to subsection k. of section 6
23 of P.L.1968, c.413 (C.30:4D-6) and in accordance with 42 U.S.C.
24 s.1396a(ii).

25 j. "Recipient" means any qualified applicant receiving benefits
26 under this act.

27 k. "Resident" means a person who is living in the State
28 voluntarily with the intention of making his home here and not for a
29 temporary purpose. Temporary absences from the State, with
30 subsequent returns to the State or intent to return when the purposes
31 of the absences have been accomplished, do not interrupt continuity
32 of residence.

33 l. "State Medicaid Commission" means the Governor, the
34 Commissioner of Human Services, the President of the Senate and
35 the Speaker of the General Assembly, hereby constituted a
36 commission to approve and direct the means and method for the
37 payment of claims pursuant to P.L.1968, c.413.

38 m. "Third party" means any person, institution, corporation,
39 insurance company, group health plan as defined in section 607(1)
40 of the federal "Employee Retirement and Income Security Act of
41 1974," 29 U.S.C. s.1167(1), service benefit plan, health
42 maintenance organization, or other prepaid health plan, or public,
43 private or governmental entity who is or may be liable in contract,
44 tort, or otherwise by law or equity to pay all or part of the medical
45 cost of injury, disease or disability of an applicant for or recipient
46 of medical assistance payable under P.L.1968, c.413.

47 n. "Governmental peer grouping system" means a separate
48 class of skilled nursing and intermediate care facilities administered

- 1 by the State or county governments, established for the purpose of
2 screening their reported costs and setting reimbursement rates under
3 the Medicaid program that are reasonable and adequate to meet the
4 costs that must be incurred by efficiently and economically operated
5 State or county skilled nursing and intermediate care facilities.
- 6 o. "Comprehensive maternity or pediatric care provider" means
7 any person or public or private health care facility that is a provider
8 and that is approved by the commissioner to provide comprehensive
9 maternity care or comprehensive pediatric care as defined in
10 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
11 (C.30:4D-6).
- 12 p. "Poverty level" means the official poverty level based on
13 family size established and adjusted under Section 673(2) of
14 Subtitle B, the "Community Services Block Grant Act," of
15 Pub.L.97-35 (42 U.S.C. s.9902(2)).
- 16 q. "Eligible alien" means one of the following:
- 17 (1) an alien present in the United States prior to August 22,
18 1996, who is:
- 19 (a) a lawful permanent resident;
- 20 (b) a refugee pursuant to section 207 of the federal "Immigration
21 and Nationality Act" (8 U.S.C. s.1157);
- 22 (c) an asylee pursuant to section 208 of the federal
23 "Immigration and Nationality Act" (8 U.S.C. s.1158);
- 24 (d) an alien who has had deportation withheld pursuant to
25 section 243(h) of the federal "Immigration and Nationality Act" (8
26 U.S.C. s.1253 (h));
- 27 (e) an alien who has been granted parole for less than one year
28 by the U.S. Citizenship and Immigration Services pursuant to
29 section 212(d)(5) of the federal "Immigration and Nationality Act"
30 (8 U.S.C. s.1182(d)(5));
- 31 (f) an alien granted conditional entry pursuant to section
32 203(a)(7) of the federal "Immigration and Nationality Act" (8
33 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or
- 34 (g) an alien who is honorably discharged from or on active duty
35 in the United States armed forces and the alien's spouse and
36 unmarried dependent child.
- 37 (2) An alien who entered the United States on or after August
38 22, 1996, who is:
- 39 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of
40 this subsection; or
- 41 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
42 subsection who entered the United States at least five years ago.
- 43 (3) A legal alien who is a victim of domestic violence in
44 accordance with criteria specified for eligibility for public benefits
45 as provided in Title V of the federal "Illegal Immigration Reform
46 and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
47 (cf: P.L.2012, c.16, s.114)

1 2. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
2 as follows:

3 6. a. Subject to the requirements of Title XIX of the federal
4 Social Security Act, the limitations imposed by this act and by the
5 rules and regulations promulgated pursuant thereto, the department
6 shall provide medical assistance to qualified applicants, including
7 authorized services within each of the following classifications:

- 8 (1) Inpatient hospital services;
- 9 (2) Outpatient hospital services;
- 10 (3) Other laboratory and X-ray services;
- 11 (4) (a) Skilled nursing or intermediate care facility services;
- 12 (b) Early and periodic screening and diagnosis of individuals
13 who are eligible under the program and are under age 21, to
14 ascertain their physical or mental health status and the health care,
15 treatment, and other measures to correct or ameliorate defects and
16 chronic conditions discovered thereby, as may be provided in
17 regulations of the Secretary of the federal Department of Health and
18 Human Services and approved by the commissioner;
- 19 (5) Physician's services furnished in the office, the patient's
20 home, a hospital, a skilled nursing, or intermediate care facility or
21 elsewhere.

22 As used in this subsection, "laboratory and X-ray services"
23 includes HIV drug resistance testing, including, but not limited to,
24 genotype assays that have been cleared or approved by the federal
25 Food and Drug Administration, laboratory developed genotype
26 assays, phenotype assays, and other assays using phenotype
27 prediction with genotype comparison, for persons diagnosed with
28 HIV infection or AIDS.

29 b. Subject to the limitations imposed by federal law, by this
30 act, and by the rules and regulations promulgated pursuant thereto,
31 the medical assistance program may be expanded to include
32 authorized services within each of the following classifications:

- 33 (1) Medical care not included in subsection a.(5) above, or any
34 other type of remedial care recognized under State law, furnished
35 by licensed practitioners within the scope of their practice, as
36 defined by State law;
- 37 (2) Home health care services;
- 38 (3) Clinic services;
- 39 (4) Dental services;
- 40 (5) Physical therapy and related services;
- 41 (6) Prescribed drugs, dentures, and prosthetic devices; and
42 eyeglasses prescribed by a physician skilled in diseases of the eye
43 or by an optometrist, whichever the individual may select;
- 44 (7) Optometric services;
- 45 (8) Podiatric services;
- 46 (9) Chiropractic services;
- 47 (10) Psychological services;

- 1 (11) Inpatient psychiatric hospital services for individuals under
2 21 years of age, or under age 22 if they are receiving such services
3 immediately before attaining age 21;
- 4 (12) Other diagnostic, screening, preventive, and rehabilitative
5 services, and other remedial care;
- 6 (13) Inpatient hospital services, nursing facility services, and
7 intermediate care facility services for individuals 65 years of age or
8 over in an institution for mental diseases;
- 9 (14) Intermediate care facility services;
- 10 (15) Transportation services;
- 11 (16) Services in connection with the inpatient or outpatient
12 treatment or care of substance use disorder, when the treatment is
13 prescribed by a physician and provided in a licensed hospital or in a
14 narcotic and substance use disorder treatment center approved by
15 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
16 et seq.) and whose staff includes a medical director, and limited to
17 those services eligible for federal financial participation under Title
18 XIX of the federal Social Security Act;
- 19 (17) Any other medical care and any other type of remedial care
20 recognized under State law, specified by the Secretary of the federal
21 Department of Health and Human Services, and approved by the
22 commissioner;
- 23 (18) Comprehensive maternity care, which may include: the
24 basic number of prenatal and postpartum visits recommended by the
25 American College of Obstetrics and Gynecology; additional
26 prenatal and postpartum visits that are medically necessary;
27 necessary laboratory, nutritional assessment and counseling, health
28 education, personal counseling, managed care, outreach, and
29 follow-up services; treatment of conditions which may complicate
30 pregnancy; and physician or certified nurse-midwife delivery
31 services;
- 32 (19) Comprehensive pediatric care, which may include:
33 ambulatory, preventive, and primary care health services. The
34 preventive services shall include, at a minimum, the basic number
35 of preventive visits recommended by the American Academy of
36 Pediatrics;
- 37 (20) Services provided by a hospice which is participating in the
38 Medicare program established pursuant to Title XVIII of the Social
39 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
40 services shall be provided subject to approval of the Secretary of
41 the federal Department of Health and Human Services for federal
42 reimbursement;
- 43 (21) Mammograms, subject to approval of the Secretary of the
44 federal Department of Health and Human Services for federal
45 reimbursement, including one baseline mammogram for women
46 who are at least 35 but less than 40 years of age; one mammogram
47 examination every two years or more frequently, if recommended
48 by a physician, for women who are at least 40 but less than 50 years

1 of age; and one mammogram examination every year for women
2 age 50 and over;

3 (22) Upon referral by a physician, advanced practice nurse, or
4 physician assistant of a person who has been diagnosed with
5 diabetes, gestational diabetes, or pre-diabetes, in accordance with
6 standards adopted by the American Diabetes Association :

7 (a) Expenses for diabetes self-management education or training
8 to ensure that a person with diabetes, gestational diabetes, or pre-
9 diabetes can optimize metabolic control, prevent and manage
10 complications, and maximize quality of life. Diabetes self-
11 management education shall be provided by an in-State provider
12 who is:

13 (i) a licensed, registered, or certified health care professional
14 who is certified by the National Certification Board of Diabetes
15 Educators as a Certified Diabetes Educator, or certified by the
16 American Association of Diabetes Educators with a Board
17 Certified-Advanced Diabetes Management credential, including, but
18 not limited to: a physician, an advanced practice or registered nurse,
19 a physician assistant, a pharmacist, a chiropractor, a dietitian
20 registered by a nationally recognized professional association of
21 dietitians, or a nutritionist holding a certified nutritionist specialist
22 (CNS) credential from the Board for Certification of Nutrition
23 Specialists ; or

24 (ii) an entity meeting the National Standards for Diabetes Self-
25 Management Education and Support, as evidenced by a recognition
26 by the American Diabetes Association or accreditation by the
27 American Association of Diabetes Educators;

28 (b) Expenses for medical nutrition therapy as an effective
29 component of the person's overall treatment plan upon a: diagnosis
30 of diabetes, gestational diabetes, or pre-diabetes; change in the
31 beneficiary's medical condition, treatment, or diagnosis; or
32 determination of a physician, advanced practice nurse, or physician
33 assistant that reeducation or refresher education is necessary.
34 Medical nutrition therapy shall be provided by an in-State provider
35 who is a dietitian registered by a nationally-recognized professional
36 association of dietitians, or a nutritionist holding a certified
37 nutritionist specialist (CNS) credential from the Board for
38 Certification of Nutrition Specialists, who is familiar with the
39 components of diabetes medical nutrition therapy;

40 (c) For a person diagnosed with pre-diabetes, items and services
41 furnished under an in-State diabetes prevention program that meets
42 the standards of the National Diabetes Prevention Program, as
43 established by the federal Centers for Disease Control and
44 Prevention; and

45 (d) Expenses for any medically appropriate and necessary
46 supplies and equipment recommended or prescribed by a physician,
47 advanced practice nurse, or physician assistant for the management
48 and treatment of diabetes, gestational diabetes, or pre-diabetes,

1 including, but not limited to: equipment and supplies for self-
2 management of blood glucose; insulin pens; insulin pumps and
3 related supplies; and other insulin delivery devices.

4 c. Payments for the foregoing services, goods, and supplies
5 furnished pursuant to this act shall be made to the extent authorized
6 by this act, the rules and regulations promulgated pursuant thereto
7 and, where applicable, subject to the agreement of insurance
8 provided for under this act. The payments shall constitute payment
9 in full to the provider on behalf of the recipient. Every provider
10 making a claim for payment pursuant to this act shall certify in
11 writing on the claim submitted that no additional amount will be
12 charged to the recipient, the recipient's family, the recipient's
13 representative or others on the recipient's behalf for the services,
14 goods, and supplies furnished pursuant to this act.

15 No provider whose claim for payment pursuant to this act has
16 been denied because the services, goods, or supplies were
17 determined to be medically unnecessary shall seek reimbursement
18 from the recipient, his family, his representative or others on his
19 behalf for such services, goods, and supplies provided pursuant to
20 this act; provided, however, a provider may seek reimbursement
21 from a recipient for services, goods, or supplies not authorized by
22 this act, if the recipient elected to receive the services, goods or
23 supplies with the knowledge that they were not authorized.

24 d. Any individual eligible for medical assistance (including
25 drugs) may obtain such assistance from any person qualified to
26 perform the service or services required (including an organization
27 which provides such services, or arranges for their availability on a
28 prepayment basis), who undertakes to provide the individual such
29 services.

30 No copayment or other form of cost-sharing shall be imposed on
31 any individual eligible for medical assistance, except as mandated
32 by federal law as a condition of federal financial participation.

33 e. Anything in this act to the contrary notwithstanding, no
34 payments for medical assistance shall be made under this act with
35 respect to care or services for any individual who:

36 (1) Is an inmate of a public institution (except as a patient in a
37 medical institution); provided, however, that an individual who is
38 otherwise eligible may continue to receive services for the month in
39 which he becomes an inmate, should the commissioner determine to
40 expand the scope of Medicaid eligibility to include such an
41 individual, subject to the limitations imposed by federal law and
42 regulations, or

43 (2) Has not attained 65 years of age and who is a patient in an
44 institution for mental diseases, or

45 (3) Is over 21 years of age and who is receiving inpatient
46 psychiatric hospital services in a psychiatric facility; provided,
47 however, that an individual who was receiving such services
48 immediately prior to attaining age 21 may continue to receive such

1 services until the individual reaches age 22. Nothing in this
2 subsection shall prohibit the commissioner from extending medical
3 assistance to all eligible persons receiving inpatient psychiatric
4 services; provided that there is federal financial participation
5 available.

6 f. (1) A third party as defined in section 3 of P.L.1968, c.413
7 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
8 this or another state when determining the person's eligibility for
9 enrollment or the provision of benefits by that third party.

10 (2) In addition, any provision in a contract of insurance, health
11 benefits plan, or other health care coverage document, will, trust,
12 agreement, court order, or other instrument which reduces or
13 excludes coverage or payment for health care-related goods and
14 services to or for an individual because of that individual's actual or
15 potential eligibility for or receipt of Medicaid benefits shall be null
16 and void, and no payments shall be made under this act as a result
17 of any such provision.

18 (3) Notwithstanding any provision of law to the contrary, the
19 provisions of paragraph (2) of this subsection shall not apply to a
20 trust agreement that is established pursuant to 42 U.S.C.
21 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
22 provided by government entities to a person who is disabled as
23 defined in section 1614(a)(3) of the federal Social Security Act (42
24 U.S.C. s.1382c (a)(3)).

25 g. The following services shall be provided to eligible
26 medically needy individuals as follows:

27 (1) Pregnant women shall be provided prenatal care and delivery
28 services and postpartum care, including the services cited in
29 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
30 (10), (12), (15), and (17) of this section, and nursing facility
31 services cited in subsection b.(13) of this section.

32 (2) Dependent children shall be provided with services cited in
33 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
34 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
35 nursing facility services cited in subsection b.(13) of this section.

36 (3) Individuals who are 65 years of age or older shall be
37 provided with services cited in subsection a.(3) and (5) of this
38 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
39 (8), (10), (12), (15), and (17) of this section, and nursing facility
40 services cited in subsection b.(13) of this section.

41 (4) Individuals who are blind or disabled shall be provided with
42 services cited in subsection a.(3) and (5) of this section and
43 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
44 (12), (15), and (17) of this section, and nursing facility services
45 cited in subsection b.(13) of this section.

46 (5) (a) Inpatient hospital services, subsection a.(1) of this
47 section, shall only be provided to eligible medically needy
48 individuals, other than pregnant women, if the federal Department

1 of Health and Human Services discontinues the State's waiver to
2 establish inpatient hospital reimbursement rates for the Medicare
3 and Medicaid programs under the authority of section 601(c)(3) of
4 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
5 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
6 extended to other eligible medically needy individuals if the federal
7 Department of Health and Human Services directs that these
8 services be included.

9 (b) Outpatient hospital services, subsection a.(2) of this section,
10 shall only be provided to eligible medically needy individuals if the
11 federal Department of Health and Human Services discontinues the
12 State's waiver to establish outpatient hospital reimbursement rates
13 for the Medicare and Medicaid programs under the authority of
14 section 601(c)(3) of the Social Security Amendments of 1983,
15 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
16 services may be extended to all or to certain medically needy
17 individuals if the federal Department of Health and Human Services
18 directs that these services be included. However, the use of
19 outpatient hospital services shall be limited to clinic services and to
20 emergency room services for injuries and significant acute medical
21 conditions.

22 (c) The division shall monitor the use of inpatient and outpatient
23 hospital services by medically needy persons.

24 h. In the case of a qualified disabled and working individual
25 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
26 only medical assistance provided under this act shall be the
27 payment of premiums for Medicare part A under 42 U.S.C.
28 ss.1395i-2 and 1395r.

29 i. In the case of a specified low-income Medicare beneficiary
30 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical
31 assistance provided under this act shall be the payment of premiums
32 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
33 U.S.C. s.1396d(p)(3)(A)(ii).

34 j. In the case of a qualified individual pursuant to 42 U.S.C.
35 s.1396a(aa), the only medical assistance provided under this act
36 shall be payment for authorized services provided during the period
37 in which the individual requires treatment for breast or cervical
38 cancer, in accordance with criteria established by the commissioner.

39 k. In the case of a qualified individual pursuant to 42 U.S.C.
40 s.1396a(ii), the only medical assistance provided under this act shall
41 be payment for family planning services and supplies as described
42 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
43 treatment services that are provided pursuant to a family planning
44 service in a family planning setting.

45 (cf: P.L.2017, c.161, s.1)

46
47 3. The Commissioner of Human Services, pursuant to the
48 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et

1 seq.), shall adopt rules and regulations necessary to implement the
2 provisions of this act.

3

4 4. This act shall take effect on the first day of the fourth month
5 next following the date of enactment, but the Commissioner of
6 Human Services may take such anticipatory administrative action in
7 advance thereof, including, but not limited to, the submission of a
8 State plan amendment to the federal Centers for Medicare &
9 Medicaid Services, as may be necessary for the implementation of
10 this act.

ASSEMBLY, No. 1656

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Assemblywoman ELIANA PINTOR MARIN

District 29 (Essex)

Assemblyman JOSEPH A. LAGANA

District 38 (Bergen and Passaic)

Assemblywoman MILA M. JASEY

District 27 (Essex and Morris)

Assemblyman RAJ MUKHERJI

District 33 (Hudson)

Assemblywoman JOANN DOWNEY

District 11 (Monmouth)

Co-Sponsored by:

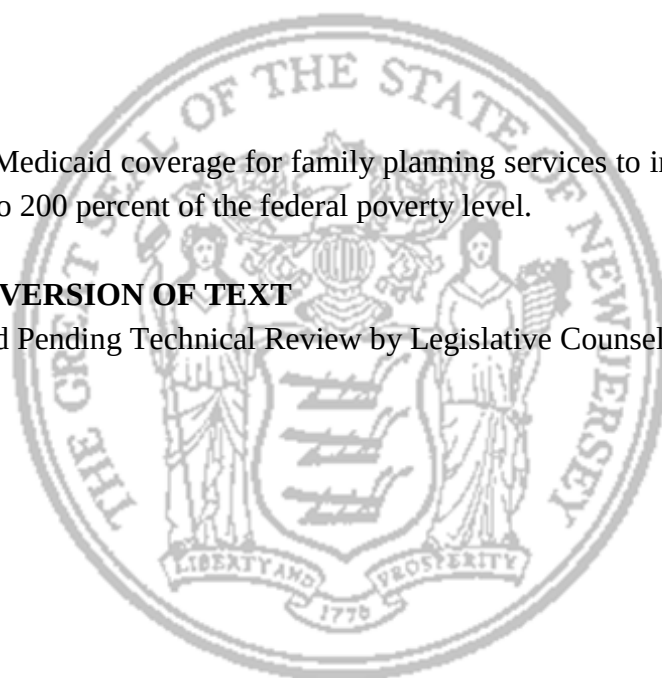
**Assemblyman McKeon, Assemblywomen Mosquera, Muoio, Caride,
Assemblymen Houghtaling, Johnson, Kennedy, Assemblywomen Tucker,
Pinkin, Assemblymen Coughlin, Benson, Wimberly and Assemblywoman
Vainieri Huttie**

SYNOPSIS

Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



(Sponsorship Updated As Of: 1/30/2018)

1 **AN ACT** concerning Medicaid coverage for family planning services
2 and amending P.L.1968, c.413.

3

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

6

7 1. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read
8 as follows:

9 3. Definitions. As used in P.L.1968, c.413 (C.30:4D-1 et seq.),
10 and unless the context otherwise requires:

11 a. "Applicant" means any person who has made application for
12 purposes of becoming a "qualified applicant."

13 b. "Commissioner" means the Commissioner of Human
14 Services.

15 c. "Department" means the Department of Human Services,
16 which is herein designated as the single State agency to administer
17 the provisions of this act.

18 d. "Director" means the Director of the Division of Medical
19 Assistance and Health Services.

20 e. "Division" means the Division of Medical Assistance and
21 Health Services.

22 f. "Medicaid" means the New Jersey Medical Assistance and
23 Health Services Program.

24 g. "Medical assistance" means payments on behalf of recipients
25 to providers for medical care and services authorized under
26 P.L.1968, c.413.

27 h. "Provider" means any person, public or private institution,
28 agency, or business concern approved by the division lawfully
29 providing medical care, services, goods, and supplies authorized
30 under P.L.1968, c.413, holding, where applicable, a current valid
31 license to provide such services or to dispense such goods or
32 supplies.

33 i. "Qualified applicant" means a person who is a resident of
34 this State, and either a citizen of the United States or an eligible
35 alien, and is determined to need medical care and services as
36 provided under P.L.1968, c.413, with respect to whom the period
37 for which eligibility to be a recipient is determined shall be the
38 maximum period permitted under federal law, and who:

39 (1) Is a dependent child or parent or caretaker relative of a
40 dependent child who would be, except for resources, eligible for the
41 aid to families with dependent children program under the State
42 Plan for Title IV-A of the federal Social Security Act as of July 16,
43 1996;

44 (2) Is a recipient of Supplemental Security Income for the Aged,

**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.

- 1 Blind and Disabled under Title XVI of the Social Security Act;
- 2 (3) Is an "ineligible spouse" of a recipient of Supplemental
- 3 Security Income for the Aged, Blind and Disabled under Title XVI
- 4 of the Social Security Act, as defined by the federal Social Security
- 5 Administration;
- 6 (4) Would be eligible to receive Supplemental Security Income
- 7 under Title XVI of the federal Social Security Act or, without
- 8 regard to resources, would be eligible for the aid to families with
- 9 dependent children program under the State Plan for Title IV-A of
- 10 the federal Social Security Act as of July 16, 1996, except for
- 11 failure to meet an eligibility condition or requirement imposed
- 12 under such State program which is prohibited under Title XIX of
- 13 the federal Social Security Act such as a durational residency
- 14 requirement, relative responsibility, consent to imposition of a lien;
- 15 (5) (Deleted by amendment, P.L.2000, c.71).
- 16 (6) Is an individual under 21 years of age who, without regard to
- 17 resources, would be, except for dependent child requirements,
- 18 eligible for the aid to families with dependent children program
- 19 under the State Plan for Title IV-A of the federal Social Security
- 20 Act as of July 16, 1996, or groups of such individuals, including but
- 21 not limited to, children in resource family placement under
- 22 supervision of the Division of Child Protection and Permanency in
- 23 the Department of Children and Families whose maintenance is
- 24 being paid in whole or in part from public funds, children placed in
- 25 a resource family home or institution by a private adoption agency
- 26 in New Jersey or children in intermediate care facilities, including
- 27 developmental centers for the developmentally disabled, or in
- 28 psychiatric hospitals;
- 29 (7) Would be eligible for the Supplemental Security Income
- 30 program, but is not receiving such assistance and applies for
- 31 medical assistance only;
- 32 (8) Is determined to be medically needy and meets all the
- 33 eligibility requirements described below:
- 34 (a) The following individuals are eligible for services, if they
- 35 are determined to be medically needy:
- 36 (i) Pregnant women;
- 37 (ii) Dependent children under the age of 21;
- 38 (iii) Individuals who are 65 years of age and older; and
- 39 (iv) Individuals who are blind or disabled pursuant to either 42
- 40 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
- 41 (b) The following income standard shall be used to determine
- 42 medically needy eligibility:
- 43 (i) For one person and two person households, the income
- 44 standard shall be the maximum allowable under federal law, but
- 45 shall not exceed 133 1/3% of the State's payment level to two
- 46 person households under the aid to families with dependent children
- 47 program under the State Plan for Title IV-A of the federal Social
- 48 Security Act in effect as of July 16, 1996; and

- 1 (ii) For households of three or more persons, the income
2 standard shall be set at 133 1/3% of the State's payment level to
3 similar size households under the aid to families with dependent
4 children program under the State Plan for Title IV-A of the federal
5 Social Security Act in effect as of July 16, 1996.
- 6 (c) The following resource standard shall be used to determine
7 medically needy eligibility:
- 8 (i) For one person households, the resource standard shall be
9 200% of the resource standard for recipients of Supplemental
10 Security Income pursuant to 42 U.S.C. s.1382(1)(B);
- 11 (ii) For two person households, the resource standard shall be
12 200% of the resource standard for recipients of Supplemental
13 Security Income pursuant to 42 U.S.C. s.1382(2)(B);
- 14 (iii) For households of three or more persons, the resource
15 standard in subparagraph (c)(ii) above shall be increased by
16 \$100.00 for each additional person; and
- 17 (iv) The resource standards established in (i), (ii), and (iii) are
18 subject to federal approval and the resource standard may be lower
19 if required by the federal Department of Health and Human
20 Services.
- 21 (d) Individuals whose income exceeds those established in
22 subparagraph (b) of paragraph (8) of this subsection may become
23 medically needy by incurring medical expenses as defined in 42
24 C.F.R.435.831(c) which will reduce their income to the applicable
25 medically needy income established in subparagraph (b) of
26 paragraph (8) of this subsection.
- 27 (e) A six-month period shall be used to determine whether an
28 individual is medically needy.
- 29 (f) Eligibility determinations for the medically needy program
30 shall be administered as follows:
- 31 (i) County welfare agencies and other entities designated by the
32 commissioner are responsible for determining and certifying the
33 eligibility of pregnant women and dependent children. The division
34 shall reimburse county welfare agencies for 100% of the reasonable
35 costs of administration which are not reimbursed by the federal
36 government for the first 12 months of this program's operation.
37 Thereafter, 75% of the administrative costs incurred by county
38 welfare agencies which are not reimbursed by the federal
39 government shall be reimbursed by the division;
- 40 (ii) The division is responsible for certifying the eligibility of
41 individuals who are 65 years of age and older and individuals who
42 are blind or disabled. The division may enter into contracts with
43 county welfare agencies to determine certain aspects of eligibility.
44 In such instances the division shall provide county welfare agencies
45 with all information the division may have available on the
46 individual.
- 47 The division shall notify all eligible recipients of the
48 Pharmaceutical Assistance to the Aged and Disabled program,

1 P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the
2 medically needy program and the program's general requirements.
3 The division shall take all reasonable administrative actions to
4 ensure that Pharmaceutical Assistance to the Aged and Disabled
5 recipients, who notify the division that they may be eligible for the
6 program, have their applications processed expeditiously, at times
7 and locations convenient to the recipients; and
8 (iii) The division is responsible for certifying incurred medical
9 expenses for all eligible persons who attempt to qualify for the
10 program pursuant to subparagraph (d) of paragraph (8) of this
11 subsection;
12 (9) (a) Is a child who is at least one year of age and under 19
13 years of age and, if older than six years of age but under 19 years of
14 age, is uninsured; and
15 (b) Is a member of a family whose income does not exceed
16 133% of the poverty level and who meets the federal Medicaid
17 eligibility requirements set forth in section 9401 of Pub.L.99-509
18 (42 U.S.C. s.1396a);
19 (10) Is a pregnant woman who is determined by a provider to be
20 presumptively eligible for medical assistance based on criteria
21 established by the commissioner, pursuant to section 9407 of
22 Pub.L.99-509 (42 U.S.C. s.1396a(a));
23 (11) Is an individual 65 years of age and older, or an individual
24 who is blind or disabled pursuant to section 301 of Pub.L.92-603
25 (42 U.S.C. s.1382c), whose income does not exceed 100% of the
26 poverty level, adjusted for family size, and whose resources do not
27 exceed 100% of the resource standard used to determine medically
28 needy eligibility pursuant to paragraph (8) of this subsection;
29 (12) Is a qualified disabled and working individual pursuant to
30 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
31 does not exceed 200% of the poverty level and whose resources do
32 not exceed 200% of the resource standard used to determine
33 eligibility under the Supplemental Security Income Program,
34 P.L.1973, c.256 (C.44:7-85 et seq.);
35 (13) Is a pregnant woman or is a child who is under one year of
36 age and is a member of a family whose income does not exceed
37 185% of the poverty level and who meets the federal Medicaid
38 eligibility requirements set forth in section 9401 of Pub.L.99-509
39 (42 U.S.C. s.1396a), except that a pregnant woman who is
40 determined to be a qualified applicant shall, notwithstanding any
41 change in the income of the family of which she is a member,
42 continue to be deemed a qualified applicant until the end of the 60-
43 day period beginning on the last day of her pregnancy;
44 (14) (Deleted by amendment, P.L.1997, c.272).
45 (15) (a) Is a specified low-income Medicare beneficiary pursuant
46 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January
47 1, 1993 do not exceed 200% of the resource standard used to
48 determine eligibility under the Supplemental Security Income

1 program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income
2 beginning January 1, 1993 does not exceed 110% of the poverty
3 level, and beginning January 1, 1995 does not exceed 120% of the
4 poverty level.

5 (b) An individual who has, within 36 months, or within 60
6 months in the case of funds transferred into a trust, of applying to
7 be a qualified applicant for Medicaid services in a nursing facility
8 or a medical institution, or for home or community-based services
9 under section 1915(c) of the federal Social Security Act (42 U.S.C.
10 s.1396n(c)), disposed of resources or income for less than fair
11 market value shall be ineligible for assistance for nursing facility
12 services, an equivalent level of services in a medical institution, or
13 home or community-based services under section 1915(c) of the
14 federal Social Security Act (42 U.S.C. s.1396n(c)). The period of
15 the ineligibility shall be the number of months resulting from
16 dividing the uncompensated value of the transferred resources or
17 income by the average monthly private payment rate for nursing
18 facility services in the State as determined annually by the
19 commissioner. In the case of multiple resource or income transfers,
20 the resulting penalty periods shall be imposed sequentially.
21 Application of this requirement shall be governed by 42 U.S.C.
22 s.1396p(c). In accordance with federal law, this provision is
23 effective for all transfers of resources or income made on or after
24 August 11, 1993. Notwithstanding the provisions of this subsection
25 to the contrary, the State eligibility requirements concerning
26 resource or income transfers shall not be more restrictive than those
27 enacted pursuant to 42 U.S.C. s.1396p(c).

28 (c) An individual seeking nursing facility services or home or
29 community-based services and who has a community spouse shall
30 be required to expend those resources which are not protected for
31 the needs of the community spouse in accordance with section
32 1924(c) of the federal Social Security Act (42 U.S.C. s.1396r-5(c))
33 on the costs of long-term care, burial arrangements, and any other
34 expense deemed appropriate and authorized by the commissioner.
35 An individual shall be ineligible for Medicaid services in a nursing
36 facility or for home or community-based services under section
37 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)) if
38 the individual expends funds in violation of this subparagraph. The
39 period of ineligibility shall be the number of months resulting from
40 dividing the uncompensated value of transferred resources and
41 income by the average monthly private payment rate for nursing
42 facility services in the State as determined by the commissioner.
43 The period of ineligibility shall begin with the month that the
44 individual would otherwise be eligible for Medicaid coverage for
45 nursing facility services or home or community-based services.

46 This subparagraph shall be operative only if all necessary
47 approvals are received from the federal government including, but

1 not limited to, approval of necessary State plan amendments and
2 approval of any waivers;

3 (16) Subject to federal approval under Title XIX of the federal
4 Social Security Act, is a dependent child, parent or specified
5 caretaker relative of a child who is a qualified applicant, who would
6 be eligible, without regard to resources, for the aid to families with
7 dependent children program under the State Plan for Title IV-A of
8 the federal Social Security Act as of July 16, 1996, except for the
9 income eligibility requirements of that program, and whose family
10 earned income,

11 (a) if a dependent child, does not exceed 133% of the poverty
12 level; and

13 (b) if a parent or specified caretaker relative, beginning
14 September 1, 2005 does not exceed 100% of the poverty level,
15 beginning September 1, 2006 does not exceed 115% of the poverty
16 level and beginning September 1, 2007 does not exceed 133% of
17 the poverty level,

18 plus such earned income disregards as shall be determined
19 according to a methodology to be established by regulation of the
20 commissioner;

21 The commissioner may increase the income eligibility limits for
22 children and parents and specified caretaker relatives, as funding
23 permits;

24 (17) Is an individual from 18 through 20 years of age who is not a
25 dependent child and would be eligible for medical assistance
26 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
27 income or resources, who, on the individual's 18th birthday was in
28 resource family care under the care and custody of the Division of
29 Child Protection and Permanency in the Department of Children
30 and Families and whose maintenance was being paid in whole or in
31 part from public funds;

32 (18) Is a person between the ages of 16 and 65 who is
33 permanently disabled and working, and:

34 (a) whose income is at or below 250% of the poverty level, plus
35 other established disregards;

36 (b) who pays the premium contribution and other cost sharing as
37 established by the commissioner, subject to the limits and
38 conditions of federal law; and

39 (c) whose assets, resources and unearned income do not exceed
40 limitations as established by the commissioner;

41 (19) Is an uninsured individual under 65 years of age who:

42 (a) has been screened for breast or cervical cancer under the
43 federal Centers for Disease Control and Prevention breast and
44 cervical cancer early detection program;

45 (b) requires treatment for breast or cervical cancer based upon
46 criteria established by the commissioner;

47 (c) has an income that does not exceed the income standard
48 established by the commissioner pursuant to federal guidelines;

1 (d) meets all other Medicaid eligibility requirements; and

2 (e) in accordance with Pub.L.106-354, is determined by a
3 qualified entity to be presumptively eligible for medical assistance
4 pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established
5 by the commissioner pursuant to section 1920B of the federal Social
6 Security Act (42 U.S.C. s.1396r-1b); **【or】**

7 (20) Subject to federal approval under Title XIX of the federal
8 Social Security Act, is a single adult or couple, without dependent
9 children, whose income in 2006 does not exceed 50% of the poverty
10 level, in 2007 does not exceed 75% of the poverty level and in 2008
11 and each year thereafter does not exceed 100% of the poverty level;
12 except that a person who is a recipient of Work First New Jersey
13 general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107
14 et seq.), shall not be a qualified applicant; or

15 (21) is an individual who:

16 (a) has an income that does not exceed the highest income
17 eligibility level for pregnant women established under the State
18 plan under Title XIX or Title XXI of the federal Social Security
19 Act;

20 (b) is not pregnant; and

21 (c) is eligible to receive family planning services provided
22 under the Medicaid program pursuant to subsection k. of section 6
23 of P.L.1968, c.413 (C.30:4D-6) and in accordance with 42 U.S.C.
24 s.1396a(ii).

25 j. "Recipient" means any qualified applicant receiving benefits
26 under this act.

27 k. "Resident" means a person who is living in the State
28 voluntarily with the intention of making his home here and not for a
29 temporary purpose. Temporary absences from the State, with
30 subsequent returns to the State or intent to return when the purposes
31 of the absences have been accomplished, do not interrupt continuity
32 of residence.

33 l. "State Medicaid Commission" means the Governor, the
34 Commissioner of Human Services, the President of the Senate and
35 the Speaker of the General Assembly, hereby constituted a
36 commission to approve and direct the means and method for the
37 payment of claims pursuant to P.L.1968, c.413.

38 m. "Third party" means any person, institution, corporation,
39 insurance company, group health plan as defined in section 607(1)
40 of the federal "Employee Retirement and Income Security Act of
41 1974," 29 U.S.C. s.1167(1), service benefit plan, health
42 maintenance organization, or other prepaid health plan, or public,
43 private or governmental entity who is or may be liable in contract,
44 tort, or otherwise by law or equity to pay all or part of the medical
45 cost of injury, disease or disability of an applicant for or recipient
46 of medical assistance payable under P.L.1968, c.413.

47 n. "Governmental peer grouping system" means a separate
48 class of skilled nursing and intermediate care facilities administered

- 1 by the State or county governments, established for the purpose of
2 screening their reported costs and setting reimbursement rates under
3 the Medicaid program that are reasonable and adequate to meet the
4 costs that must be incurred by efficiently and economically operated
5 State or county skilled nursing and intermediate care facilities.
- 6 o. "Comprehensive maternity or pediatric care provider" means
7 any person or public or private health care facility that is a provider
8 and that is approved by the commissioner to provide comprehensive
9 maternity care or comprehensive pediatric care as defined in
10 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
11 (C.30:4D-6).
- 12 p. "Poverty level" means the official poverty level based on
13 family size established and adjusted under Section 673(2) of
14 Subtitle B, the "Community Services Block Grant Act," of
15 Pub.L.97-35 (42 U.S.C. s.9902(2)).
- 16 q. "Eligible alien" means one of the following:
17 (1) an alien present in the United States prior to August 22,
18 1996, who is:
19 (a) a lawful permanent resident;
20 (b) a refugee pursuant to section 207 of the federal "Immigration
21 and Nationality Act" (8 U.S.C. s.1157);
22 (c) an asylee pursuant to section 208 of the federal
23 "Immigration and Nationality Act" (8 U.S.C. s.1158);
24 (d) an alien who has had deportation withheld pursuant to
25 section 243(h) of the federal "Immigration and Nationality Act" (8
26 U.S.C. s.1253 (h));
27 (e) an alien who has been granted parole for less than one year
28 by the U.S. Citizenship and Immigration Services pursuant to
29 section 212(d)(5) of the federal "Immigration and Nationality Act"
30 (8 U.S.C. s.1182(d)(5));
31 (f) an alien granted conditional entry pursuant to section
32 203(a)(7) of the federal "Immigration and Nationality Act" (8
33 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or
34 (g) an alien who is honorably discharged from or on active duty
35 in the United States armed forces and the alien's spouse and
36 unmarried dependent child.
- 37 (2) An alien who entered the United States on or after August
38 22, 1996, who is:
39 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of
40 this subsection; or
41 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
42 subsection who entered the United States at least five years ago.
- 43 (3) A legal alien who is a victim of domestic violence in
44 accordance with criteria specified for eligibility for public benefits
45 as provided in Title V of the federal "Illegal Immigration Reform
46 and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
47 (cf: P.L.2012, c.16, s.114)

1 2. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
2 as follows:

3 6. a. Subject to the requirements of Title XIX of the federal
4 Social Security Act, the limitations imposed by this act and by the
5 rules and regulations promulgated pursuant thereto, the department
6 shall provide medical assistance to qualified applicants, including
7 authorized services within each of the following classifications:

- 8 (1) Inpatient hospital services;
9 (2) Outpatient hospital services;
10 (3) Other laboratory and X-ray services;
11 (4) (a) Skilled nursing or intermediate care facility services;
12 (b) Early and periodic screening and diagnosis of individuals
13 who are eligible under the program and are under age 21, to
14 ascertain their physical or mental defects and the health care,
15 treatment, and other measures to correct or ameliorate defects and
16 chronic conditions discovered thereby, as may be provided in
17 regulations of the Secretary of the federal Department of Health and
18 Human Services and approved by the commissioner;
19 (5) Physician's services furnished in the office, the patient's
20 home, a hospital, a skilled nursing, or intermediate care facility or
21 elsewhere.

22 As used in this subsection, "laboratory and X-ray services"
23 includes HIV drug resistance testing, including, but not limited to,
24 genotype assays that have been cleared or approved by the federal
25 Food and Drug Administration, laboratory developed genotype
26 assays, phenotype assays, and other assays using phenotype
27 prediction with genotype comparison, for persons diagnosed with
28 HIV infection or AIDS.

29 b. Subject to the limitations imposed by federal law, by this
30 act, and by the rules and regulations promulgated pursuant thereto,
31 the medical assistance program may be expanded to include
32 authorized services within each of the following classifications:

- 33 (1) Medical care not included in subsection a.(5) above, or any
34 other type of remedial care recognized under State law, furnished
35 by licensed practitioners within the scope of their practice, as
36 defined by State law;
37 (2) Home health care services;
38 (3) Clinic services;
39 (4) Dental services;
40 (5) Physical therapy and related services;
41 (6) Prescribed drugs, dentures, and prosthetic devices; and
42 eyeglasses prescribed by a physician skilled in diseases of the eye
43 or by an optometrist, whichever the individual may select;
44 (7) Optometric services;
45 (8) Podiatric services;
46 (9) Chiropractic services;
47 (10) Psychological services;

- 1 (11) Inpatient psychiatric hospital services for individuals under
2 21 years of age, or under age 22 if they are receiving such services
3 immediately before attaining age 21;
- 4 (12) Other diagnostic, screening, preventive, and rehabilitative
5 services, and other remedial care;
- 6 (13) Inpatient hospital services, nursing facility services, and
7 intermediate care facility services for individuals 65 years of age or
8 over in an institution for mental diseases;
- 9 (14) Intermediate care facility services;
- 10 (15) Transportation services;
- 11 (16) Services in connection with the inpatient or outpatient
12 treatment or care of drug abuse, when the treatment is prescribed by
13 a physician and provided in a licensed hospital or in a narcotic and
14 drug abuse treatment center approved by the Department of Health
15 pursuant to P.L.1970, c.334 (C.26:2G-21 et seq.) and whose staff
16 includes a medical director, and limited to those services eligible
17 for federal financial participation under Title XIX of the federal
18 Social Security Act;
- 19 (17) Any other medical care and any other type of remedial care
20 recognized under State law, specified by the Secretary of the federal
21 Department of Health and Human Services, and approved by the
22 commissioner;
- 23 (18) Comprehensive maternity care, which may include: the
24 basic number of prenatal and postpartum visits recommended by the
25 American College of Obstetrics and Gynecology; additional
26 prenatal and postpartum visits that are medically necessary;
27 necessary laboratory, nutritional assessment and counseling, health
28 education, personal counseling, managed care, outreach, and
29 follow-up services; treatment of conditions which may complicate
30 pregnancy; and physician or certified nurse-midwife delivery
31 services;
- 32 (19) Comprehensive pediatric care, which may include:
33 ambulatory, preventive, and primary care health services. The
34 preventive services shall include, at a minimum, the basic number
35 of preventive visits recommended by the American Academy of
36 Pediatrics;
- 37 (20) Services provided by a hospice which is participating in the
38 Medicare program established pursuant to Title XVIII of the Social
39 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
40 services shall be provided subject to approval of the Secretary of
41 the federal Department of Health and Human Services for federal
42 reimbursement;
- 43 (21) Mammograms, subject to approval of the Secretary of the
44 federal Department of Health and Human Services for federal
45 reimbursement, including one baseline mammogram for women
46 who are at least 35 but less than 40 years of age; one mammogram
47 examination every two years or more frequently, if recommended
48 by a physician, for women who are at least 40 but less than 50 years

1 of age; and one mammogram examination every year for women
2 age 50 and over.

3 c. Payments for the foregoing services, goods, and supplies
4 furnished pursuant to this act shall be made to the extent authorized
5 by this act, the rules and regulations promulgated pursuant thereto
6 and, where applicable, subject to the agreement of insurance
7 provided for under this act. The payments shall constitute payment
8 in full to the provider on behalf of the recipient. Every provider
9 making a claim for payment pursuant to this act shall certify in
10 writing on the claim submitted that no additional amount will be
11 charged to the recipient, the recipient's family, the recipient's
12 representative or others on the recipient's behalf for the services,
13 goods, and supplies furnished pursuant to this act.

14 No provider whose claim for payment pursuant to this act has
15 been denied because the services, goods, or supplies were
16 determined to be medically unnecessary shall seek reimbursement
17 from the recipient, his family, his representative or others on his
18 behalf for such services, goods, and supplies provided pursuant to
19 this act; provided, however, a provider may seek reimbursement
20 from a recipient for services, goods, or supplies not authorized by
21 this act, if the recipient elected to receive the services, goods or
22 supplies with the knowledge that they were not authorized.

23 d. Any individual eligible for medical assistance (including
24 drugs) may obtain such assistance from any person qualified to
25 perform the service or services required (including an organization
26 which provides such services, or arranges for their availability on a
27 prepayment basis), who undertakes to provide the individual such
28 services.

29 No copayment or other form of cost-sharing shall be imposed on
30 any individual eligible for medical assistance, except as mandated
31 by federal law as a condition of federal financial participation.

32 e. Anything in this act to the contrary notwithstanding, no
33 payments for medical assistance shall be made under this act with
34 respect to care or services for any individual who:

35 (1) Is an inmate of a public institution (except as a patient in a
36 medical institution); provided, however, that an individual who is
37 otherwise eligible may continue to receive services for the month in
38 which he becomes an inmate, should the commissioner determine to
39 expand the scope of Medicaid eligibility to include such an
40 individual, subject to the limitations imposed by federal law and
41 regulations, or

42 (2) Has not attained 65 years of age and who is a patient in an
43 institution for mental diseases, or

44 (3) Is over 21 years of age and who is receiving inpatient
45 psychiatric hospital services in a psychiatric facility; provided,
46 however, that an individual who was receiving such services
47 immediately prior to attaining age 21 may continue to receive such
48 services until the individual reaches age 22. Nothing in this

1 subsection shall prohibit the commissioner from extending medical
2 assistance to all eligible persons receiving inpatient psychiatric
3 services; provided that there is federal financial participation
4 available.

5 f. (1) A third party as defined in section 3 of P.L.1968, c.413
6 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
7 this or another state when determining the person's eligibility for
8 enrollment or the provision of benefits by that third party.

9 (2) In addition, any provision in a contract of insurance, health
10 benefits plan, or other health care coverage document, will, trust,
11 agreement, court order, or other instrument which reduces or
12 excludes coverage or payment for health care-related goods and
13 services to or for an individual because of that individual's actual or
14 potential eligibility for or receipt of Medicaid benefits shall be null
15 and void, and no payments shall be made under this act as a result
16 of any such provision.

17 (3) Notwithstanding any provision of law to the contrary, the
18 provisions of paragraph (2) of this subsection shall not apply to a
19 trust agreement that is established pursuant to 42 U.S.C.
20 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
21 provided by government entities to a person who is disabled as
22 defined in section 1614(a)(3) of the federal Social Security Act (42
23 U.S.C. s.1382c (a)(3)).

24 g. The following services shall be provided to eligible
25 medically needy individuals as follows:

26 (1) Pregnant women shall be provided prenatal care and delivery
27 services and postpartum care, including the services cited in
28 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
29 (10), (12), (15), and (17) of this section, and nursing facility
30 services cited in subsection b.(13) of this section.

31 (2) Dependent children shall be provided with services cited in
32 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
33 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
34 nursing facility services cited in subsection b.(13) of this section.

35 (3) Individuals who are 65 years of age or older shall be
36 provided with services cited in subsection a.(3) and (5) of this
37 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
38 (8), (10), (12), (15), and (17) of this section, and nursing facility
39 services cited in subsection b.(13) of this section.

40 (4) Individuals who are blind or disabled shall be provided with
41 services cited in subsection a.(3) and (5) of this section and
42 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
43 (12), (15), and (17) of this section, and nursing facility services
44 cited in subsection b.(13) of this section.

45 (5) (a) Inpatient hospital services, subsection a.(1) of this
46 section, shall only be provided to eligible medically needy
47 individuals, other than pregnant women, if the federal Department
48 of Health and Human Services discontinues the State's waiver to

1 establish inpatient hospital reimbursement rates for the Medicare
2 and Medicaid programs under the authority of section 601(c)(3) of
3 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
4 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
5 extended to other eligible medically needy individuals if the federal
6 Department of Health and Human Services directs that these
7 services be included.

8 (b) Outpatient hospital services, subsection a.(2) of this section,
9 shall only be provided to eligible medically needy individuals if the
10 federal Department of Health and Human Services discontinues the
11 State's waiver to establish outpatient hospital reimbursement rates
12 for the Medicare and Medicaid programs under the authority of
13 section 601(c)(3) of the Social Security Amendments of 1983,
14 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
15 services may be extended to all or to certain medically needy
16 individuals if the federal Department of Health and Human Services
17 directs that these services be included. However, the use of
18 outpatient hospital services shall be limited to clinic services and to
19 emergency room services for injuries and significant acute medical
20 conditions.

21 (c) The division shall monitor the use of inpatient and outpatient
22 hospital services by medically needy persons.

23 h. In the case of a qualified disabled and working individual
24 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
25 only medical assistance provided under this act shall be the
26 payment of premiums for Medicare part A under 42 U.S.C.
27 ss.1395i-2 and 1395r.

28 i. In the case of a specified low-income Medicare beneficiary
29 pursuant to 42 U.S.C. s.1396a(a)(10)(E)iii, the only medical
30 assistance provided under this act shall be the payment of premiums
31 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
32 U.S.C. s.1396d(p)(3)(A)(ii).

33 j. In the case of a qualified individual pursuant to 42 U.S.C.
34 s.1396a(aa), the only medical assistance provided under this act
35 shall be payment for authorized services provided during the period
36 in which the individual requires treatment for breast or cervical
37 cancer, in accordance with criteria established by the commissioner.

38 k. In the case of a qualified individual pursuant to 42 U.S.C.
39 s.1396a(ii), the only medical assistance provided under this act shall
40 be payment for family planning services and supplies as described
41 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
42 treatment services that are provided pursuant to a family planning
43 service in a family planning setting.

44 (cf: P.L.2012, c.17, s.359)

45
46 3. The Commissioner of Human Services, pursuant to the
47 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et

1 seq.), shall adopt rules and regulations necessary to implement the
2 provisions of this act.

3
4 4. This act shall take effect on the first day of the fourth month
5 next following the date of enactment, but the Commissioner of
6 Human Services may take such anticipatory administrative action in
7 advance thereof, including, but not limited to, the submission of a
8 State plan amendment to the federal Centers for Medicare &
9 Medicaid Services, as may be necessary for the implementation of
10 this act.

11

12

13

STATEMENT

14

15

16 This bill provides Medicaid coverage for family planning
17 services to individuals whose income does not exceed 200 percent
18 of the federal poverty level.

19 Specifically, the bill expands coverage of family planning
20 services to non-pregnant individuals whose income does not exceed
21 the highest income eligibility level established for pregnant women
22 under the State plan under Title XIX or Title XXI of the federal
23 Social Security Act (Medicaid and the Children's Health Insurance
24 Program, respectively), which is currently 200 percent of the
25 federal poverty level in New Jersey.

26 This bill exercises a new State option provided under the federal
27 "Patient Protection and Affordable Care Act," Pub.L.111-148, as
28 amended by the "Health Care and Education Reconciliation Act of
29 2010," Pub.L.111-152, which permits states to expand family
30 planning services through a State plan amendment, rather than
31 through a demonstration waiver under section 1115 of the Social
32 Security Act. Under federal law, the federal government would pay
33 90 percent of the costs for these services.

34 The bill takes effect on the first day of the fourth month
35 following its enactment, but authorizes the Commissioner of Human
36 Services to take such prior administrative action as may be
37 necessary for implementation.

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1656

STATE OF NEW JERSEY

DATED: JANUARY 29, 2018

The Assembly Health and Senior Services Committee reports favorably Assembly Bill No. 1656.

This bill provides Medicaid coverage for family planning services to individuals whose income does not exceed 200 percent of the federal poverty level.

Specifically, the bill expands coverage of family planning services to non-pregnant individuals whose income does not exceed the highest income eligibility level established for pregnant women under the State plan under Title XIX or Title XXI of the federal Social Security Act (Medicaid and the Children's Health Insurance Program, respectively), which is currently 200 percent of the federal poverty level in New Jersey.

This bill exercises a new State option provided under the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, which permits states to expand family planning services through a State plan amendment, rather than through a demonstration waiver under section 1115 of the Social Security Act. Under federal law, the federal government would pay 90 percent of the costs for these services.

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

LEGISLATIVE FISCAL ESTIMATE
ASSEMBLY, No. 1656
STATE OF NEW JERSEY
218th LEGISLATURE

DATED: FEBRUARY 9, 2018

SUMMARY

Synopsis: Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

Type of Impact: Annual expenditure increase to the State General Fund; partially offset by enhanced federal Medicaid funds.

Agencies Affected: Department of Human Services.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
Annual State Expenditure Increase	Indeterminate – See comments below
Annual State Revenue Increase	Indeterminate – See comments below

- The Office of Legislative Services (OLS) estimates that the State may incur annual net costs to provide family planning services to individuals who enroll in the Medicaid family planning expansion established by the bill. However, due to the fairly narrow target population and the 90 percent federal matching rate, total annual net State costs are likely to be insignificant.

BILL DESCRIPTION

This bill would provide Medicaid coverage for family planning services to individuals whose income does not exceed 200 percent of the federal poverty level.

Specifically, the bill would expand coverage of family planning services to non-pregnant individuals whose income does not exceed the highest income eligibility level established for pregnant women under the State plan under Title XIX or Title XXI of the federal Social Security Act (Medicaid and the Children’s Health Insurance Program, respectively), which is currently 200 percent of the federal poverty level in New Jersey.

This bill would exercise a State option provided under the federal Affordable Care Act, which permits states to expand family planning services through a State plan amendment rather

than through a demonstration waiver under section 1115 of the Social Security Act. The federal government would pay 90 percent of the costs for these services.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates that the State may incur annual net costs to provide family planning services to individuals who enroll in the Medicaid family planning expansion established by the bill. It is not possible to quantify the total annual net State costs for this expansion, but they are likely to be insignificant because the federal Affordable Care Act provides that 90 percent of the total costs would be covered by the federal government and because it is likely that only a fairly small number of individuals would be eligible and apply for the program.

Due to the Affordable Care Act, individuals who earn less than 138 percent of the federal poverty level are eligible for Medicaid, which covers family planning services. Therefore, the bill's program would be targeted to people who earn between 138 percent and 200 percent of the federal poverty level. Many of the individuals who have this income level may also qualify for heavily subsidized health insurance through the Affordable Care Act and thus may also already have access to family planning services. It is not possible for the OLS to determine the number of individuals who meet the financial eligibility criteria but do not purchase insurance and need access to family planning services, but it is likely to be marginal. Without information on the number of likely recipients, the OLS cannot quantify the cost of this legislation, but it is likely to be insignificant.

Section: Human Services

*Analyst: David Drescher
Senior Fiscal Analyst*

*Approved: Frank W. Haines III
Legislative Budget and Finance Officer*

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

ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1656

STATE OF NEW JERSEY

DATED: FEBRUARY 12, 2018

The Assembly Budget Committee reports favorably Assembly Bill No. 1656.

This bill provides Medicaid coverage for family planning services to individuals whose income does not exceed 200 percent of the federal poverty level.

Specifically, the bill expands coverage of family planning services to non-pregnant individuals whose income does not exceed the highest income eligibility level established for pregnant women under the State plan under Title XIX or Title XXI of the federal Social Security Act (Medicaid and the Children's Health Insurance Program, respectively), which is currently 200 percent of the federal poverty level in New Jersey.

This bill exercises a new State option provided under the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, which permits states to expand family planning services through a State plan amendment, rather than through a demonstration waiver under section 1115 of the Social Security Act. Under federal law, the federal government would pay 90 percent of the costs for these services.

The bill takes effect on the first day of the fourth month following its enactment, but authorizes the Commissioner of Human Services to take such prior administrative action as may be necessary for its implementation.

As reported, this bill is identical to Senate Bill No. 105, as also reported by the committee.

FISCAL IMPACT:

The Office of Legislative Services (OLS) estimates that this bill may cause the State to incur costs to provide family planning services to individuals who enroll in the Medicaid family planning expansion established by the bill. However, due to the fairly narrow target population and the 90 percent federal matching rate, total State costs are likely to be minimal.

ASSEMBLY, No. 1656

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Assemblywoman ELIANA PINTOR MARIN

District 29 (Essex)

Assemblyman JOSEPH A. LAGANA

District 38 (Bergen and Passaic)

Assemblywoman MILA M. JASEY

District 27 (Essex and Morris)

Assemblyman RAJ MUKHERJI

District 33 (Hudson)

Assemblywoman JOANN DOWNEY

District 11 (Monmouth)

Co-Sponsored by:

Assemblyman McKeon, Assemblywomen Mosquera, Muoio, Caride, Assemblymen Houghtaling, Johnson, Kennedy, Assemblywomen Tucker, Pinkin, Assemblymen Coughlin, Benson, Wimberly, Assemblywoman Vainieri Huttie, Assemblyman Holley, Assemblywomen Reynolds-Jackson, Murphy, McKnight and Quijano

SYNOPSIS

Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

CURRENT VERSION OF TEXT

As reported by the Assembly Health and Senior Services Committee with technical review.

(Sponsorship Updated As Of: 2/16/2018)

1 **AN ACT** concerning Medicaid coverage for family planning services
2 and amending P.L.1968, c.413.

3

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

6

7 1. Section 3 of P.L.1968, c.413 (C.30:4D-3) is amended to read
8 as follows:

9 3. Definitions. As used in P.L.1968, c.413 (C.30:4D-1 et seq.),
10 and unless the context otherwise requires:

11 a. "Applicant" means any person who has made application for
12 purposes of becoming a "qualified applicant."

13 b. "Commissioner" means the Commissioner of Human
14 Services.

15 c. "Department" means the Department of Human Services,
16 which is herein designated as the single State agency to administer
17 the provisions of this act.

18 d. "Director" means the Director of the Division of Medical
19 Assistance and Health Services.

20 e. "Division" means the Division of Medical Assistance and
21 Health Services.

22 f. "Medicaid" means the New Jersey Medical Assistance and
23 Health Services Program.

24 g. "Medical assistance" means payments on behalf of recipients
25 to providers for medical care and services authorized under
26 P.L.1968, c.413.

27 h. "Provider" means any person, public or private institution,
28 agency, or business concern approved by the division lawfully
29 providing medical care, services, goods, and supplies authorized
30 under P.L.1968, c.413, holding, where applicable, a current valid
31 license to provide such services or to dispense such goods or
32 supplies.

33 i. "Qualified applicant" means a person who is a resident of
34 this State, and either a citizen of the United States or an eligible
35 alien, and is determined to need medical care and services as
36 provided under P.L.1968, c.413, with respect to whom the period
37 for which eligibility to be a recipient is determined shall be the
38 maximum period permitted under federal law, and who:

39 (1) Is a dependent child or parent or caretaker relative of a
40 dependent child who would be, except for resources, eligible for the
41 aid to families with dependent children program under the State
42 Plan for Title IV-A of the federal Social Security Act as of July 16,
43 1996;

44 (2) Is a recipient of Supplemental Security Income for the Aged,

**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.

- 1 Blind and Disabled under Title XVI of the Social Security Act;
- 2 (3) Is an "ineligible spouse" of a recipient of Supplemental
- 3 Security Income for the Aged, Blind and Disabled under Title XVI
- 4 of the Social Security Act, as defined by the federal Social Security
- 5 Administration;
- 6 (4) Would be eligible to receive Supplemental Security Income
- 7 under Title XVI of the federal Social Security Act or, without
- 8 regard to resources, would be eligible for the aid to families with
- 9 dependent children program under the State Plan for Title IV-A of
- 10 the federal Social Security Act as of July 16, 1996, except for
- 11 failure to meet an eligibility condition or requirement imposed
- 12 under such State program which is prohibited under Title XIX of
- 13 the federal Social Security Act such as a durational residency
- 14 requirement, relative responsibility, consent to imposition of a lien;
- 15 (5) (Deleted by amendment, P.L.2000, c.71).
- 16 (6) Is an individual under 21 years of age who, without regard to
- 17 resources, would be, except for dependent child requirements,
- 18 eligible for the aid to families with dependent children program
- 19 under the State Plan for Title IV-A of the federal Social Security
- 20 Act as of July 16, 1996, or groups of such individuals, including but
- 21 not limited to, children in resource family placement under
- 22 supervision of the Division of Child Protection and Permanency in
- 23 the Department of Children and Families whose maintenance is
- 24 being paid in whole or in part from public funds, children placed in
- 25 a resource family home or institution by a private adoption agency
- 26 in New Jersey or children in intermediate care facilities, including
- 27 developmental centers for the developmentally disabled, or in
- 28 psychiatric hospitals;
- 29 (7) Would be eligible for the Supplemental Security Income
- 30 program, but is not receiving such assistance and applies for
- 31 medical assistance only;
- 32 (8) Is determined to be medically needy and meets all the
- 33 eligibility requirements described below:
- 34 (a) The following individuals are eligible for services, if they
- 35 are determined to be medically needy:
- 36 (i) Pregnant women;
- 37 (ii) Dependent children under the age of 21;
- 38 (iii) Individuals who are 65 years of age and older; and
- 39 (iv) Individuals who are blind or disabled pursuant to either 42
- 40 C.F.R.435.530 et seq. or 42 C.F.R.435.540 et seq., respectively.
- 41 (b) The following income standard shall be used to determine
- 42 medically needy eligibility:
- 43 (i) For one person and two person households, the income
- 44 standard shall be the maximum allowable under federal law, but
- 45 shall not exceed 133 1/3% of the State's payment level to two
- 46 person households under the aid to families with dependent children
- 47 program under the State Plan for Title IV-A of the federal Social
- 48 Security Act in effect as of July 16, 1996; and

- 1 (ii) For households of three or more persons, the income
2 standard shall be set at 133 1/3% of the State's payment level to
3 similar size households under the aid to families with dependent
4 children program under the State Plan for Title IV-A of the federal
5 Social Security Act in effect as of July 16, 1996.
- 6 (c) The following resource standard shall be used to determine
7 medically needy eligibility:
- 8 (i) For one person households, the resource standard shall be
9 200% of the resource standard for recipients of Supplemental
10 Security Income pursuant to 42 U.S.C. s.1382(1)(B);
- 11 (ii) For two person households, the resource standard shall be
12 200% of the resource standard for recipients of Supplemental
13 Security Income pursuant to 42 U.S.C. s.1382(2)(B);
- 14 (iii) For households of three or more persons, the resource
15 standard in subparagraph (c)(ii) above shall be increased by
16 \$100.00 for each additional person; and
- 17 (iv) The resource standards established in (i), (ii), and (iii) are
18 subject to federal approval and the resource standard may be lower
19 if required by the federal Department of Health and Human
20 Services.
- 21 (d) Individuals whose income exceeds those established in
22 subparagraph (b) of paragraph (8) of this subsection may become
23 medically needy by incurring medical expenses as defined in 42
24 C.F.R.435.831(c) which will reduce their income to the applicable
25 medically needy income established in subparagraph (b) of
26 paragraph (8) of this subsection.
- 27 (e) A six-month period shall be used to determine whether an
28 individual is medically needy.
- 29 (f) Eligibility determinations for the medically needy program
30 shall be administered as follows:
- 31 (i) County welfare agencies and other entities designated by the
32 commissioner are responsible for determining and certifying the
33 eligibility of pregnant women and dependent children. The division
34 shall reimburse county welfare agencies for 100% of the reasonable
35 costs of administration which are not reimbursed by the federal
36 government for the first 12 months of this program's operation.
37 Thereafter, 75% of the administrative costs incurred by county
38 welfare agencies which are not reimbursed by the federal
39 government shall be reimbursed by the division;
- 40 (ii) The division is responsible for certifying the eligibility of
41 individuals who are 65 years of age and older and individuals who
42 are blind or disabled. The division may enter into contracts with
43 county welfare agencies to determine certain aspects of eligibility.
44 In such instances the division shall provide county welfare agencies
45 with all information the division may have available on the
46 individual.
- 47 The division shall notify all eligible recipients of the
48 Pharmaceutical Assistance to the Aged and Disabled program,

1 P.L.1975, c.194 (C.30:4D-20 et seq.) on an annual basis of the
2 medically needy program and the program's general requirements.
3 The division shall take all reasonable administrative actions to
4 ensure that Pharmaceutical Assistance to the Aged and Disabled
5 recipients, who notify the division that they may be eligible for the
6 program, have their applications processed expeditiously, at times
7 and locations convenient to the recipients; and
8 (iii) The division is responsible for certifying incurred medical
9 expenses for all eligible persons who attempt to qualify for the
10 program pursuant to subparagraph (d) of paragraph (8) of this
11 subsection;
12 (9) (a) Is a child who is at least one year of age and under 19
13 years of age and, if older than six years of age but under 19 years of
14 age, is uninsured; and
15 (b) Is a member of a family whose income does not exceed
16 133% of the poverty level and who meets the federal Medicaid
17 eligibility requirements set forth in section 9401 of Pub.L.99-509
18 (42 U.S.C. s.1396a);
19 (10) Is a pregnant woman who is determined by a provider to be
20 presumptively eligible for medical assistance based on criteria
21 established by the commissioner, pursuant to section 9407 of
22 Pub.L.99-509 (42 U.S.C. s.1396a(a));
23 (11) Is an individual 65 years of age and older, or an individual
24 who is blind or disabled pursuant to section 301 of Pub.L.92-603
25 (42 U.S.C. s.1382c), whose income does not exceed 100% of the
26 poverty level, adjusted for family size, and whose resources do not
27 exceed 100% of the resource standard used to determine medically
28 needy eligibility pursuant to paragraph (8) of this subsection;
29 (12) Is a qualified disabled and working individual pursuant to
30 section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d) whose income
31 does not exceed 200% of the poverty level and whose resources do
32 not exceed 200% of the resource standard used to determine
33 eligibility under the Supplemental Security Income Program,
34 P.L.1973, c.256 (C.44:7-85 et seq.);
35 (13) Is a pregnant woman or is a child who is under one year of
36 age and is a member of a family whose income does not exceed
37 185% of the poverty level and who meets the federal Medicaid
38 eligibility requirements set forth in section 9401 of Pub.L.99-509
39 (42 U.S.C. s.1396a), except that a pregnant woman who is
40 determined to be a qualified applicant shall, notwithstanding any
41 change in the income of the family of which she is a member,
42 continue to be deemed a qualified applicant until the end of the 60-
43 day period beginning on the last day of her pregnancy;
44 (14) (Deleted by amendment, P.L.1997, c.272).
45 (15) (a) Is a specified low-income Medicare beneficiary pursuant
46 to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January
47 1, 1993 do not exceed 200% of the resource standard used to
48 determine eligibility under the Supplemental Security Income

1 program, P.L.1973, c.256 (C.44:7-85 et seq.) and whose income
2 beginning January 1, 1993 does not exceed 110% of the poverty
3 level, and beginning January 1, 1995 does not exceed 120% of the
4 poverty level.

5 (b) An individual who has, within 36 months, or within 60
6 months in the case of funds transferred into a trust, of applying to
7 be a qualified applicant for Medicaid services in a nursing facility
8 or a medical institution, or for home or community-based services
9 under section 1915(c) of the federal Social Security Act (42 U.S.C.
10 s.1396n(c)), disposed of resources or income for less than fair
11 market value shall be ineligible for assistance for nursing facility
12 services, an equivalent level of services in a medical institution, or
13 home or community-based services under section 1915(c) of the
14 federal Social Security Act (42 U.S.C. s.1396n(c)). The period of
15 the ineligibility shall be the number of months resulting from
16 dividing the uncompensated value of the transferred resources or
17 income by the average monthly private payment rate for nursing
18 facility services in the State as determined annually by the
19 commissioner. In the case of multiple resource or income transfers,
20 the resulting penalty periods shall be imposed sequentially.
21 Application of this requirement shall be governed by 42 U.S.C.
22 s.1396p(c). In accordance with federal law, this provision is
23 effective for all transfers of resources or income made on or after
24 August 11, 1993. Notwithstanding the provisions of this subsection
25 to the contrary, the State eligibility requirements concerning
26 resource or income transfers shall not be more restrictive than those
27 enacted pursuant to 42 U.S.C. s.1396p(c).

28 (c) An individual seeking nursing facility services or home or
29 community-based services and who has a community spouse shall
30 be required to expend those resources which are not protected for
31 the needs of the community spouse in accordance with section
32 1924(c) of the federal Social Security Act (42 U.S.C. s.1396r-5(c))
33 on the costs of long-term care, burial arrangements, and any other
34 expense deemed appropriate and authorized by the commissioner.
35 An individual shall be ineligible for Medicaid services in a nursing
36 facility or for home or community-based services under section
37 1915(c) of the federal Social Security Act (42 U.S.C. s.1396n(c)) if
38 the individual expends funds in violation of this subparagraph. The
39 period of ineligibility shall be the number of months resulting from
40 dividing the uncompensated value of transferred resources and
41 income by the average monthly private payment rate for nursing
42 facility services in the State as determined by the commissioner.
43 The period of ineligibility shall begin with the month that the
44 individual would otherwise be eligible for Medicaid coverage for
45 nursing facility services or home or community-based services.

46 This subparagraph shall be operative only if all necessary
47 approvals are received from the federal government including, but

1 not limited to, approval of necessary State plan amendments and
2 approval of any waivers;

3 (16) Subject to federal approval under Title XIX of the federal
4 Social Security Act, is a dependent child, parent or specified
5 caretaker relative of a child who is a qualified applicant, who would
6 be eligible, without regard to resources, for the aid to families with
7 dependent children program under the State Plan for Title IV-A of
8 the federal Social Security Act as of July 16, 1996, except for the
9 income eligibility requirements of that program, and whose family
10 earned income,

11 (a) if a dependent child, does not exceed 133% of the poverty
12 level; and

13 (b) if a parent or specified caretaker relative, beginning
14 September 1, 2005 does not exceed 100% of the poverty level,
15 beginning September 1, 2006 does not exceed 115% of the poverty
16 level and beginning September 1, 2007 does not exceed 133% of
17 the poverty level,

18 plus such earned income disregards as shall be determined
19 according to a methodology to be established by regulation of the
20 commissioner;

21 The commissioner may increase the income eligibility limits for
22 children and parents and specified caretaker relatives, as funding
23 permits;

24 (17) Is an individual from 18 through 20 years of age who is not a
25 dependent child and would be eligible for medical assistance
26 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to
27 income or resources, who, on the individual's 18th birthday was in
28 resource family care under the care and custody of the Division of
29 Child Protection and Permanency in the Department of Children
30 and Families and whose maintenance was being paid in whole or in
31 part from public funds;

32 (18) Is a person between the ages of 16 and 65 who is
33 permanently disabled and working, and:

34 (a) whose income is at or below 250% of the poverty level, plus
35 other established disregards;

36 (b) who pays the premium contribution and other cost sharing as
37 established by the commissioner, subject to the limits and
38 conditions of federal law; and

39 (c) whose assets, resources and unearned income do not exceed
40 limitations as established by the commissioner;

41 (19) Is an uninsured individual under 65 years of age who:

42 (a) has been screened for breast or cervical cancer under the
43 federal Centers for Disease Control and Prevention breast and
44 cervical cancer early detection program;

45 (b) requires treatment for breast or cervical cancer based upon
46 criteria established by the commissioner;

47 (c) has an income that does not exceed the income standard
48 established by the commissioner pursuant to federal guidelines;

1 (d) meets all other Medicaid eligibility requirements; and

2 (e) in accordance with Pub.L.106-354, is determined by a
3 qualified entity to be presumptively eligible for medical assistance
4 pursuant to 42 U.S.C. s.1396a(aa), based upon criteria established
5 by the commissioner pursuant to section 1920B of the federal Social
6 Security Act (42 U.S.C. s.1396r-1b); **【or】**

7 (20) Subject to federal approval under Title XIX of the federal
8 Social Security Act, is a single adult or couple, without dependent
9 children, whose income in 2006 does not exceed 50% of the poverty
10 level, in 2007 does not exceed 75% of the poverty level and in 2008
11 and each year thereafter does not exceed 100% of the poverty level;
12 except that a person who is a recipient of Work First New Jersey
13 general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107
14 et seq.), shall not be a qualified applicant; or

15 (21) is an individual who:

16 (a) has an income that does not exceed the highest income
17 eligibility level for pregnant women established under the State
18 plan under Title XIX or Title XXI of the federal Social Security
19 Act;

20 (b) is not pregnant; and

21 (c) is eligible to receive family planning services provided
22 under the Medicaid program pursuant to subsection k. of section 6
23 of P.L.1968, c.413 (C.30:4D-6) and in accordance with 42 U.S.C.
24 s.1396a(ii).

25 j. "Recipient" means any qualified applicant receiving benefits
26 under this act.

27 k. "Resident" means a person who is living in the State
28 voluntarily with the intention of making his home here and not for a
29 temporary purpose. Temporary absences from the State, with
30 subsequent returns to the State or intent to return when the purposes
31 of the absences have been accomplished, do not interrupt continuity
32 of residence.

33 l. "State Medicaid Commission" means the Governor, the
34 Commissioner of Human Services, the President of the Senate and
35 the Speaker of the General Assembly, hereby constituted a
36 commission to approve and direct the means and method for the
37 payment of claims pursuant to P.L.1968, c.413.

38 m. "Third party" means any person, institution, corporation,
39 insurance company, group health plan as defined in section 607(1)
40 of the federal "Employee Retirement and Income Security Act of
41 1974," 29 U.S.C. s.1167(1), service benefit plan, health
42 maintenance organization, or other prepaid health plan, or public,
43 private or governmental entity who is or may be liable in contract,
44 tort, or otherwise by law or equity to pay all or part of the medical
45 cost of injury, disease or disability of an applicant for or recipient
46 of medical assistance payable under P.L.1968, c.413.

47 n. "Governmental peer grouping system" means a separate
48 class of skilled nursing and intermediate care facilities administered

- 1 by the State or county governments, established for the purpose of
2 screening their reported costs and setting reimbursement rates under
3 the Medicaid program that are reasonable and adequate to meet the
4 costs that must be incurred by efficiently and economically operated
5 State or county skilled nursing and intermediate care facilities.
- 6 o. "Comprehensive maternity or pediatric care provider" means
7 any person or public or private health care facility that is a provider
8 and that is approved by the commissioner to provide comprehensive
9 maternity care or comprehensive pediatric care as defined in
10 subsection b. (18) and (19) of section 6 of P.L.1968, c.413
11 (C.30:4D-6).
- 12 p. "Poverty level" means the official poverty level based on
13 family size established and adjusted under Section 673(2) of
14 Subtitle B, the "Community Services Block Grant Act," of
15 Pub.L.97-35 (42 U.S.C. s.9902(2)).
- 16 q. "Eligible alien" means one of the following:
- 17 (1) an alien present in the United States prior to August 22,
18 1996, who is:
- 19 (a) a lawful permanent resident;
- 20 (b) a refugee pursuant to section 207 of the federal "Immigration
21 and Nationality Act" (8 U.S.C. s.1157);
- 22 (c) an asylee pursuant to section 208 of the federal
23 "Immigration and Nationality Act" (8 U.S.C. s.1158);
- 24 (d) an alien who has had deportation withheld pursuant to
25 section 243(h) of the federal "Immigration and Nationality Act" (8
26 U.S.C. s.1253 (h));
- 27 (e) an alien who has been granted parole for less than one year
28 by the U.S. Citizenship and Immigration Services pursuant to
29 section 212(d)(5) of the federal "Immigration and Nationality Act"
30 (8 U.S.C. s.1182(d)(5));
- 31 (f) an alien granted conditional entry pursuant to section
32 203(a)(7) of the federal "Immigration and Nationality Act" (8
33 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or
- 34 (g) an alien who is honorably discharged from or on active duty
35 in the United States armed forces and the alien's spouse and
36 unmarried dependent child.
- 37 (2) An alien who entered the United States on or after August
38 22, 1996, who is:
- 39 (a) an alien as described in paragraph (1)(b), (c), (d) or (g) of
40 this subsection; or
- 41 (b) an alien as described in paragraph (1)(a), (e) or (f) of this
42 subsection who entered the United States at least five years ago.
- 43 (3) A legal alien who is a victim of domestic violence in
44 accordance with criteria specified for eligibility for public benefits
45 as provided in Title V of the federal "Illegal Immigration Reform
46 and Immigrant Responsibility Act of 1996" (8 U.S.C. s.1641).
47 (cf: P.L.2012, c.16, s.114)

1 2. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
2 as follows:

3 6. a. Subject to the requirements of Title XIX of the federal
4 Social Security Act, the limitations imposed by this act and by the
5 rules and regulations promulgated pursuant thereto, the department
6 shall provide medical assistance to qualified applicants, including
7 authorized services within each of the following classifications:

- 8 (1) Inpatient hospital services;
- 9 (2) Outpatient hospital services;
- 10 (3) Other laboratory and X-ray services;
- 11 (4) (a) Skilled nursing or intermediate care facility services;
- 12 (b) Early and periodic screening and diagnosis of individuals
13 who are eligible under the program and are under age 21, to
14 ascertain their physical or mental health status and the health care,
15 treatment, and other measures to correct or ameliorate defects and
16 chronic conditions discovered thereby, as may be provided in
17 regulations of the Secretary of the federal Department of Health and
18 Human Services and approved by the commissioner;
- 19 (5) Physician's services furnished in the office, the patient's
20 home, a hospital, a skilled nursing, or intermediate care facility or
21 elsewhere.

22 As used in this subsection, "laboratory and X-ray services"
23 includes HIV drug resistance testing, including, but not limited to,
24 genotype assays that have been cleared or approved by the federal
25 Food and Drug Administration, laboratory developed genotype
26 assays, phenotype assays, and other assays using phenotype
27 prediction with genotype comparison, for persons diagnosed with
28 HIV infection or AIDS.

29 b. Subject to the limitations imposed by federal law, by this
30 act, and by the rules and regulations promulgated pursuant thereto,
31 the medical assistance program may be expanded to include
32 authorized services within each of the following classifications:

- 33 (1) Medical care not included in subsection a.(5) above, or any
34 other type of remedial care recognized under State law, furnished
35 by licensed practitioners within the scope of their practice, as
36 defined by State law;
- 37 (2) Home health care services;
- 38 (3) Clinic services;
- 39 (4) Dental services;
- 40 (5) Physical therapy and related services;
- 41 (6) Prescribed drugs, dentures, and prosthetic devices; and
42 eyeglasses prescribed by a physician skilled in diseases of the eye
43 or by an optometrist, whichever the individual may select;
- 44 (7) Optometric services;
- 45 (8) Podiatric services;
- 46 (9) Chiropractic services;
- 47 (10) Psychological services;

- 1 (11) Inpatient psychiatric hospital services for individuals under
2 21 years of age, or under age 22 if they are receiving such services
3 immediately before attaining age 21;
- 4 (12) Other diagnostic, screening, preventive, and rehabilitative
5 services, and other remedial care;
- 6 (13) Inpatient hospital services, nursing facility services, and
7 intermediate care facility services for individuals 65 years of age or
8 over in an institution for mental diseases;
- 9 (14) Intermediate care facility services;
- 10 (15) Transportation services;
- 11 (16) Services in connection with the inpatient or outpatient
12 treatment or care of substance use disorder, when the treatment is
13 prescribed by a physician and provided in a licensed hospital or in a
14 narcotic and substance use disorder treatment center approved by
15 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
16 et seq.) and whose staff includes a medical director, and limited to
17 those services eligible for federal financial participation under Title
18 XIX of the federal Social Security Act;
- 19 (17) Any other medical care and any other type of remedial care
20 recognized under State law, specified by the Secretary of the federal
21 Department of Health and Human Services, and approved by the
22 commissioner;
- 23 (18) Comprehensive maternity care, which may include: the
24 basic number of prenatal and postpartum visits recommended by the
25 American College of Obstetrics and Gynecology; additional
26 prenatal and postpartum visits that are medically necessary;
27 necessary laboratory, nutritional assessment and counseling, health
28 education, personal counseling, managed care, outreach, and
29 follow-up services; treatment of conditions which may complicate
30 pregnancy; and physician or certified nurse-midwife delivery
31 services;
- 32 (19) Comprehensive pediatric care, which may include:
33 ambulatory, preventive, and primary care health services. The
34 preventive services shall include, at a minimum, the basic number
35 of preventive visits recommended by the American Academy of
36 Pediatrics;
- 37 (20) Services provided by a hospice which is participating in the
38 Medicare program established pursuant to Title XVIII of the Social
39 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
40 services shall be provided subject to approval of the Secretary of
41 the federal Department of Health and Human Services for federal
42 reimbursement;
- 43 (21) Mammograms, subject to approval of the Secretary of the
44 federal Department of Health and Human Services for federal
45 reimbursement, including one baseline mammogram for women
46 who are at least 35 but less than 40 years of age; one mammogram
47 examination every two years or more frequently, if recommended
48 by a physician, for women who are at least 40 but less than 50 years

1 of age; and one mammogram examination every year for women
2 age 50 and over;

3 (22) Upon referral by a physician, advanced practice nurse, or
4 physician assistant of a person who has been diagnosed with
5 diabetes, gestational diabetes, or pre-diabetes, in accordance with
6 standards adopted by the American Diabetes Association :

7 (a) Expenses for diabetes self-management education or training
8 to ensure that a person with diabetes, gestational diabetes, or pre-
9 diabetes can optimize metabolic control, prevent and manage
10 complications, and maximize quality of life. Diabetes self-
11 management education shall be provided by an in-State provider
12 who is:

13 (i) a licensed, registered, or certified health care professional
14 who is certified by the National Certification Board of Diabetes
15 Educators as a Certified Diabetes Educator, or certified by the
16 American Association of Diabetes Educators with a Board
17 Certified-Advanced Diabetes Management credential, including, but
18 not limited to: a physician, an advanced practice or registered nurse,
19 a physician assistant, a pharmacist, a chiropractor, a dietitian
20 registered by a nationally recognized professional association of
21 dietitians, or a nutritionist holding a certified nutritionist specialist
22 (CNS) credential from the Board for Certification of Nutrition
23 Specialists ; or

24 (ii) an entity meeting the National Standards for Diabetes Self-
25 Management Education and Support, as evidenced by a recognition
26 by the American Diabetes Association or accreditation by the
27 American Association of Diabetes Educators;

28 (b) Expenses for medical nutrition therapy as an effective
29 component of the person's overall treatment plan upon a: diagnosis
30 of diabetes, gestational diabetes, or pre-diabetes; change in the
31 beneficiary's medical condition, treatment, or diagnosis; or
32 determination of a physician, advanced practice nurse, or physician
33 assistant that reeducation or refresher education is necessary.
34 Medical nutrition therapy shall be provided by an in-State provider
35 who is a dietitian registered by a nationally-recognized professional
36 association of dietitians, or a nutritionist holding a certified
37 nutritionist specialist (CNS) credential from the Board for
38 Certification of Nutrition Specialists, who is familiar with the
39 components of diabetes medical nutrition therapy;

40 (c) For a person diagnosed with pre-diabetes, items and services
41 furnished under an in-State diabetes prevention program that meets
42 the standards of the National Diabetes Prevention Program, as
43 established by the federal Centers for Disease Control and
44 Prevention; and

45 (d) Expenses for any medically appropriate and necessary
46 supplies and equipment recommended or prescribed by a physician,
47 advanced practice nurse, or physician assistant for the management
48 and treatment of diabetes, gestational diabetes, or pre-diabetes,

1 including, but not limited to: equipment and supplies for self-
2 management of blood glucose; insulin pens; insulin pumps and
3 related supplies; and other insulin delivery devices.

4 c. Payments for the foregoing services, goods, and supplies
5 furnished pursuant to this act shall be made to the extent authorized
6 by this act, the rules and regulations promulgated pursuant thereto
7 and, where applicable, subject to the agreement of insurance
8 provided for under this act. The payments shall constitute payment
9 in full to the provider on behalf of the recipient. Every provider
10 making a claim for payment pursuant to this act shall certify in
11 writing on the claim submitted that no additional amount will be
12 charged to the recipient, the recipient's family, the recipient's
13 representative or others on the recipient's behalf for the services,
14 goods, and supplies furnished pursuant to this act.

15 No provider whose claim for payment pursuant to this act has
16 been denied because the services, goods, or supplies were
17 determined to be medically unnecessary shall seek reimbursement
18 from the recipient, his family, his representative or others on his
19 behalf for such services, goods, and supplies provided pursuant to
20 this act; provided, however, a provider may seek reimbursement
21 from a recipient for services, goods, or supplies not authorized by
22 this act, if the recipient elected to receive the services, goods or
23 supplies with the knowledge that they were not authorized.

24 d. Any individual eligible for medical assistance (including
25 drugs) may obtain such assistance from any person qualified to
26 perform the service or services required (including an organization
27 which provides such services, or arranges for their availability on a
28 prepayment basis), who undertakes to provide the individual such
29 services.

30 No copayment or other form of cost-sharing shall be imposed on
31 any individual eligible for medical assistance, except as mandated
32 by federal law as a condition of federal financial participation.

33 e. Anything in this act to the contrary notwithstanding, no
34 payments for medical assistance shall be made under this act with
35 respect to care or services for any individual who:

36 (1) Is an inmate of a public institution (except as a patient in a
37 medical institution); provided, however, that an individual who is
38 otherwise eligible may continue to receive services for the month in
39 which he becomes an inmate, should the commissioner determine to
40 expand the scope of Medicaid eligibility to include such an
41 individual, subject to the limitations imposed by federal law and
42 regulations, or

43 (2) Has not attained 65 years of age and who is a patient in an
44 institution for mental diseases, or

45 (3) Is over 21 years of age and who is receiving inpatient
46 psychiatric hospital services in a psychiatric facility; provided,
47 however, that an individual who was receiving such services
48 immediately prior to attaining age 21 may continue to receive such

1 services until the individual reaches age 22. Nothing in this
2 subsection shall prohibit the commissioner from extending medical
3 assistance to all eligible persons receiving inpatient psychiatric
4 services; provided that there is federal financial participation
5 available.

6 f. (1) A third party as defined in section 3 of P.L.1968, c.413
7 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
8 this or another state when determining the person's eligibility for
9 enrollment or the provision of benefits by that third party.

10 (2) In addition, any provision in a contract of insurance, health
11 benefits plan, or other health care coverage document, will, trust,
12 agreement, court order, or other instrument which reduces or
13 excludes coverage or payment for health care-related goods and
14 services to or for an individual because of that individual's actual or
15 potential eligibility for or receipt of Medicaid benefits shall be null
16 and void, and no payments shall be made under this act as a result
17 of any such provision.

18 (3) Notwithstanding any provision of law to the contrary, the
19 provisions of paragraph (2) of this subsection shall not apply to a
20 trust agreement that is established pursuant to 42 U.S.C.
21 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
22 provided by government entities to a person who is disabled as
23 defined in section 1614(a)(3) of the federal Social Security Act (42
24 U.S.C. s.1382c (a)(3)).

25 g. The following services shall be provided to eligible
26 medically needy individuals as follows:

27 (1) Pregnant women shall be provided prenatal care and delivery
28 services and postpartum care, including the services cited in
29 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
30 (10), (12), (15), and (17) of this section, and nursing facility
31 services cited in subsection b.(13) of this section.

32 (2) Dependent children shall be provided with services cited in
33 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
34 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
35 nursing facility services cited in subsection b.(13) of this section.

36 (3) Individuals who are 65 years of age or older shall be
37 provided with services cited in subsection a.(3) and (5) of this
38 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
39 (8), (10), (12), (15), and (17) of this section, and nursing facility
40 services cited in subsection b.(13) of this section.

41 (4) Individuals who are blind or disabled shall be provided with
42 services cited in subsection a.(3) and (5) of this section and
43 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
44 (12), (15), and (17) of this section, and nursing facility services
45 cited in subsection b.(13) of this section.

46 (5) (a) Inpatient hospital services, subsection a.(1) of this
47 section, shall only be provided to eligible medically needy
48 individuals, other than pregnant women, if the federal Department

1 of Health and Human Services discontinues the State's waiver to
2 establish inpatient hospital reimbursement rates for the Medicare
3 and Medicaid programs under the authority of section 601(c)(3) of
4 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
5 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
6 extended to other eligible medically needy individuals if the federal
7 Department of Health and Human Services directs that these
8 services be included.

9 (b) Outpatient hospital services, subsection a.(2) of this section,
10 shall only be provided to eligible medically needy individuals if the
11 federal Department of Health and Human Services discontinues the
12 State's waiver to establish outpatient hospital reimbursement rates
13 for the Medicare and Medicaid programs under the authority of
14 section 601(c)(3) of the Social Security Amendments of 1983,
15 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
16 services may be extended to all or to certain medically needy
17 individuals if the federal Department of Health and Human Services
18 directs that these services be included. However, the use of
19 outpatient hospital services shall be limited to clinic services and to
20 emergency room services for injuries and significant acute medical
21 conditions.

22 (c) The division shall monitor the use of inpatient and outpatient
23 hospital services by medically needy persons.

24 h. In the case of a qualified disabled and working individual
25 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
26 only medical assistance provided under this act shall be the
27 payment of premiums for Medicare part A under 42 U.S.C.
28 ss.1395i-2 and 1395r.

29 i. In the case of a specified low-income Medicare beneficiary
30 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical
31 assistance provided under this act shall be the payment of premiums
32 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
33 U.S.C. s.1396d(p)(3)(A)(ii).

34 j. In the case of a qualified individual pursuant to 42 U.S.C.
35 s.1396a(aa), the only medical assistance provided under this act
36 shall be payment for authorized services provided during the period
37 in which the individual requires treatment for breast or cervical
38 cancer, in accordance with criteria established by the commissioner.

39 k. In the case of a qualified individual pursuant to 42 U.S.C.
40 s.1396a(ii), the only medical assistance provided under this act shall
41 be payment for family planning services and supplies as described
42 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
43 treatment services that are provided pursuant to a family planning
44 service in a family planning setting.

45 (cf: P.L.2017, c.161, s.1)

46
47 3. The Commissioner of Human Services, pursuant to the
48 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et

1 seq.), shall adopt rules and regulations necessary to implement the
2 provisions of this act.

3

4 4. This act shall take effect on the first day of the fourth month
5 next following the date of enactment, but the Commissioner of
6 Human Services may take such anticipatory administrative action in
7 advance thereof, including, but not limited to, the submission of a
8 State plan amendment to the federal Centers for Medicare &
9 Medicaid Services, as may be necessary for the implementation of
10 this act.

Bill S105

Session 2018 - 2019



Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

Bills and Joint Resolutions Signed by the Governor

Identical Bill Number: A1656

Last Session Bill Number: S1017 A1963 A32 S3248

This bill has been certified by OLS for a fiscal note.

Primary Sponsor:

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Greenstein, Linda R.
Pintor Marin, Eliana
Lagana, Joseph A.
Jasey, Mila M.
Mukherji, Raj
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Co-Sponsor:

Cunningham, Sandra B.
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Caride, Marlene
Houghtaling, Eric
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Kennedy, James J.

Tucker, Cleopatra G.

Pinkin, Nancy J.

Coughlin, Craig J.

Benson, Daniel R.

Wimberly, Benjie E.

Vainieri Huttie, Valerie

Holley, Jamel C.

Reynolds-Jackson, Verlina

Murphy, Carol A.

McKnight, Angela V.

Quijano, Annette

1/9/2018	Introduced in the Senate, Referred to Senate Health, Human Services and Senior Citizens Committee
1/22/2018	Reported from Senate Committee, 2nd Reading
2/1/2018	Passed by the Senate (35-5)
2/1/2018	Received in the Assembly, Referred to Assembly Budget Committee
2/12/2018	Reported out of Assembly Committee, 2nd Reading
2/15/2018	Substituted for A1656
2/15/2018	Passed Assembly (Passed Both Houses) (52-20-0)
2/21/2018	Approved P.L.2018, c.1.

Introduced

(15 pages) [PDF Format](#) [HTML Format](#)

Statement - SHH 1/22/18

(1 pages) [PDF Format](#) [HTML Format](#)

Fiscal Estimate - 2/8/18; as introduced

(2 pages) [PDF Format](#) [HTML Format](#)

Statement - ABU 2/12/18

(1 pages) [PDF Format](#) [HTML Format](#)

Technical Review Of Prefiled Bill

(16 pages) [PDF Format](#) [HTML Format](#)

Pamphlet Law

(11 pages) [PDF Format](#) [HTML Format](#)

Advance Law

(15 pages) [PDF Format](#) [HTML Format](#)

Committee Voting:

SHH - 1/22/2018 - r/favorably

Yes: 8 No: 0 Not Voting: 0 Abstain: 1

Roll Call

ABU - 2/12/2018 - r/favorably

Yes: 8 No: 3 Not Voting: 1 Abstain: 0

Roll Call

Session Voting:

Asm. 02/15/2018 - SUB FOR A-1656

Yes:	No:	Not Voting:	Abstain:	- Voice Vote
0	0	80	0	Passed

Asm. 02/15/2018 - 3RDG FINAL PASSAGE

Yes: 52 No: 20 Not Voting: 8 Abstain: 0

Roll Call

Sen. 02/01/2018 - 3RDG FINAL PASSAGE

Yes: 35 No: 5 Not Voting: 0

Roll Call

**indicates synopsis was amended*

Bill A1656

Session 2018 - 2019



Provides Medicaid coverage for family planning services to individuals with incomes up to 200 percent of the federal poverty level.

Substituted by another Bill

Identical Bill Number: S105

Last Session Bill Number: A1963 A32

This bill has been certified by OLS for a fiscal note.

Primary Sponsor:

Pintor Marin, Eliana

Lagana, Joseph A.

Jasey, Mila M.

Mukherji, Raj

Downey, Joann

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Houghtaling, Eric

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Kennedy, James J.

Tucker, Cleopatra G.

Pinkin, Nancy J.

Coughlin, Craig J.

Benson, Daniel R.

Wimberly, Benjie E.

Vainieri Huttie, Valerie

Holley, Jamel C.
Reynolds-Jackson, Verlina
Murphy, Carol A.
McKnight, Angela V.
Quijano, Annette

1/9/2018	Introduced, Referred to Assembly Women and Children Committee
1/29/2018	Transferred to Assembly Health and Senior Services Committee
1/29/2018	Reported and Referred to Assembly Budget Committee
2/12/2018	Reported out of Assembly Committee, 2nd Reading
2/15/2018	Substituted by S105

Introduced

(15 pages) [PDF Format](#) [HTML Format](#)

Statement - AHE 1/29/18

(1 pages) [PDF Format](#) [HTML Format](#)

Fiscal Estimate - 2/9/18; as introduced

(2 pages) [PDF Format](#) [HTML Format](#)

Statement - ABU 2/12/18

(1 pages) [PDF Format](#) [HTML Format](#)

Technical Review Of Prefiled Bill

(16 pages) [PDF Format](#) [HTML Format](#)

Committee Voting:

AHE - 1/29/2018 - r/favorably

Yes: 8 No: 2 Not Voting: 3 Abstain: 0

Roll Call

ABU - 2/12/2018 - r/favorably

Yes: 8 No: 3 Not Voting: 1 Abstain: 0

Roll Call

**indicates synopsis was amended*





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Newark, N.J.

Governor Murphy Signs Bill Restoring \$7.45 Million in Women's Health Care Funding

02/21/2018

Trenton – Governor Phil Murphy today signed a bill restoring \$7.45 million in funding to Planned Parenthood and other women's health facilities, the first legislation he has signed since taking office as New Jersey Governor.

"We cannot immediately undo the damage of eight years of vetoed women's health care funding under Governor Christie," Governor Murphy said. "But we can put the era of putting personal politics before the needs of countless thousands of New Jerseyans behind us. We are one state, one family, and we will stand in support of everyone's access to family planning, to prenatal care, and to life-saving cancer screenings."

The bill (S120/A2134) was sponsored by State Sen. Loretta Weinberg, Senate President Steve Sweeney, Senator Kip Bateman, and Senator Linda Greenstein. In the Assembly, the bill was sponsored by Assembly members Vince Mazzeo, Joanne Downey, Gabby Mosquera, Pam Lampitt, Valerie Vainieri Huttie, Angelica Jimenez, Eliana Pintor Marin, Shavonda Sumter, Joe Lagana, Raj Mukherji, and Mila Jasey.

Governor Murphy also signed legislation (S105/A1656) providing Medicaid coverage for family planning services to low-income individuals.

The Governor also announced that New Jersey will remove NJ FamilyCare's restriction on Long-Acting Reversible Contraception immediately post-partum. That change will decrease the odds of rapid repeat pregnancies that have higher incidence of adverse costly perinatal complications, including low birth weight and an increased rate of preterm delivery.

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