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,

[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 Childreu"]***** *****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.).****

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

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

a. Low-income pregnant women are at higher risk of poor birth outcomes by virtue of their poverty status and non-whites in New Jersey are more likely to be indigent than whites; in 1983, 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 and non-white infants in New Jersey are nearly twice as likely to die before their first birthday than white infants; the non-white and white infant mortality rates in 1983 were 19.3 and 9.2, respectively, and in 1984 the rates for black and white infants were 19.7 and 9.0, respectively; there has been no significant improvement in the infant mortality rate among older infants, ages one month to one year, during the last decade; the percentage of babies born 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.**

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

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

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

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

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

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

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

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

c. "Department" means the State Department of Human Services.

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

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

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

****[f.]**** ****e.**** ''Qualified ****[recipient]**** ****woman or child****'' means****, as appropriate**** a person who is a resident of this State and meets the following eligibility requirements:

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

(2) Is **[eligible for]** **receiving** benefits under the Medicaid program or has a gross annual ***[household]*** ***family*** income which is at or below the poverty level ***for a family size equal to the size of the family including the unborn child; except that, a pregnant woman who is determined to be a qualified recipient shall remain eligible for the program until the end of her pregnancy, notwithstanding a change in her family income***.]**** ****(a) Is a pregnant woman, or (b) Is a child who:

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

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

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

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

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

(2) 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 42 U. S. C. 1936a, as amended and supplemented by Pub. L. 99-509, except that a pregnant woman who is determined to be a qualified woman shall, notwithstanding any change in the income of the family of which she is a member, continue to be deemed a qualified woman until the end of the 60 day period beginning on the last day of her pregnancy.****

****[g.]**** ****f.**** "Program" means the "Health Care Program for Pregnant Women and Children" established pursuant to this act.[]*****

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

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

Under this program:

a. ****[Pregnant women]**** ****On and after the 270th day following the effective date of this act, a qualified woman**** shall ****be eligible to**** receive ****, in addition to any benefits for which the woman is eligible pursuant to the "New Jersey Medical Assistance and Health Services Act," P. L. 1968, c. 413 (C. 30:4D–1 et seq.),**** 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 which 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 pregnancy***; and physician or certified nurse-midwife delivery services.

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

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

a. Develop criteria and standards for participation by providers in the program and determine whether a provider who requests to participate in the program meets the department's criteria and standards.

b. Develop a comprehensive program of maternity care services in accordance with recommendations of the American ***[Academy]*** ***College*** of Obstetrics and Gynecology, which defines the type of services to be provided, the level of services to be provided, and the frequency with which qualified ****[recipients]**** ****women**** are to receive services pursuant to this act.

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

d. 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.]*****

****[5.]**** *****[****6.**** In consultation with the Commissioner of the Department of Health, the commissioner shall establish provider reimbursement rates for health care delivered under the program.]*****

****[6.]**** *****[****7.**** Participation by a qualified ****[recipient]**** ****woman or child**** in the program and acceptance of services provided under the program is voluntary. The commissioner shall adopt patient rights safeguards for recipients of the services under the program.]*****

* ****[7.]**** *****[****8.**** *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 and annually thereafter on the activities of the program and its effectiveness in meeting its objectives, accompanying the report with any recommendations for changes in the law or regulations governing the program that the commissioners deem necessary.**]*****

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

*****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;

(4) 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));

(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 133⅓% 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 133⅓% 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.

(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, 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 (d) of paragraph (8) of this subsection;

(9) (a) Is a pregnant women, 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 temporarily 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 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 B, 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, 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;

(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 22 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 pregnancy; and physician or certified nurse-midwife delivery 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 their 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 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 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. § 1395ww (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 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 3i. (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 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 3i. (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;

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 the 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 an 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 or 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 until federal financial participation is available for such interest payments;

n. To issue, or designate another to issue, subpenas 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 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% 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 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 andd 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.******

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

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

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

This act shall take effect ****[on the 270th day following enactment]**** *****[****immediately****]***** *****on the 270th day after enactment, except that section 2 shall take effect on 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.

d 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.

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

6. Participation by a qualified recipient in the program and acceptance of services provided under the program is voluntary. The commissioner shall adopt patient rights safeguards for recipients of the services under the program.

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

8. This act shall take effect on the 270th day following enactment.

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 effectivenss 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 Pregnan 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 I, 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, New

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

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

(4) 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));

(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.

(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,

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 (d) 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

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 B, 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.

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;

(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 22 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

pregnancy and physician or certified nurse-midwife delivery 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 their

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

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

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

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 3i. (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

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 3i. (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;

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 an

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

until federal financial participation is available for such interest payments;

n. To issue, or designate another to issue, subpenas 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

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%

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

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
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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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