

30:4D-2.1 et al

LEGISLATIVE HISTORY CHECKLIST

NJSA: 30:4D-2.1 et al "Health Care Program for Pregnant Women and Children"

LAWS OF: 1987 CHAPTER: 115

Bill No: A2733

Sponsor(s): Villane and others

Date Introduced: June 9, 1986

Committee: Assembly: Health and Human Resources

Senate: Revenue, Finance and Appropriations

Amended during passage: Yes Amendments denoted by asterisks according to Governor's recommendations.

Date of Passage: Assembly: June 26, 1986 Re-enacted 3-12-87

Senate: December 15, 1986 Re-enacted 4-23-87

Date of Approval: May 4, 1987

Following statements are attached if available:

Sponsor statement: Yes

Committee statement: Assembly Yes

Senate Yes

Fiscal Note: Yes

Veto Message: Yes

Message on Signing: Yes

Following were printed:

Reports: Yes

Hearings: No

974.90 New Jersey. Governor's Task Force on Services for Disabled Persons.
H236 Final report . . . April 1, 1987.
1987 (see recommendation #4)

(OVER)

Recommendations by American College of Obstetricians and Gynecologists:

R362.198 American College of Obstetricians and Gynecologists.

A512.6 Committee on Professional Standards.

Standards for obstetric- gynecologic services.
Committee on Professional Standards. 6th edition.
Washington, D.C., 1985.

R618.32 American Academy of Pediatrics and American College of Obstetricians and
G946 Gynecologists.

Guidelines for prenatal care. American Academy of Pediatrics/American
College of Obstetricians and Gynecologists. Evanston, Illinois and Washington,
D.C., 1983,

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[FOURTH OFFICIAL COPY REPRINT]

ASSEMBLY, No. 2733

STATE OF NEW JERSEY

INTRODUCED JUNE 9, 1986

By Assemblyman VILLANE, Assemblywoman DONOVAN, Assemblyman Brown, Assemblywomen Garvin, Muhler, Ogden, Smith and Crecco

AN ACT *****[establishing the "Health Care Program for Pregnant Women and Children"]***** providing for health care for pregnant women and children and amending***** and supplementing *****[Title 30 of the Revised Statutes]***** P. L. 1968, c. 413 (C. 30:4D-1 et seq.).*****

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

1 1. ***** (New section)***** The Legislature finds and declares
1A that:

2 a. Low-income pregnant women are at higher risk of poor birth
3 outcomes by virtue of their poverty status and non-whites in
4 New Jersey are more likely to be indigent than whites; in 1983,
5 more than 1,100 babies in New Jersey died before their first birth-
6 day; the State's infant mortality rate, 11.3 deaths per 1,000 live
7 births, is among the 17 highest in the country and non-white
8 infants in New Jersey are nearly twice as likely to die before
9 their first birthday than white infants; the non-white and white
10 infant mortality rates in 1983 were 19.3 and 9.2, respectively, and
11 in 1984 the rates for black and white infants were 19.7 and 9.0,
12 respectively; there has been no significant improvement in the
13 infant mortality rate among older infants, ages one month to
14 one year, during the last decade; the percentage of babies born
15 at low birthweight, a condition which places babies at high risk

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 printed in italics *thus* is new matter.

Matter enclosed in asterisks or stars has been adopted as follows:

*—Assembly committee amendments adopted June 16, 1986.

**—Assembly committee amendment adopted June 19, 1986.

***—Senate committee amendments adopted September 8, 1986.

****—Senate committee amendments adopted December 4, 1986.

*****—Assembly amendments adopted in accordance with Governor's recommendations March 5, 1987.

16 of permanent disability and death, is higher in New Jersey than
 17 the national average and is among the highest third of all states;
 18 and while early continuous and comprehensive prenatal care can
 19 prevent low birthweight and infant death, only 64% of babies
 20 born to non-white mothers benefited from any early prenatal
 21 care in the State in 1983.

22 b. Teenage mothers are at special risk of poor pregnancy out-
 23 come in New Jersey, in 1983, 11% of all babies born to teenage
 24 mothers had low birthweights, compared to 7.2% of all births;
 25 New Jersey's low birthweight rate among teenagers is the fourth
 26 highest in the nation, and only 52% of babies born to teenagers
 27 in 1983 benefited from any early prenatal care.

28 c. Access to existing maternal and child health services is often
 29 limited and some basic services that are necessary to reduce poor
 30 birth outcomes are not universally available to all pregnant
 31 women with incomes below the federal poverty level; and there
 32 is a need to provide more effective coordination between ma-
 33 ternal and child health services offered through programs ad-
 34 ministered by the Departments of Human Services and Health.

35 d. The State of New Jersey is committed to ensuring access to
 36 quality health care for pregnant women and children as a means
 37 of improving the health of State residents and reducing overall
 38 State expenditures; and the basic health service needs of low-
 39 income pregnant women and children can best be met by a co-
 40 ordinated program of comprehensive health care.

41 e. It is the State's objective to provide early comprehensive
 42 maternity care for pregnant women and comprehensive health
 43 care for infants *****and young children***** to reduce infant
 44 deaths and morbidity, *****to improve child health status,*****
 45 and to realize a substantial reduction in costly hospitalization.

1 *****[2. As used in this act:

2 a. "Commissioner" means the Commissioner of the Department
 3 of Human Services.

4 b. "Comprehensive service provider" means any person or
 5 public or private health care facility who is a *****[Medicaid pro-
 6 vider]***** *****certified provider pursuant to the "New Jersey
 7 Medical Assistance and Health Services Act," P. L. 1968, c. 413
 8 (C. 30:4D-1 et seq.),***** and who is approved by the commissioner
 9 to provide health care services pursuant to this act.

10 c. "Department" means the State Department of Human Ser-
 11 vices.

12 *****[d. "Medicaid" means the "New Jersey Medical Assistance

13 and Health Services Act” established pursuant to P. L. 1968,
14 c. 413 (C. 30:4D-1 et seq.).]****

15 ****[e.]**** ****d.**** “Poverty level” means the official
16 poverty ****[line]**** ****level**** based on family size estab-
17 lished and adjusted under section 673 (2) of Subtitle B, the
18 “Community Services Block Grant Act,” of Pub. L. 97-35 (42
19 U. S. C. § 9902 (2)).

20 ****[f.]**** ****e.**** “Qualified ****[recipient]****
21 ****woman or child****” means****, as appropriate**** a per-
22 son who is a resident of this State and meets the following
22A eligibility requirements:

22B (1) ****[Is a pregnant woman, a child under the age of 19
22C months born to a woman enrolled in the program, or a child under
22D the age of 19 months who is a member of a family that meets the
22E income requirements of the program; and

23 (2) Is **[eligible for]** **receiving** benefits under the Medi-
24 caid program or has a gross annual ***[household]*** ****fami-
25 ly*** income which is at or below the poverty level ***for a family
26 size equal to the size of the family including the unborn child;
27 except that, a pregnant woman who is determined to be a qualified
28 recipient shall remain eligible for the program until the end of her
29 pregnancy, notwithstanding a change in her family in-
30 come***.]**** ****(a) Is a pregnant woman, or (b) Is a child who:

31 (i) On and after April 1, 1987, and prior to October 1, 1987,
32 is under one year of age;

33 (ii) On and after October 1, 1987, is a child under two years
34 of age;

35 (iii) On and after October 1, 1988, is a child under three years
36 of age;

37 (iv) On and after October 1, 1989, is a child under four years
38 of age; and

39 (v) On and after October 1, 1990, is a child under five years
40 of age; and

41 (2) Is a member of a family whose income does not exceed
42 the poverty level and who meets the federal medicaid eligi-
43 bility requirements set forth in 42 U. S. C. 1936a, as amended
44 and supplemented by Pub. L. 99-509, except that a pregnant
45 woman who is determined to be a qualified woman shall, notwith-
46 standing any change in the income of the family of which she is
47 a member, continue to be deemed a qualified woman until the end
48 of the 60 day period beginning on the last day of her preg-
49 nancy.****

50 ****[g.]**** ****f.**** “Program” means the “Health Care
51 Program for Pregnant Women and Children” established pur-
52 suant to this act.]****

1 ****[****3. On and after April 1, 1987, a qualified woman or
2 child shall be eligible to receive benefits under the “New Jersey
3 Medical Assistance and Health Services Act,” P. L. 1968, c. 413 (C.
4 30:4D-1 et seq.), regardless of whether or not, prior to April 1,
5 1987, that woman or child, as the case may be, is a qualified appli-
6 cant under that act.****]

1 ****[3.]**** ****[****4.**** The commissioner, in cooperation
2 with the Commissioner of the Department of Health, shall establish
3 the “Health Care Program for Pregnant Women and Children.”

4 Under this program:

5 a. ****[Pregnant women]**** ****On and after the 270th day
6 following the effective date of this act, a qualified woman****
7 shall ****be eligible to**** receive ****, in addition to any ben-
8 efits for which the woman is eligible pursuant to the “New
9 Jersey Medical Assistance and Health Services Act,” P. L. 1968,
10 c. 413 (C. 30:4D-1 et seq.),**** comprehensive maternity care
11 which may include: the basic number of prenatal and postpartum
12 visits recommended by the American College of Obstetrics and
13 Gynecology; additional prenatal and postpartum visits which
14 are medically necessary; necessary laboratory, nutritional assess-
15 ment and counseling, health education, personal counseling, man-
16 aged care, outreach and follow-up services; ****treatment of condi-
17 tions which may complicate pregnancy****; and physician or certi-
18 fied nurse-midwife delivery services.

19 b. ****[Children may]**** ****On and after the 270th day
20 following the effective date of this act, a qualified child shall be
21 eligible to**** receive****, in addition to any benefits for which the
22 child is eligible pursuant to the “New Jersey Medical Assistance
23 and Health Services Act,” P. L. 1968, c. 413 (C. 30:4D-1
24 et seq.),**** a defined range of comprehensive, ambulatory, pre-
25 ventive and primary care health services. The defined range of
26 preventive services shall be consistent with standards established
27 by the American Academy of Pediatrics.]****

1 ****[4.]**** ****[****5.**** The commissioner, jointly with
2 the Commissioner of the Department of Health, shall:

3 a. Develop criteria and standards for participation by providers
4 in the program and determine whether a provider who requests
5 to participate in the program meets the department’s criteria
6 and standards.

7 b. Develop a comprehensive program of maternity care services
 8 in accordance with recommendations of the American ***[Aca-
 9 demy]*** ***College*** of Obstetrics and Gynecology, which
 10 defines the type of services to be provided, the level of services to
 11 be provided, and the frequency with which qualified ****[re-
 12 cipients]**** ****women**** are to receive services pursuant
 12A to this act.

13 c. Develop a comprehensive program of child health services
 14 in accordance with recommendations of the American Academy of
 15 Pediatrics which defines the type of services to be provided, the
 16 level of services to be provided, and the frequency with which
 17 qualified ****[recipients]**** ****children**** are to receive
 17A services pursuant to this act.

18 d. Develop and implement a system for monitoring the quality
 19 and delivery of services and a system for evaluating the effective-
 20 ness of the program in meeting its objectives.】****

1 ****[5.]**** ****[****6.**** In consultation with the Com-
 2 missioner of the Department of Health, the commissioner shall
 3 establish provider reimbursement rates for health care delivered
 4 under the program.】****

1 ****[6.]**** ****[****7.**** Participation by a qualified
 2 ****[recipient]**** ****woman or child**** in the program and
 3 acceptance of services provided under the program is voluntary.
 4 The commissioner shall adopt patient rights safeguards for re-
 5 cipients of the services under the program.】****

1 * ****[7.]**** ****[****8.**** *The commissioner, jointly with*
 2 *the Commissioner of Health, shall report to the Governor and the*
 3 *Legislature no later than two years following the date of enact-*
 4 *ment and annually thereafter on the activities of the program*
 5 *and its effectiveness in meeting its objectives, accompanying the*
 6 *report with any recommendations for changes in the law or regu-*
 7 *lations governing the program that the commissioners deem nec-*
 8 *essary.*】*****

1 ****[****9. Nothing in this act shall be construed to deny bene-
 2 fits under the "New Jersey Medical Assistance and Health Services
 3 Act." P. L. 1968, c. 413 (C. 30:4D-1 et seq.) to any person who,
 4 prior to April 1, 1987, is a qualified applicant under that
 5 act.****】****

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

3 3. Definitions. As used in this act, and unless the context other-
 4 wise requires:

- 5 a. "Applicant" means any person who has made application for
6 purposes of becoming a "qualified applicant."
- 7 b. "Commissioner" means the Commissioner of the Department
8 of Human Services.
- 9 c. "Department" means the Department of Human Services,
10 which is herein designated as the single State agency to administer
11 the provisions of this act.
- 12 d. "Director" means the Director of the Division of Medical
13 Assistance and Health Services.
- 14 e. "Division" means the Division of Medical Assistance and
15 Health Services.
- 16 f. "Medicaid" means the New Jersey Medical Assistance and
17 Health Services Program.
- 18 g. "Medical assistance" means payments on behalf of recipients
19 to providers for medical care and services authorized under this
20 act.
- 21 h. "Provider" means any person, public or private institution,
22 agency or business concern approved by the division lawfully
23 providing medical care, services, goods and supplies authorized
24 under this act, holding, where applicable, a current valid license to
25 provide such services or to dispense such goods or supplies.
- 26 i. "Qualified applicant" means a person who is a resident of this
27 State and is determined to need medical care and services as
28 provided under this act, and who:
- 29 (1) Is a recipient of Aid to Families with Dependent Children;
30 (2) Is a recipient of Supplemental Security Income for the
31 Aged, Blind and Disabled under Title XVI of the Social Security
32 Act;
- 33 (3) Is an "ineligible spouse" of a recipient of Supplemental
34 Security Income for the Aged, Blind and Disabled under Title XVI
35 of the Social Security Act, as defined by the federal Social Security
36 Administration;
- 37 (4) Would be eligible to receive public assistance under a cate-
38 gorical assistance program except for failure to meet an eligibility
39 condition or requirement imposed under such State program which
40 is prohibited under Title XIX of the federal Social Security Act
41 such as a durational residency requirement, relative responsibility,
42 consent to imposition of a lien;
- 43 (5) Is a child between 18 and 21 years of age who would be
44 eligible for Aid to Families with Dependent Children, living in the
45 family group except for lack of school attendance or pursuit of
46 formalized vocational or technical training;

47 (6) Is an individual under 21 years of age who qualifies for
 48 categorical assistance on the basis of financial eligibility, but does
 49 not qualify as a dependent child under the State's program of Aid
 50 to Families with Dependent Children (AFDC), or groups of such
 51 individuals, including but not limited to, children in foster place-
 52 ment under supervision of the Division of Youth and Family
 53 Services whose maintenance is being paid in whole or in part from
 54 public funds, children placed in a foster home or institution by a
 55 private adoption agency in New Jersey or children in intermediate
 56 care facilities, including institutions for the mentally retarded, or
 57 in psychiatric hospitals;

58 (7) Meets the standard of need applicable to his circumstances
 59 under a categorical assistance program or Supplemental Security
 60 Income program, but is not receiving such assistance and applies
 61 for medical assistance only.

62 A person shall not be considered a qualified applicant if, within
 63 24 months of becoming or making application to become a qualified
 64 applicant, he has made a voluntary assignment or transfer of real
 65 or personal property, or any interest or estate in property, for
 66 less than adequate consideration. Such voluntary assignment or
 67 transfer of property shall be deemed to have been made for the
 68 purpose of becoming a qualified applicant in the absence of evidence
 69 to the contrary supplied by the applicant. This requirement shall
 70 not be applicable to Supplemental Security Income applicants or
 71 aged, blind or disabled applicants for Medicaid only unless autho-
 72 rized by federal law. Implementation of this requirement shall
 73 conform with the provisions of section 132 of Pub. L. 97-248 (42
 74 U. S. C. § 1396 p. (c));

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

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

- 79 (i) Pregnant women;
- 80 (ii) Dependent children under the age of 21;
- 81 (iii) Individuals who are 65 years of age and older; and
- 82 (iv) Individuals who are blind or disabled pursuant to
 83 either 42 C. F. R. 435.530 et seq. or 42 C. F. R. 435.540 et seq.,
 84 respectively.

85 (b) The following income standard shall be used to deter-
 86 mine medically needy eligibility:

- 87 (i) For one person and two person households, the income
 88 standard shall be the maximum allowable under federal law,
 89 but shall not exceed 133 $\frac{1}{3}$ % of the State's payment level to

90 two person households eligible to receive assistance pursuant
91 to P. L. 1959, c. 86 (C. 44:10-1 et seq.); and

92 (ii) For households of three or more persons, the income
93 standard shall be set at 133 $\frac{1}{3}$ % of the State's payment level
94 to similar size households eligible to receive assistance
95 pursuant to P. L. 1959, c. 86 (C. 44:10-1 et seq.).

96 (c) The following resource standard shall be used to deter-
97 mine medically needy eligibility:

98 (i) For one person households, the resource standard shall
99 be 200% of the resource standard for recipients of Supple-
100 mental Security Income pursuant to 42 U. S. C. § 1382 (1)
101 (B);

102 (ii) For two person households, the resource standard
103 shall be 200% of the resource standard for recipients of
104 Supplemental Security Income pursuant to 42 U. S. C. § 1382
105 (2) (B); and

106 (iii) For households of three or more persons, the resource
107 standard in subparagraph (c) (ii) above shall be increased
108 by \$100.00 for each additional person.

109 (iv) The resource standards established in (i), (ii), and
110 (iii) are subject to federal approval and the resource
111 standard may be lower if required by the federal Depart-
112 ment of Health and Human Services.

113 (d) Individuals whose income exceeds those established in
114 subparagraph (b) of paragraph (8) of this subsection may
115 become medically needy by incurring medical expenses as
116 defined in 42 C. F. R. 435.831 (c) which will reduce their
117 income to the applicable medically needy income established
118 in subparagraph (b) of paragraph (8) of this subsection.

119 (e) A six month period shall be used to determine whether
120 an individual is medically needy.

121 (f) Eligibility determinations for the medically needy pro-
122 gram shall be administered as follows:

123 (i) County welfare agencies are responsible for deter-
124 mining and certifying the eligibility of pregnant women and
125 dependent children. The division shall reimburse county
126 welfare agencies for 100% of the reasonable costs of admini-
127 stration which are not reimbursed by the federal government
128 for the first 12 months of this program's operation. There-
129 after, 75% of the administrative costs incurred by county
130 welfare agencies which are not reimbursed by the federal
131 government shall be reimbursed by the division;

132 (ii) The division is responsible for certifying the eligi-
 133 bility of individuals who are 65 years of age and older and
 134 individuals who are blind or disabled. The division may
 135 enter into contracts with county welfare agencies to deter-
 136 mine certain aspects of eligibility. In such instances the
 137 division shall provide county welfare agencies with all
 138 information the division may have available on the indivi-
 139 dual.

140 The division shall notify all eligible recipients of the
 141 Pharmaceutical Assistance to the Aged and Disabled pro-
 142 gram, P. L. 1975, c. 194 (C. 30:4D-20 et seq.) on an annual
 143 basis of the medically needy program and the program's
 144 general requirements. The division shall take all reasonable
 145 administrative actions to ensure that Pharmaceutical Assist-
 146 ance to the Aged and Disabled recipients, who notify the
 147 division that they may be eligible for the program, have
 148 their applications processed expeditiously, at times and
 149 locations convenient to the recipients; and

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

154 (9) (a) *Is a pregnant women, or is a child who is under one year*
 155 *of age, or, on and after October 1, 1987, is a child under two years*
 156 *of age; and*

157 (b) *Is a member of a family whose income does not exceed*
 158 *the poverty level and who meets the federal Medicaid eligibility*
 159 *requirements set forth in section 9401 of Pub. L. 99-509 (42*
 160 *U. S. C. § 1396a), except that a pregnant woman who is deter-*
 161 *mined to be a qualified applicant shall, notwithstanding any*
 162 *change in the income of the family of which she is a member,*
 163 *continue to be deemed a qualified applicant until the end of*
 164 *the 60 day period beginning on the last day of her pregnancy.*

165 (10) *Is a pregnant woman who is determined by a provider to be*
 166 *presumptively eligible for medical assistance based on criteria*
 167 *established by the commissioner, pursuant to section 9407 of Pub.*
 168 *L. 99-509 (42 U. S. C. § 1396a(a)).*

169 j. "Recipient" means any qualified applicant receiving benefits
 170 under this act.

171 k. "Resident" means a person who is living in the State volun-
 172 tarily with the intention of making his home here and not for a
 173 temporarily purpose. Temporary absences from the State, with
 174 subsequent returns to the State or intent to return when the

175 purposes of the absences have been accomplished, do not interrupt
176 continuity of residence.

177 l. "State Medicaid Commission" means the Governor, the Com-
178 missioner of Human Services, the President of the Senate and the
179 Speaker of the General Assembly, hereby constituted a commission
180 to approve and direct the means and method for the payment of
181 claims pursuant to this act.

182 m. "Third party" means any person, institution, corporation,
183 insurance company, public, private or governmental entity who is
184 or may be liable in contract, tort, or otherwise by law or equity to
185 pay all or part of the medical cost of injury, disease or disability
186 of an applicant for or recipient of medical assistance payable under
187 this act.

188 n. "Governmental peer grouping system" means a separate class
189 of skilled nursing and intermediate care facilities administered by
190 the State or county governments, established for the purpose of
191 screening their reported costs and setting reimbursement rates
192 under the Medicaid program that are reasonable and adequate to
193 meet the costs that must be incurred by efficiently and economically
194 operated State or county skilled nursing and intermediate care
195 facilities.

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

202 p. *"Poverty level" means the official poverty level based on family*
203 *size established and adjusted under Section 673 (2) of Subtitle B,*
204 *the "Community Services Block Grant Act," of Pub. L. 97-35*
205 *(42 U. S. C. § 9902(2)).*

1 3. Section 6 of P. L. 1968, c. 413 (C. 30:4D-6) is amended to
2 read 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 depart-
6 ment shall provide medical assistance to qualified applicants,
7 including authorized services within each of the following classifi-
8 cations:

- 9 (1) Inpatient hospital services;
- 10 (2) Outpatient hospital services;
- 11 (3) Other laboratory and X-ray services;

12 (4) (a) Skilled nursing or intermediate care facility services;
13 (b) Such early and periodic screening and diagnosis of
14 individuals who are eligible under the program and are under
15 age 21, ascertain their physical or mental defects and such
16 health care, treatment, and other measures to correct or
17 ameliorate defects and chronic conditions discovered thereby,
18 as may be provided in regulations of the Secretary of the
19 federal Department of Health and Human Services and
20 approved by the commissioner;

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

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

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

32 (2) Home health care services;

33 (3) Clinic services;

34 (4) Dental services;

35 (5) Physical therapy and related services;

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

39 (7) Optometric services;

40 (8) Podiatric services;

41 (9) Chiropractic services;

42 (10) Psychological services;

43 (11) Inpatient psychiatric hospital services for individuals under
44 21 years of age, or under age 22 if they are receiving such services
45 immediately before attaining age 21;

46 (12) Other diagnostic, screening, preventive, and rehabilitative
47 services, and other remedial care;

48 (13) Inpatient hospital services, skilled nursing facility services
49 and intermediate care facility services for individuals 65 years of
50 age or over in an institution for mental diseases;

51 (14) Intermediate care facility services;

52 (15) Transportation services;

53 (16) Services in connection with the inpatient or outpatient
54 treatment or care of drug abuse, when the treatment is prescribed

55 by a physician and provided in a licensed hospital or in a narcotic
56 and drug abuse treatment center approved by the Department of
57 Health pursuant to P. L. 1970, c. 334 (C. 26:2G-21 et seq.) and
58 whose staff includes a medical director, and limited to those
59 services eligible for federal financial participation under Title XIX
60 of the federal Social Security Act;

61 (17) Any other medical care and any other type of remedial care
62 recognized under State law, specified by the Secretary of the
63 federal Department of Health and Human Services, and approved
64 by the commissioner;

65 (18) *Comprehensive maternity care, which may include: the basic*
66 *number of prenatal and postpartum visits recommended by the*
67 *American College of Obstetrics and Gynecology; additional pre-*
68 *natal and postpartum visits that are medically necessary; necessary*
69 *laboratory, nutritional assessment and counseling, health education,*
70 *personal counseling, managed care, outreach and follow-up ser-*
71 *vices; treatment of conditions which may complicate pregnancy;*
72 *and physician or certified nurse-midwife delivery services;*

73 (19) *Comprehensive pediatric care, which may include: ambula-*
74 *tory, preventive and primary care health services. The preventive*
75 *services shall include, at a minimum, the basic number of preventive*
76 *visits recommended by the American Academy of Pediatrics.*

77 c. Payments for the foregoing services, goods and supplies
78 furnished pursuant to this act shall be made to the extent autho-
79 rized by this act, the rules and regulations promulgated pursuant
80 thereto and, where applicable, subject to the agreement of insur-
81 ance provided for under this act. Said payments shall constitute
82 payment in full to the provider on behalf of the recipient. Every
83 provider making a claim for payment pursuant to this act shall
84 certify in writing on the claim submitted that no additional amount
85 will be charged to the recipient, his family, his representative or
86 others on his behalf for the services, goods and supplies furnished
87 pursuant to this act.

88 No provider whose claim for payment pursuant to this act has
89 been denied because the services, goods or supplies were determined
90 to be medically unnecessary shall seek reimbursement from the
91 recipient, his family, his representative or others on his behalf for
92 such services, goods and supplies provided pursuant to this act;
93 provided, however, a provider may seek reimbursement from a
94 recipient for services, goods or supplies not authorized by this act,
95 if the recipient elected to receive the services, goods or supplies
96 with the knowledge that they were not authorized.

97 d. Any individual eligible for medical assistance (including
98 drugs) may obtain such assistance from any person qualified to
99 perform the service or services required (including an organization
100 which provides such services, or arranges for their availability on
101 a prepayment basis), who undertakes to provide him such services.

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

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

108 (1) Is an inmate of a public institution (except as a patient in a
109 medical institution); provided, however, that an individual who is
110 otherwise eligible may continue to receive services for the month
111 in which he becomes an inmate, should the commissioner determine
112 to expand the scope of Medicaid eligibility to include such an
113 individual, subject to the limitations imposed by federal law and
114 regulations, or

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

117 (3) Is over 21 years of age and who is receiving inpatient
118 psychiatric hospital services in a psychiatric facility; provided,
119 however, that an individual who was receiving such services
120 immediately prior to attaining age 21 may continue to receive such
121 services until he reaches age 22. Nothing in this subsection shall
122 prohibit the commissioner from extending medical assistance to all
123 eligible persons receiving inpatient psychiatric services; provided
124 that there is federal financial participation available.

125 f. Any provision in a contract of insurance, will, trust agreement
126 or other instrument which reduces or excludes coverage or payment
127 for goods and services to an individual because of that individual's
128 eligibility for or receipt of Medicaid benefits shall be null and void,
129 and no payments shall be made under this act as a result of any
130 such provision.

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

133 (1) Pregnant women shall be provided prenatal care and delivery
134 services and postpartum care, including the services cited in
135 subsection a. (1), (3) and (5) of section 6 of P. L. 1963, c. 413
136 (C. 30:4D-6a. (1), (3) and (5)) and subsection b. (1)-(10), (12),
137 (15) and (17) of section 6 of P. L. 1963, c. 413 (C. 30:4D-6b.
138 (1)-(10), (12), (15) and (17)).

139 (2) Dependent children shall be provided with services cited in
 140 subsection a. (3) and (5) of section 6 of P. L. 1968, c. 413 (C.
 141 30:4D-6a. (3) and (5)) and subsection b. (1), (2), (3), (4), (5),
 142 (6), (7), (10), (12), (15) and (17) of section 6 of P. L. 1968, c. 413
 143 (C. 30:4D-6b. (1), (2), (3), (4), (5), (6), (7), (10), (12), (15) and
 144 (17)).

145 (3) Individuals who are 65 years of age or older shall be
 146 provided with services cited in subsection a. (3) and (5) of section
 147 6 of P. L. 1968, c. 413 (C. 30:4D-6a. (3) and (5)) and subsection b.
 148 (1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15)
 149 and (17) of section 6 of P. L. 1968, c. 413 (C. 30:4D-6b. (1)-(5),
 150 (6) excluding prescribed drugs, (7), (8), (10), (12), (15) and (17)).

151 (4) Individuals who are blind or disabled shall be provided with
 152 services cited in subsection a. (3) and (5) of section 6 of P. L. 1968,
 153 c. 413 (C. 30:4D-6a. (3) and (5)) and subsection b. (1)-(5), (6)
 154 excluding prescribed drugs, (7), (8), (10), (12), (15) and (17) of
 155 section 6 of P. L. 1968, c. 413 (C. 30:4D-6b. (1)-(5), (6) excluding
 156 prescribed drugs, (7), (8), (10), (12), (15) and (17)).

157 (5) (a) Inpatient hospital services, subsection a. (1) of section 6
 158 of P. L. 1968, c. 413 (C. 30:4D-6a. (1)), shall only be provided to
 159 eligible medically needy individuals, other than pregnant women,
 160 if the federal Department of Health and Human Services dis-
 161 continues the State's waiver to establish inpatient hospital reim-
 162 bursement rates for the Medicare and Medicaid programs under
 163 the authority of section 601 (c) (3) of the Social Security Act
 164 Amendments of 1983, Pub. L. 98-21 (42 U. S. C. § 1395ww (c) (5)).
 165 Inpatient hospital services may be extended to other eligible
 166 medically needy individuals if the federal Department of Health
 167 and Human Services directs that these services be included.

168 (b) Outpatient hospital services, subsection a. (2) of section 6
 169 of P. L. 1968, c. 413 (C. 30:4D-6a.(2)), shall only be provided to
 170 eligible medically needy individuals if the federal Department of
 171 Health and Human Services discontinues the State's waiver to
 172 establish outpatient hospital reimbursement rates for the Medicare
 173 and Medicaid programs under the authority of section 601 (c) (3)
 174 of the Social Security Amendments of 1983, Pub. L. 98-21 (42
 175 U. S. C. § 1395ww (c) (5)). Outpatient hospital services may be
 176 extended to all or to certain medically needy individuals if the
 177 federal Department of Health and Human Services directs that
 178 these services be included. However, the use of outpatient hospital
 179 services shall be limited to clinic services and to emergency room
 180 services for injuries and significant acute medical conditions.

181 (c) The division shall monitor the use of inpatient and out-
182 patient hospital services by medically needy persons.

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

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

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

24 b. Subject to the limits imposed by this act, to determine the
25 amount and scope of services to be covered, that the amounts to be
26 paid are reasonable, and the duration of medical assistance to be
27 furnished; provided, however, that the department shall provide
28 medical assistance on behalf of all recipients of categorical assist-
29 ance and such other related groups as are mandatory under federal
30 laws and rules and regulations, as they now are or as they may be
31 hereafter amended, in order to obtain federal matching funds for
32 such purposes and, in addition, provide medical assistance for the
33 foster children specified in section 3i. (7) of this act. The medical
34 assistance provided for these groups shall not be less in scope,
35 duration, or amount than is currently furnished such groups, and
36 in addition, shall include at least the minimum services required
37 under federal laws and rules and regulations to obtain federal
38 matching funds for such purposes.

39 The commissioner is authorized and empowered, at such times as
40 he may determine feasible, within the limits of appropriated funds
41 for any fiscal year, to extend the scope, duration, and amount of

42 medical assistance on behalf of these groups of categorical assist-
43 ance recipients, related groups as are mandatory, and foster
44 children authorized pursuant to section 3i. (7) of this act, so as to
45 include, in whole or in part, the optional medical services autho-
46 rized under federal laws and rules and regulations, and the
47 commissioner shall have the authority to establish and maintain
48 the priorities given such optional medical services; provided,
49 however, that medical assistance shall be provided to at least such
50 groups and in such scope, duration, and amount as are required to
51 obtain federal matching funds.

52 The commissioner is further authorized and empowered, at such
53 times as he may determine feasible, within the limits of appro-
54 priated funds for any fiscal year, to issue, or cause to be issued
55 through the Division of Medical Assistance and Health Services,
56 all necessary rules, regulations and administrative orders, and to
57 do or cause to be done all other acts and things necessary to
58 implement and administer demonstration projects pursuant to
59 Title XI, section 1115 of the federal Social Security Act, including,
60 but not limited to waiving compliance with specific provisions of
61 this act, to the extent and for the period of time the commissioner
62 deems necessary, as well as contracting with any legal entity,
63 including but not limited to corporations organized pursuant to
64 Title 14A, New Jersey Statutes (N. J. S. 14A:1-1 et seq.), Title 15,
65 Revised Statutes (R. S. 15:1-1 et seq.) and Title 15A, New Jersey
66 Statutes (N. J. S. 15A:1-1 et seq.) as well as boards, groups,
67 agencies, persons and other public or private entities;

68 c. To administer the provisions of this act;

69 d. To make reports to the federal Department of Health and
70 Human Services as from time to time may be required by such
71 federal department and to the New Jersey Legislature as herein-
72 after provided;

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

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

80 g. To provide safeguards to restrict the use or disclosure of
81 information concerning applicants and recipients to purposes di-
82 rectly connected with administration of this act;

83 h. To take all necessary action to recover any and all payments
84 incorrectly made to or illegally received by a provider from such

85 provider or his estate or from any other person, firm, corporation,
86 partnership or entity responsible for or receiving the benefit or
87 possession of the incorrect or illegal payments or their estates,
88 successors or assigns, and to assess and collect such penalties as
89 are provided for herein:

90 i. To take all necessary action to recover the cost of benefits
91 incorrectly provided to or illegally obtained by a recipient, includ-
92 ing those made after a voluntary divestiture of real or personal
93 property or any interest or estate in property for less than ade-
94 quate consideration made for the purpose of qualifying for assis-
95 tance. The division shall take action to recover the cost of benefits
96 from a recipient, legally responsible relative, representative payee,
97 or any other party or parties whose action or inaction resulted
98 in the incorrect or illegal payments or who received the benefit
99 of the divestiture, or from their respective estates, as the case
100 may be and to assess and collect the penalties as are provided for
101 herein, except that no lien shall be imposed against property of
102 the recipient prior to his death except in accordance with section 17
103 of P. L. 1968, c. 413 (C. 30:4D-17). No recovery action shall be
104 initiated more than five years after an incorrect payment has been
105 made to a recipient when the incorrect payment was due solely
106 to an error on the part of the State or any agency, agent or sub-
107 division thereof;

108 j. To take all necessary action or recover the cost of benefits
109 correctly provided to a recipient from the estate of said recipient
110 in accordance with sections 6 through 12 of this amendatory and
111 supplementary act;

112 k. To take all reasonable measures to ascertain the legal or
112 equitable liability of third parties to pay for care and services
113 (available under the plan) arising out of injury, disease, or dis-
114 ability; where it is known that a third party has a liability, to
115 treat such liability as a resource of the individual on whose behalf
116 the care and services are made available for purposes of deter-
117 mining eligibility; and in any case where such a liability is found
118 to exist after medical assistance has been made available on behalf
119 of the individual, to seek reimbursement for such assistance to
120 the extent of such liability;

121 l. To compromise, waive or settle and execute a release of any
122 claim arising under this act including interest or other penalties,
123 or designate another to compromise, waive or settle and execute
124 a release of any claim arising under this act. The commissioner
125 or his designee whose title shall be specified by regulation may

126 compromise, settle or waive any such claim in whole or in part,
127 either in the interest of the Medicaid program or for any other
128 reason which the commissioner by regulation shall establish;

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

137 n. To issue, or designate another to issue, subpoenas to compel
138 the attendance of witnesses and the production of books, records,
139 accounts, papers and documents of any party, whether or not that
140 party is a provider, which directly or indirectly relate to goods
141 or services provided under this act, for the purpose of assisting
142 in any investigation, examination, or inspection, or in any sus-
143 pension, debarment, disqualification, recovery, or other proceeding
144 arising under this act;

145 o. To solicit, receive and review bids pursuant to the provisions
146 of P. L. 1954, c. 48 (C. 52:34-6 et seq.) and all amendments and
147 supplements thereto, by authorized insurance companies and non-
148 profit hospital service corporations or medical service corporations,
149 incorporated in New Jersey, and authorized to do business pur-
150 suant to P. L. 1938, c. 366 (C. 17:48-1 et seq.) or P. L. 1940, c. 74
151 (C. 17:48A-1 et seq.), and to make recommendations in connection
152 therewith to the State Medicaid Commission;

153 p. To contract, or otherwise provide as in this act provided, for
154 the payment of claims in the manner approved by the State Medi-
155 aid Commission;

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

159 r. To enter into contracts with federal, State, or local govern-
160 mental agencies, or other appropriate parties, when necessary to
161 carry out the provisions of this act;

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

165 t. To provide for the reimbursement of State and county-ad-
166 ministered skilled nursing and intermediate care facilities through
167 the use of a governmental peer grouping system, subject to federal
168 approval and the availability of federal reimbursement.

169 (1) In establishing a governmental peer grouping system, the
170 State's financial participation is limited to an amount equal to the
171 nonfederal share of the reimbursement which would be due each
172 facility if the governmental peer grouping system was not estab-
173 lished, and each county's financial participation in this reimburse-
174 ment system is equal to the nonfederal share of the increase in
175 reimbursement for its facility or facilities which results from the
176 establishment of the governmental peer grouping system.

177 (2) On or before December 1 of each year, the commissioner
178 shall estimate and certify to the Director of the Division of Local
179 Government Services in the Department of Community Affairs
180 the amount of increased federal reimbursement a county may
181 receive under the governmental peer grouping system. On or
182 before December 15 of each year, the Director of the Division of
183 Local Government Services shall certify the increased federal re-
184 imbursement to the chief financial officer of each county. If the
185 amount of increased federal reimbursement to a county exceeds or
186 is less than the amount certified, the certification for the next year
187 shall account for the actual amount of federal reimbursement that
188 the county received during the prior calendar year.

189 (3) The governing body of each county entitled to receive
190 increased federal reimbursement under the provisions of this
191 amendatory act shall, by March 31 of each year, submit a report
192 to the commissioner on the intended use of the savings in county
193 expenditures which result from the increased federal reimburse-
194 ment. The governing body of each county, with the advice of
195 agencies providing social and health related services, shall use not
196 less than 10% and no more than 50% of the savings in county
197 expenditures which result from the increased federal reimburse-
198 ment for community-based social and health related programs for
199 elderly and disabled persons who may otherwise require nursing
200 home care. This percentage shall be negotiated annually between
201 the governing body and the commissioner and shall take into
202 account a county's social, demographic and fiscal conditions, a
203 county's social and health related expenditures and needs, and
204 estimates of federal revenues to support county operations in the
205 upcoming year, particularly in the areas of social and health related
206 services.

207 (4) The commissioner, subject to approval by law, may terminate
208 the governmental peer grouping system if federal reimbursement
209 is significantly reduced or if the Medicaid program is significantly
210 altered or changed by the federal government subsequent to the
211 enactment of this amendatory act. The commissioner, prior to

212 terminating the governmental peer grouping system, shall submit
 213 to the Legislature and to the governing body of each county a
 214 report as to the reasons for terminating the governmental peer
 215 grouping system;

216 *u. The commissioner, in consultation with the Commissioner of*
 217 *Health, shall:*

218 (1) *Develop criteria and standards for comprehensive maternity*
 219 *or pediatric care providers and determine whether a provider who*
 220 *requests to become a comprehensive maternity or pediatric care*
 221 *provider meets the department's criteria and standards;*

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

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

232 (4) *Develop and implement a system for monitoring the quality*
 233 *and delivery of comprehensive maternity and pediatric care ser-*
 234 *vices and a system for evaluating the effectiveness of the services*
 235 *programs in meeting their objectives;*

236 (5) *Establish provider reimbursement rates for the comprehen-*
 237 *sive maternity and pediatric care services;*

238 *v. The commissioner, jointly with the Commissioner of Health,*
 239 *shall report to the Governor and the Legislature no later than two*
 240 *years following the date of enactment of P. L. , c.*

241 *(C.) (now pending before the Legislature as this bill)*
 242 *and annually thereafter on the status of the comprehensive ma-*
 243 *ternity and pediatric care services and their effectiveness in meet-*
 244 *ing the objectives set forth in section 1 of P. L. , c.*

245 *(C.) (now pending before the Legislature as this bill),*
 246 *accompanying the report with any recommendations for changes*
 247 *in the law governing the services that the commissioners deem*
 248 *necessary.******

1 ***[7.]*** *******[*8.*]******* *******[*****10.*****]******* *****5.*****

2 Pursuant to the "Administrative Procedure Act," P. L. 1968, c. 410
 3 (C. 52:14B-1 et seq.), the commissioner shall adopt rules and
 4 regulations necessary to effectuate the purposes of this act.

1 ***[8.]*** *******[*9.*]******* *******[*****11.*****]******* *****6.*****

2 This act shall take effect ****[on the 270th day following enact-
3 ment]**** ****[****immediately****]**** ****on the 270th
4 day after enactment, except that section 2 shall take effect on
5 April 1, 1987 or upon enactment, whichever is later.****

PUBLIC ASSISTANCE

Establishes the "Health Care Program for Pregnant Women and
Children" in the Department of Human Services.

18 d Develop and implement a system for monitoring the quality
19 and delivery of services and a system for evaluating the effective-
20 ness of the program in meeting its objective.

1 5. In consultation with the Commissioner of the Department of
2 Health, the commissioner shall establish provider reimbursement
3 rates for health care delivered under the program.

1 6. Participation by a qualified recipient in the program and
2 acceptance of services provided under the program is voluntary.
3 The commissioner shall adopt patient rights safeguards for re-
4 cipients of the services under the program.

1 7. Pursuant to the "Administrative Procedure Act," P. L. 1968,
2 c. 410 (C. 52:14B-1 et seq.), the commissioner shall adopt rules
3 and regulations necessary to effectuate the purposes of this act.

1 8. This act shall take effect on the 270th day following enact-
2 ment.

STATEMENT

This bill establishes the "Health Care Program for Pregnant Women and Children" in the Department of Human Services. The program shall provide comprehensive maternity and child health services to pregnant women and children under the age of 19 months who are eligible for either Medicaid or the medically needy program, or whose incomes are at or below the poverty level. The Commissioner of the Department of Human Services shall work cooperatively in the development and administration of the program with the Commissioner of the Department of Health.

PUBLIC ASSISTANCE

Establishes the "Health Care Program for Pregnant Women and Children" in the Department of Human Services.

ASSEMBLY HEALTH AND HUMAN RESOURCES
COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2733

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: JUNE 16, 1986

The Assembly Health and Human Resources Committee reports favorably Assembly Bill No. 2733 with committee amendments.

This bill establishes the "Health Care Program for Pregnant Women and Children" in the Department of Human Services. This program would provide comprehensive maternity care and a defined range of comprehensive ambulatory, preventive and primary care child health services to pregnant women and children under 19 months of age who are eligible for Medicaid or the medically needy program established under P. L. 1985, c. 371 (C. 30:4D-3 et seq.), or whose incomes are at or below the poverty level.

As amended by the committee, this bill directs the Commissioner of Human Services, jointly with the Commissioner of Health, to:

- a. Develop criteria and standards for provider participation in the program and determine whether a provider who requests to participate in the program meets those criteria and standards;
- b. Develop a comprehensive program of maternity care and child health services in accordance with recommendations of the American Academy of Obstetrics and Gynecology and the American Academy of Pediatrics, respectively, which defines the types, levels and frequency of services to be provided to qualified recipients;
- c. Develop and implement a system for monitoring the quality and delivery of services and a system for evaluating the effectiveness of the program in meeting its objectives;
- d. Establish provider reimbursement rates for health care delivered under the program; and

e. Report to the Governor and the Legislature within two years of the enactment date of the bill and annually thereafter on the activities of the program and its effectiveness in meeting its objectives, including in that report any recommendations for changes in the law or regulations governing the program that the commissioners deem necessary.

The committee amended the bill to include the requirement that the Commissioners of Human Services and Health report to the Governor and the Legislature on the activities and effectiveness of the program.

SENATE REVENUE, FINANCE AND APPROPRIATIONS
COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2733

[SENATE REPRINT/SECOND OFFICIAL COPY REPRINT]

with Senate committee amendments

STATE OF NEW JERSEY

DATED: NOVEMBER 24, 1986

The Senate Revenue, Finance and Appropriations Committee reported this bill favorably, with amendments.

As amended, this bill establishes the "Health Care Program for Pregnant Women and Children," in the Department of Human Services. Beginning 270 days after the enactment of the bill, this program will provide comprehensive maternity care, and a defined range of comprehensive ambulatory, preventive and primary child health services to pregnant women and certain children whose family incomes do not exceed the poverty level, and who are otherwise qualified under federal medicaid guidelines. Prior to October 1, 1987, children up to one year of age will be eligible; on October 1, 1987, children up to age two will be eligible; on October 1, 1988, children up to age three will be eligible; on October 1, 1989, children up to age four will be eligible; and on October 1, 1990, children up to age five will be eligible.

The Commissioner of Human Services, jointly with the Commissioner of Health, is to develop the maternity and child health care packages in accordance with recommendations of the American College of Obstetrics and Gynecology and the American Academy of Pediatrics, respectively. In addition, the commissioners are to develop criteria and standards for care providers, monitor and evaluate the quality and delivery of services, establish provider reimbursement rates and report to the Governor and the Legislature on the activities and effectiveness of the program.

The bill also clarifies that, effective April 1, 1987, certain pregnant women, and certain children, who were previously ineligible for general State medicaid benefits will become eligible. Essentially, this newly eligible group will include persons whose family incomes are below the federal poverty level, but above the levels set in the "New Jersey Medical Assistance and Health Services Act," P. L. 1968, c. 413 (C. 30:4D-1 et seq.). This provision of the bill is permitted by recent changes in federal medicaid policy.

COMMITTEE AMENDMENTS:

The committee amendments:

(1) Change the category of children covered from those under 19 months of age to those up to five years of age, by one-year increments;

(2) Clarify that newly qualified pregnant women, and newly qualified children will be eligible for current State medicaid benefits as of April 1, 1987; and

(3) Clarify that any person currently eligible for State medicaid benefits, and who is also covered by this bill, will not be denied current benefits before April 1, 1987 because of the operative dates in the bill.

Other amendments are technical in nature, and are intended to clarify certain terminology and references.

FISCAL IMPACT:

In testimony before the Assembly Health and Human Resources Committee, on June 6, 1986, the Department of Health estimated that the previous version of this bill would affect approximately 33,000 persons (pregnant women, and children under 19 months of age) throughout the State, at a total cost of \$7,200,000.00 per year. At that time, the department estimated that the costs for 90% of the client population would be matched—dollar for dollar—by federal funds under the medicaid and medically needy programs. The State would bear the full costs of the remaining 10% who were not expected to be eligible under medicaid and medically needy because their family incomes, while below the federal poverty level, would have been too high for medicaid and medically needy.

This would result in a total State cost of approximately \$3,960,000.00. The department estimated the State cost to be approximately \$4,500,000.00.

Since that time, federal medicaid policy has been revised so as to expand the client population for which the State may receive matching funds. Specifically, the State could receive matching funds for pregnant women with family incomes below the poverty level, and for certain children from families with such incomes. Prior to October 1, 1987, matching funds would be available for children up to age one. Thus, the State costs of any new maternal and child health services which might be delivered under this bill, before October 1, 1987, should be less than originally estimated.

However, previously ineligible women and children will also be eligible for current medicaid benefits under the bill, effective April 1, 1987. The extent to which this offsets any savings effectuated by the expanded federal match, or to which extending current medicaid benefits might increase the overall costs of the bill, is not known.

In addition, children up to age two years are eligible as of October 1, 1987, and children up to age five will become eligible over the next three years. It would seem that State costs will increase commensurate with the expansion of the program.

STATE OF NEW JERSEY
EXECUTIVE DEPARTMENT

March 5 1987

ASSEMBLY BILL NO. 2733 (3rd OCR)

To the General Assembly:

Pursuant to Article V, Section 1, Paragraph 14 of the Constitution, I am returning Assembly Bill No. 2733 (3rd OCR) with my objections, for reconsideration.

This bill establishes a "Health Care Program for Pregnant Women and Children" in the Department of Human Services to expand and improve health coverage for poor pregnant women and children. Specifically, in accordance with recently passed federal legislation (Pub. L. 99-509), this bill enables the Department of Human Services to extend Medicaid optional categorically needy coverage to pregnant women and children whose family incomes are above the Aid to Families with Dependent Children (AFDC) or Medically Needy eligibility thresholds, but who are at or below the federal poverty level. Pregnant women are also able to retain eligibility until 60 days after the end of their pregnancies, regardless of changes in family income, to ensure continuity of care.

In addition, this bill will improve health coverage by authorizing the Department of Human Services, together with the Department of Health, to develop comprehensive maternity and pediatric care programs as new Medicaid service options that will serve as effective models for the delivery of health care to pregnant women and children. The programs will define the types of services to be provided, the level of services and the frequency of services. As defined in this legislation, the comprehensive maternity program may include: the basic number of prenatal and postpartum visits recommended by the American College of Obstetrics and Gynecology; additional prenatal and postpartum visits that are medically necessary; necessary laboratory, nutritional assessment and counseling, health education, personal counseling, managed care, outreach and follow-up services; treatment of conditions that may complicate pregnancy; and physician or certified nurse-midwife delivery systems.

Furthermore, under this program children will be eligible to receive, in addition to regular Medicaid benefits, a range of comprehensive ambulatory, preventive and primary care health services. The range of preventive services will be consistent with American Academy of Pediatric standards.

From its inception and throughout the legislative process this program has received my enthusiastic support. As I have noted many times in the past, my

STATE OF NEW JERSEY
EXECUTIVE DEPARTMENT

Jersey's infant mortality rate is distressingly and unacceptably high. In 1981, for example, more than 1,100 babies in New Jersey died before their first birthday. The State's infant mortality rate, 11.3 deaths per 1,000 live births, is among the 17 highest in the country. I believe that this legislation will significantly enhance the quality of health care delivered to many thousands of women and children in the State and ultimately result in healthier babies born to healthier mothers.

Although this bill as it has reached my desk is sound in concept, I have been advised by the Departments of Health and Human Services that various amendments to this legislation are necessary to allow us to take full advantage of recent changes in federal Medicaid law, thereby obtaining additional federal matching funds for this essential program. These recommended amendments, while lengthy, are essentially of a technical nature and will provide consistency with federal law, while maximizing the State's flexibility to establish appropriate program standards. Specifically, the comprehensive maternity and pediatric care services components, the program definitions, and the duties of the Commissioner of the Department of Human Services contained in this bill are placed in the State Medicaid statute to make that act consistent with federal law.

At this time, therefore, I herewith return Assembly Bill No. 2733 (2nd OCR) for reconsideration and recommend that it be amended as follows:

Page 1, Title, Lines 1-2: Omit "establishing the "Health Care Program for Pregnant Women and Children"" Insert "providing for health care for pregnant women and children and amending"

Page 1, Section 1, Line 1: After "1." Insert "(New section)"

Page 2, Section 1, Line 43: After "infants" Insert "and young children";
After "morbidity," Insert "to improve child health status,"

Pages 2-3, Section 2, Lines 1-52: Omit in entirety

Page 4, Section 3, Lines 1-6: Omit in entirety

Page 4, Section 4, Lines 1-27: Omit in entirety

Pages 4-5, Section 5, Lines 1-20: Omit in entirety

Page 5, Section 6, Lines 1-4: Omit in entirety

Page 5, Section 7, Lines 1-5: Omit in entirety

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Page 5, Section 8, Lines 1-8: Omit in entirety

Page 5, Section 9, Lines 1-4: Omit in entirety

Page 5, after Section 9: Insert new sections 2, 3 and 4 as follows:

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

3. Definitions. As used in this act, and unless the context otherwise requires:

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

b. "Commissioner" means the Commissioner of the Department of Human Services.

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

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

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

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

g. "Medical assistance" means payments on behalf of recipients to providers for medical care and services authorized under this act.

h. "Provider" means any person, public or private institution, agency or business concern approved by the division lawfully providing medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

i. "Qualified applicant" means a person who is a resident of this State and is determined to need medical care and services as provided under this act, and who:

(1) Is a recipient of Aid to Families with Dependent Children;

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

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

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Would be eligible to receive public assistance under a categorical assistance program except for failure to meet an eligibility condition or requirement imposed under such State program which is prohibited under Title XIX of the federal Social Security Act such as a durational residency requirement, relative responsibility, consent to imposition of a lien;

(5) Is a child between 18 and 21 years of age who would be eligible for Aid to Families with Dependent Children, living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training;

(6) Is an individual under 21 years of age who qualifies for categorical assistance on the basis of financial eligibility, but does not qualify as a dependent child under the State's program of Aid to Families with Dependent Children (AFDC), or groups of such individuals, including but not limited to, children in foster placement under supervision of the Division of Youth and Family Services whose maintenance is being paid in whole or in part from public funds, children placed in a foster home or institution by a private adoption agency in New Jersey or children in intermediate care facilities, including institutions for the mentally retarded, or in psychiatric hospitals;

(7) Meets the standard of need applicable to his circumstances under a categorical assistance program or Supplemental Security Income program, but is not receiving such assistance and applies for medical assistance only.

A person shall not be considered a qualified applicant if, within 24 months of becoming or making application to become a qualified applicant, he has made a voluntary assignment or transfer of real or personal property, or any interest or estate in property, for less than adequate consideration. Such voluntary assignment or transfer of property shall be deemed to have been made for the purpose of becoming a qualified applicant in the absence of evidence to the contrary supplied by the applicant. This requirement shall not be applicable to Supplemental Security Income applicants or aged, blind or disabled applicants for Medicaid only unless authorized by federal law. Implementation of this requirement shall conform with the provisions of section 132 of Pub.L. 97-248 (42 U.S.C. § 1396 p. (c));

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

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

- (i) Pregnant women;
- (ii) Dependent children under the age of 21;
- (iii) Individuals who are 65 years of age and older; and
- (iv) Individuals who are blind or disabled pursuant to either 42 C.F.R. 435.530 et seq. or 42 C.F.R. 435.540 et seq., respectively.

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

(i) For one person and two person households, the income standard shall be the maximum allowable under federal law, but shall not exceed 133 1/3% of the State's payment level to two person households eligible to receive assistance pursuant to P.L. 1959, c. 86 (C. 44:10-1 et seq.); and

(ii) For households of three or more persons, the income standard shall be set at 133 1/3% of the State's payment level to similar size households eligible to receive assistance pursuant to P.L. 1959, c. 86 (C. 44:10-1 et seq.).

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

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

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

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

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

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

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

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

(i) County welfare agencies are responsible for determining and certifying the eligibility of pregnant women and dependent children. The division shall reimburse county welfare agencies for 100% of the reasonable costs of administration which are not reimbursed by the federal government for the first 12 months of this program's operation. Thereafter, 75% of the administrative costs incurred by county welfare agencies which are not reimbursed by the federal government shall be reimbursed by the division;

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

The division shall notify all eligible recipients of the Pharmaceutical Assistance to the Aged and Disabled program, P.L. 1975, c. 194 (C. 30:4D-20 et seq.) on an annual basis of the medically needy program and the program's general requirements. The division shall take all reasonable administrative actions to ensure that Pharmaceutical Assistance to the Aged and Disabled recipients,

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who notify the division that they may be eligible for the program, have their applications processed expeditiously, at times and locations convenient to the recipients; and

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

(9)(a) Is a pregnant woman, or is a child who is under one year of age, or, on and after October 1, 1987, is a child under two years of age; and

(b) Is a member of a family whose income does not exceed the poverty level and who meets the federal Medicaid eligibility requirements set forth in section 9401 of Pub. L. 99-509 (42 U.S.C. § 1396a), except that a pregnant woman who is determined to be a qualified applicant shall, notwithstanding any change in the income of the family of which she is a member, continue to be deemed a qualified applicant until the end of the 60 day period beginning on the last day of her pregnancy.

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

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

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

l. "State Medicaid Commission" means the Governor, the Commissioner of Human Services, the President of the Senate and the Speaker of the

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General Assembly, hereby constituted a commission to approve and direct the means and method for the payment of claims pursuant to this act.

m. "Third party" means any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

n. "Governmental peer grouping system" means a separate class of skilled nursing and intermediate care facilities administered by the State or county governments, established for the purpose of screening their reported costs and setting reimbursement rates under the Medicaid program that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated State or county skilled nursing and intermediate care facilities.

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

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

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

6. a. Subject to the requirements of Title XIX of the federal Social Security Act, the limitations imposed by this act and by the rules and regulations promulgated pursuant thereto, the department shall provide medical assistance to qualified applicants.

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including authorized services within each of the following classifications:

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

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

- (1) Medical care not included in subsection a. (5) above, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice, as defined by State law;
- (2) Home health care services;
- (3) Clinic services;
- (4) Dental services;
- (5) Physical therapy and related services;
- (6) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

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- (7) Optometric services;
- (8) Podiatric services;
- (9) Chiropractic services;
- (10) Psychological services;
- (11) Inpatient psychiatric hospital services for individuals under 21 years of age, or under age 21 if they are receiving such services immediately before attaining age 21;
- (12) Other diagnostic, screening, preventive, and rehabilitative services, and other remedial care;
- (13) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;
- (14) Intermediate care facility services;
- (15) Transportation services;
- (16) Services in connection with the inpatient or outpatient treatment or care of drug abuse, when the treatment is prescribed by a physician and provided in a licensed hospital or in a narcotic and drug abuse treatment center approved by the Department of Health pursuant to P.L. 1970, c. 334 (C. 26:2G-21 et seq.) and whose staff includes a medical director, and limited to those services eligible for federal financial participation under Title XIX of the federal Social Security Act;
- (17) Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary of the federal Department of Health and Human Services, and approved by the commissioner;
- (18) Comprehensive maternity care, which may include: the basic number of prenatal and postpartum visits recommended by the American College of Obstetrics and Gynecology; additional prenatal and postpartum visits that are medically necessary; necessary laboratory, nutritional assessment and counseling, health education, personal counseling, managed care, outreach, and follow-up services; treatment of conditions which may complicate

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Pregnancy and physician or certified nurse-midwife deliver services;

(19) Comprehensive pediatric care, which may include ambulatory, preventive and primary care health services. The preventive services shall include, at a minimum, the basic number of preventive visits recommended by the American Academy of Pediatrics.

c. Payments for the foregoing services, goods and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. Said payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, his family, his representative or others on his behalf for the services, goods and supplies furnished pursuant to this act.

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

d. Any individual eligible for medical assistance (including drugs) may obtain such assistance from any person qualified to perform the service or services required (including an organization which provides such services, or arranges for treat:

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availability on a prepayment basis, who undertakes to provide him such services.

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

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

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

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

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

f. Any provision in a contract of insurance, will, trust agreement or other instrument which reduces or excludes coverage or payment for goods and services to an individual because of that individual's eligibility for or receipt of Medicaid benefits shall be null and void, and no payments shall be made under

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this act as a result of any such provision.

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

(1) Pregnant women shall be provided prenatal care and delivery services and postpartum care, including the services cited in subsection a. (1), (3) and (5) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6a. (1), (3) and (5)) and subsection b. (1)-(10), (12), (15) and (17) of section 6 of P.L. 1968,

c. 413 (C. 30:4D-6b. (1)-(10), (12), (15) and (17)).

(2) Dependent children shall be provided with services cited in subsection a. (3) and (5) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6a. (3) and (5)) and subsection b. (1), (2), (3), (4), (5), (6), (7), (10), (12), (15) and (17) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6b. (1), (2), (3), (4), (5), (6), (7), (10), (12), (15) and (17)).

(3) Individuals who are 65 years of age or older shall be provided with services cited in subsection a. (3) and (5) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6a. (3) and (5)) and subsection b. (1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15) and (17) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6b. (1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15) and (17)).

(4) Individuals who are blind or disabled shall be provided with services cited in subsection a. (3) and (5) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6a. (3) and (5)) and subsection b. (1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15) and (17) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6b. (1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15) and (17)).

(5) (a) Inpatient hospital services, subsection a. (1) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6a. (1)), shall only be provided to eligible medically needy individuals, other than

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

(b) Outpatient hospital services, subsection a.(2) of section 6 of P.L. 1968, c. 413 (C. 30:4D-6a.(2)), shall only be provided to eligible medically needy individuals if the federal Department of health and Human Services discontinues the State's waiver to establish outpatient hospital reimbursement rates for the Medicare and Medicaid programs under the authority of section 601 (c) (3) of the Social Security Amendments of 1983, Pub. L. 98-21 (42 U.S.C. § 1395 ww(c)(5)). Outpatient hospital services may be extended to all or to certain medically needy individuals if the federal Department of Health and Human Services directs that these services be included. However, the use of outpatient hospital services shall be limited to clinic services and to emergency room services for injuries and significant acute medical conditions.

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

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

7. Duties of commissioner. The commissioner is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the State of New Jersey the maximum federal participation that is available with

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respect to a program of medical assistance, consistent with fiscal responsibility and within the limits of funds available for any fiscal year, and to the extent authorized by the medical assistance program plan; to adopt fee schedules with regard to medical assistance benefits and otherwise to accomplish the purposes of this act, including specifically the following:

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

b. Subject to the limits imposed by this act, to determine the amount and scope of services to be covered, that the amounts to be paid are reasonable, and the duration of medical assistance to be furnished; provided, however, that the department shall provide medical assistance on behalf of all recipients of categorical assistance and such other related groups as are mandatory under federal laws and rules and regulations, as they now are or as they may be hereafter amended, in order to obtain federal matching funds for such purposes and, in addition, provide medical assistance for the foster children specified in section 31. (7) of this act. The medical assistance provided for these groups shall not be less in scope, duration, or amount than is currently furnished such groups, and in addition, shall include at least the minimum services required under federal laws and rules and regulations to obtain federal matching funds for such purposes.

The commissioner is authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds

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for any fiscal year, to extend the scope, duration, and amount of medical assistance on behalf of these groups of categorical assistance recipients, related groups as are mandatory, and foster children authorized pursuant to section 31. (7) of this act, so as to include, in whole or in part, the optional medical services authorized under federal laws and rules and regulations, and the commissioner shall have the authority to establish and maintain the priorities given such optional medical services; provided, however, that medical assistance shall be provided to at least such groups and in such scope, duration, and amount as are required to obtain federal matching funds.

The commissioner is further authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to issue, or cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules, regulations and administrative orders, and to do or cause to be done all other acts and things necessary to implement and administer demonstration projects pursuant to Title XI, section 1115 of the federal Social Security Act, including, but not limited to waiving compliance with specific provisions of this act, to the extent and for the period of time the commissioner deems necessary, as well as contracting with any legal entity, including but not limited to corporations organized pursuant to Title 14A, New Jersey Statutes (N.J.S. 14A:1-1 et seq.), Title 15, Revised Statutes (R.S. 15:1-1 et seq.) and Title 15A, New Jersey Statutes (N.J.S. 15A:1-1 et seq.) as well as boards, groups, agencies, persons and other public or private entities;

c. To administer the provisions of this act;

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

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

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

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

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

i. To take all necessary action to recover the cost of benefits incorrectly provided to or illegally obtained by a recipient, including those made after a voluntary divestiture of real or personal property or any interest or estate in property for less than adequate consideration made for the purpose of qualifying for assistance. The division shall take action to recover the cost of benefits from a recipient, legally responsible relative, representative payee, or any other party or parties whose action or inaction resulted in the incorrect or illegal payments or who received the benefit of the divestiture, or from their respective estates, as the case may be and to assess and collect the penalties as are provided for herein, except that no lien shall be imposed against property of the recipient prior to his death except in accordance with section 17 of P.L. 1968, c. 413 (C. 30:4D-17). No recovery action shall be initiated more than five years after ar

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incorrect payment has been made to a recipient when the incorrect payment was due solely to an error on the part of the State or any agency, agent or subdivision thereof;

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

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

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

m. To pay or credit to a provider any net amount found by final audit as defined by regulation to be owing to the provider. Such payment, if it is not made within 45 days of the final audit, shall include interest on the amount due at the maximum legal rate in effect on the date the payment became due, except that such interest shall not be paid on any obligation for the period preceding September 15, 1976. This subsection shall not apply

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until federal financial participation is available for such interest payments;

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

o. To solicit, receive and review bids pursuant to the provisions of P.L. 1954, c. 48 (C. 52:34-6 et seq.) and all amendments and supplements thereto, by authorized insurance companies and nonprofit hospital service corporations or medical service corporations, incorporated in New Jersey, and authorized to do business pursuant to P.L. 1938, c. 366 (C. 17:48-1 et seq.) or P.L. 1940, c. 74 (C. 17:48A-1 et seq.), and to make recommendations in connection therewith to the State Medicaid Commission;

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

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

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

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

t. To provide for the reimbursement of State and county-administered skilled nursing and intermediate care facilities

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through the use of a governmental peer grouping system, subject to federal approval and the availability of federal reimbursement.

(1) In establishing a governmental peer grouping system, the State's financial participation is limited to an amount equal to the nonfederal share of the reimbursement which would be due each facility if the governmental peer grouping system was not established, and each county's financial participation in this reimbursement system is equal to the nonfederal share of the increase in reimbursement for its facility or facilities which results from the establishment of the governmental peer grouping system.

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

(3) The governing body of each county entitled to receive increased federal reimbursement under the provisions of this amendatory act shall, by March 31 of each year, submit a report to the commissioner on the intended use of the savings in county expenditures which result from the increased federal reimbursement. The governing body of each county, with the advice of agencies providing social and health related services, shall use not less than 10% and no more than 50%

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of the savings in county expenditures which result from the increased federal reimbursement for community-based social and health related programs for elderly and disabled persons who may otherwise require nursing home care. This percentage shall be negotiated annually between the governing body and the commissioner and shall take into account a county's social, demographic and fiscal conditions, a county's social and health related expenditures and needs, and estimates of federal revenues to support county operations in the upcoming year, particularly in the areas of social and health related services.

(4) The commissioner, subject to approval by law, may terminate the governmental peer grouping system if federal reimbursement is significantly reduced or if the Medicaid program is significantly altered or changed by the federal government subsequent to the enactment of this amendatory act. The commissioner, prior to terminating the governmental peer grouping system, shall submit to the Legislature and to the governing body of each county a report as to the reasons for terminating the governmental peer grouping system;

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

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

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

(3) Develop a program of comprehensive pediatric care services which defines the type of services to be provided, the level of services

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to be provided, and the frequency with which qualified applicants are to receive services pursuant to P.L. 1968, c. 413 (C. 30:4D-1 et seq.);

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

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

v. The commissioner, jointly with the Commissioner of Health, shall report to the Governor and the Legislature no later than two years following the date of enactment of P.L. ..., c. ... (C. ...) (now pending before the Legislature as this bill) and annually thereafter on the status of the comprehensive maternity and pediatric care services and their effectiveness in meeting the objectives set forth in section 1 of P.L. ..., c. ... (C. ...) (now pending before the Legislature as this bill), accompanying the report with any recommendations for changes in the law governing the services that the commissioners deem necessary."

Page 5, Section 10, Line 1: Renumber "10." as "5."

Page 5, Section 11, Line 1: Renumber "11." as "6."

Page 5, Section 11, Lines 2-3: Omit "immediately" Insert "on the 270th day after enactment, except that section 2 shall take effect on April 1, 1987 or upon enactment, whichever is later"

Respectfully,

/s/ Thomas H. Kean

GOVERNOR

[seal]

Attest:

s Michael R. Cole

Chief Counsel



OFFICE OF THE GOVERNOR

NEWS RELEASE

CN-001

Contact: CARL GOLDEN
609-292-8956 OR 292-6000 EXT. 207

TRENTON, N.J. 08625

Release: MON., MAY 4, 1987

Governor Thomas H. Kean today signed legislation to establish a \$21.2 million State program to provide health care services to low income pregnant women and reduce New Jersey's high infant mortality rate.

The legislation A-2733, was sponsored by Assemblyman Anthony M. Villane, R-Monmouth, and Assemblywoman Kathleen Donovan, R-Bergen. An identical bill, S-2307, was sponsored in the Senate by Senator Richard Van Wagner, D-Monmouth.

Kean signed the bill at a public ceremony held in the Henry J. Austin Health Center in Trenton, a facility which provides prenatal care as well as health care for children.

"There is no acceptable reason, no sufficient explanation and no credible excuse for New Jersey to have an infant mortality rate higher than the national average," Kean said. "Each year, 1,100 newborns in New Jersey never reach their first birthday, a tragic statistic which places our State in the top one-third in the nation in terms of infant mortality."

"Statistics, however, are cold and unfeeling and can never adequately tell of the heartbreak and anguish of a young mother who loses an infant simply because she could not receive quality prenatal care or her child receive proper medical attention," Kean said.

The legislation signed today by Kean establishes the "Health Care Program for Pregnant Women and Children" in the Department of Human Services, and is expected to provide care for approximately 25,000 pregnant women and 43,000 children up to the age of two years.

The program extends current eligibility for Medicaid services to all poor pregnant women and their children, and enriches maternity and pediatric health care coverage for them.

The \$21.2 million State expenditure will be matched by the Federal Government through the Medicaid program, for a total expenditure of more than \$42 million.

"The prenatal care aspect of this program is exceptionally important," Kean said, "in the effort to reduce the number of low birthweight infants."

"Eleven percent of all infants born to teen-age mothers suffer low birthweight, a condition which places their health in severe danger," he said. "Proper prenatal care is crucial in avoiding this problem.

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