58:10A-37

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 186

NJSA: 58:10A-37 (Medicaid coverage – breast, cervical cancer)

BILL NO: A3218 (Substituted for S2139)

SPONSOR(S): Blee and Vandervalk

DATE INTRODUCED: February 15, 2001

COMMITTEE: **ASSEMBLY:** Health

SENATE: Budget

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** June 21, 2001

SENATE: June 28, 2001

DATE OF APPROVAL: July 27, 2001

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Original version of the bill enacted)

A3218

SPONSORS STATEMENT: (Begins on page 14 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes 3-01-2001 (Health)

5-17-2001 (Approp.)

SENATE: Yes

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: Yes

S2139

SPONSORS STATEMENT: (Begins on page 14 of original bill) Yes

Bill and Sponsors Statement identical to A3218

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes 2-26-2001 (Health)

6-25-2001 (Budget)

Identical to Assembly Statements for A3218

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: Yes

Identical to fiscal estimate for A3218

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: No

Attached: Pub. L 106-354, as mentioned in sponsor's statement

ASSEMBLY, No. 3218

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED FEBRUARY 15, 2001

Sponsored by:
Assemblyman FRANCIS J. BLEE
District 2 (Atlantic)
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)

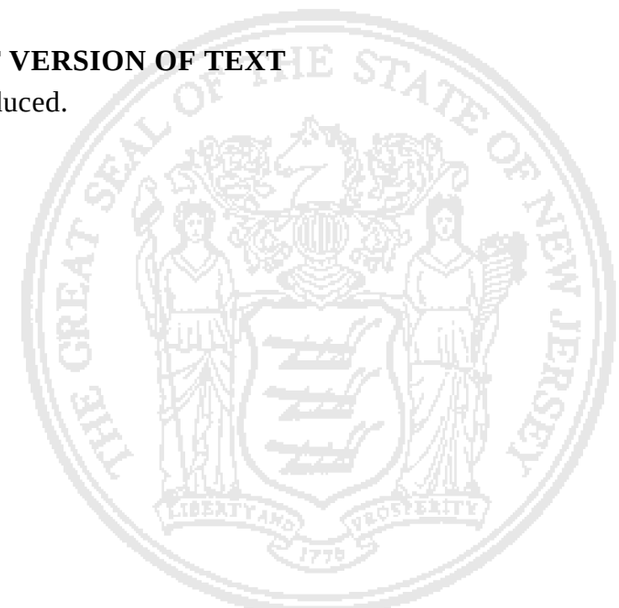
Co-Sponsored by:
Assemblywoman Gill, Assemblyman Bagger, Assemblywoman Weinberg, Assemblymen Pennacchio, Geist, Asselta, Zisa, Conaway, Assemblywoman Greenstein, Assemblyman Greenwald, Assemblywomen Heck, Previte, Senators Vitale, Sinagra, Ciesla, Lesniak, Turner and O'Toole

SYNOPSIS

Provides Medicaid coverage for certain breast and cervical cancer-related treatment services for presumptively eligible persons under federal law.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 6/29/2001)

AN ACT concerning Medicaid coverage for breast and cervical cancer-related treatment services for certain persons and amending P.L.1968, c.413.

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

1. 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 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 either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, and who:

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

(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;

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

(4) Would be eligible to receive Supplemental Security Income under Title XVI of the federal Social Security Act or, without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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) (Deleted by amendment, P.L.2000, c.71).

(6) Is an individual under 21 years of age who, without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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 developmental centers for the developmentally disabled, or in psychiatric hospitals;

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

(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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996; 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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996.

(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.s.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.s.1382(2)(B);

(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; and

(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 and other entities designated by the commissioner 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 child who is at least one year of age and under 19 years of age and, if older than six years but under 19 years of age, is uninsured; and

(b) Is a member of a family whose income does not exceed 133% of 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. s.1396a);

(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. s.1396a(a));

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

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

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of 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. s.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;

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

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

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

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

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

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker

relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds; **[**or**]**

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

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

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

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

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

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

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

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

(d) meets all other Medicaid eligibility requirements; and

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

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, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. s.1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or 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-6).

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. s.9902(2)).

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

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

(a) a lawful permanent resident;

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

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

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

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

(f) an alien granted conditional entry pursuant to section 203(a)(7)

of the federal "Immigration and Nationality Act" (8 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or

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

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

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

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

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

(cf: P.L.2000, c.116, s.1)

2. 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, to 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, 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 and Senior Services 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;

(20) Services provided by a hospice which is participating in the Medicare program established pursuant to Title XVIII of the Social

Security Act, Pub.L.89-97 (42 U.S.C.1395 et seq.). Hospice services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement;

(21) Mammograms, subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement, including one baseline mammogram for women who are at least 35 but less than 40 years of age; one mammogram examination every two years or more frequently, if recommended by a physician, for women who are at least 40 but less than 50 years of age; and one mammogram examination every year for women age 50 and over.

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

(2) In addition, any provision in a contract of insurance, health benefits plan or other health care coverage document, will, trust agreement, court order or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or potential 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.

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

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 this section and subsection b.(1)-(10), (12), (15) and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

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

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

(5) (a) Inpatient hospital services, subsection a.(1) of this section, 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 this section, 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.

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

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

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

(cf: P.L.2000, c.96, s.2)

3. The Commissioner of Human Services shall adopt rules and

regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act; except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

4. This act shall take effect immediately.

STATEMENT

This bill permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for breast or cervical cancer.

This bill enables the State to exercise its option under Pub.L.106-354 (which was signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3218

STATE OF NEW JERSEY

DATED: MARCH 1, 2001

The Assembly Health Committee reports favorably Assembly Bill No. 3218.

This bill permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for breast or cervical cancer.

The bill enables the State to exercise its option under Pub.L.106-354 (which was signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

This bill is identical to Senate Bill No. 2139 (Vitale/Sinagra), which is pending in the Senate Budget and Appropriations Committee.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3218

STATE OF NEW JERSEY

DATED: MAY 17, 2001

The Assembly Appropriations Committee reports favorably Assembly Bill No. 3218.

Assembly Bill No. 3218 permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for breast or cervical cancer.

The bill enables the State to exercise its option under federal Pub.L.106-354 (which was signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

FISCAL IMPACT:

This program is funded 65 percent with federal funds and 35 percent with State funds. Funding requirements are unknown, because the number of uninsured persons and the cost and duration of the breast and cervical cancer-related treatment services are unknown.

LEGISLATIVE FISCAL ESTIMATE
ASSEMBLY, No. 3218
STATE OF NEW JERSEY
209th LEGISLATURE

DATED: JUNE 5, 2001

SUMMARY

Synopsis: Provides Medicaid coverage for certain breast and cervical cancer-related treatment services for presumptively eligible persons under federal law.

Type of Impact: Uncertain: State expenditures may increase or expenditures may decrease.

Agencies Affected: Department of Human Services (DHS).

Office of Legislative Services Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost		Indeterminate	

- **!** The number of persons with breast and cervical cancer who may be eligible for services is not known. To the extent that such persons are already eligible for the Medicaid program, State costs may decrease as the federal matching rate for services will be greater than it is for the regular Medicaid program.
- **!** As costs to provide breast and cervical cancer treatment services will vary from individual to individual, treatment costs are not known.

BILL DESCRIPTION

Assembly Bill No. 3218 of 2001 permits DHS, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide Medicaid coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers by the federal Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program and are presumptively eligible for Medicaid during the period which a person requires treatment for breast and cervical cancer.

Federal Medicaid reimbursement under Pub.L.106-354 would be 65 percent instead of 50 percent.

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FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

Potential savings or costs cannot be determined:
While the number of persons screened by the CDC and who have breast and cervical cancer numbers about 200 annually in the State, no information is readily available as to how many already qualify for one of the Medicaid programs. For those persons with breast and cervical cancer already eligible for Medicaid, State expenditures would be reduced as the federal matching rate would increase from 50 percent to 65 percent; for those persons who are not already Medicaid eligible, State costs would increase.
Treatment costs are unknown and would vary from individual to individual, depending on how far the breast and cervical cancer has progressed.

Section:	*Human Services*
Analyst:	*Jay Hershberg* *Principal Fiscal Analyst*
Approved:	*Alan R. Kooney* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3218

STATE OF NEW JERSEY

DATED: JUNE 25, 2001

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 3218.

This bill permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for the breast or cervical cancer.

This bill enables the State to exercise its option under Pub.L.106-354 (signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

The provisions of this bill are identical to those of Senate Bill No. 2139, which the committee also reports this day.

FISCAL IMPACT:

This program is funded 65 percent with federal funds and 35 percent with State funds. Funding requirements cannot be estimated because the number of uninsured persons and the cost and duration of the breast and cervical cancer-related treatment services are unknown.

SENATE, No. 2139

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED FEBRUARY 15, 2001

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator JACK SINAGRA
District 18 (Middlesex)

Co-Sponsored by:
Senators Ciesla, Lesniak, Turner and O'Toole

SYNOPSIS

Provides Medicaid coverage for certain breast and cervical cancer-related treatment services for presumptively eligible persons under federal law.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 6/29/2001)

AN ACT concerning Medicaid coverage for breast and cervical cancer-related treatment services for certain persons and amending P.L.1968, c.413.

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

1. 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 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 either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, and who:

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

(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;

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

(4) Would be eligible to receive Supplemental Security Income under Title XVI of the federal Social Security Act or, without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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) (Deleted by amendment, P.L.2000, c.71).

(6) Is an individual under 21 years of age who, without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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 developmental centers for the developmentally disabled, or in psychiatric hospitals;

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

(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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996; 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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996.

(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.s.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.s.1382(2)(B);

(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; and

(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 and other entities designated by the commissioner 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 child who is at least one year of age and under 19 years of age and, if older than six years but under 19 years of age, is uninsured; and

(b) Is a member of a family whose income does not exceed 133% of 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. s.1396a);

(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. s.1396a(a));

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

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

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of 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. s.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;

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

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

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

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

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

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker

relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds; **[**or**]**

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

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

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

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

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

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

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

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

(d) meets all other Medicaid eligibility requirements; and

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

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, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. s.1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or 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-6).

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. s.9902(2)).

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

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

(a) a lawful permanent resident;

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

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

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

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

(f) an alien granted conditional entry pursuant to section 203(a)(7)

of the federal "Immigration and Nationality Act" (8 U.S.C. s.1153(a)(7)) in effect prior to April 1, 1980; or

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

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

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

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

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

(cf: P.L.2000, c.116, s.1)

2. 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, to 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, 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 and Senior Services 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;

(20) Services provided by a hospice which is participating in the Medicare program established pursuant to Title XVIII of the Social

Security Act, Pub.L.89-97 (42 U.S.C.1395 et seq.). Hospice services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement;

(21) Mammograms, subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement, including one baseline mammogram for women who are at least 35 but less than 40 years of age; one mammogram examination every two years or more frequently, if recommended by a physician, for women who are at least 40 but less than 50 years of age; and one mammogram examination every year for women age 50 and over.

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

(2) In addition, any provision in a contract of insurance, health benefits plan or other health care coverage document, will, trust agreement, court order or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or potential 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.

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

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 this section and subsection b.(1)-(10), (12), (15) and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

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

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

(5) (a) Inpatient hospital services, subsection a.(1) of this section, 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 this section, 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.

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

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

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

(cf: P.L.2000, c.96, s.2)

3. The Commissioner of Human Services shall adopt rules and

regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act; except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

4. This act shall take effect immediately.

STATEMENT

This bill permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for breast or cervical cancer.

This bill enables the State to exercise its option under Pub.L.106-354 (which was signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 2139

STATE OF NEW JERSEY

DATED: FEBRUARY 26, 2001

The Senate Health Committee reports favorably Senate Bill No. 2139.

This bill permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for the breast or cervical cancer.

This bill enables the State to exercise its option under Pub.L.106-354 (which was signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

This bill identical to Assembly Bill No.3218 (Blee/Vandervalk), which is pending before the Assembly Health Committee.

LEGISLATIVE FISCAL ESTIMATE
SENATE, No. 2139
STATE OF NEW JERSEY
209th LEGISLATURE

DATED: JUNE 5, 2001

SUMMARY

Synopsis: Provides Medicaid coverage for certain breast and cervical cancer-related treatment services for presumptively eligible persons under federal law.

Type of Impact: Uncertain: State expenditures may increase or expenditures may decrease.

Agencies Affected: Department of Human Services (DHS).

Office of Legislative Services Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost		Indeterminate	

- ! The number of persons with breast and cervical cancer who may be eligible for services is not known. To the extent that such persons are already eligible for the Medicaid program, State costs may decrease as the federal matching rate for services will be greater than it is for the regular Medicaid program.
- ! As costs to provide breast and cervical cancer treatment services will vary from individual to individual, treatment costs are not known.

BILL DESCRIPTION

Senate Bill No. 2139 of 2001 permits DHS, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide Medicaid coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers by the federal Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program and are presumptively eligible for Medicaid during the period which a person requires treatment for breast and cervical cancer.

Federal Medicaid reimbursement under Pub.L.106-354 would be 65 percent instead of 50 percent.

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FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

Potential savings or costs cannot be determined:

- While the number of persons screened by the CDC and who have breast and cervical cancer numbers about 200 annually in the State, no information is readily available as to how many already qualify for one of the Medicaid programs. For those persons with breast and cervical cancer already eligible for Medicaid, State expenditures would be reduced as the federal matching rate would increase from 50 percent to 65 percent; for those persons who are not already Medicaid eligible, State costs would increase.
- Treatment costs are unknown and would vary from individual to individual, depending on how far the breast and cervical cancer has progressed.

Section:	*Human Services*
Analyst:	*Jay Hershberg* *Principal Fiscal Analyst*
Approved:	*Alan R. Kooney* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE, No. 2139

STATE OF NEW JERSEY

DATED: JUNE 25, 2001

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 2139.

This bill permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for the breast or cervical cancer.

This bill enables the State to exercise its option under Pub.L.106-354 (signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

The provisions of this bill are identical to those of Assembly Bill No. 3218, which the committee also reports this day.

FISCAL IMPACT

This program is funded 65 percent with federal funds and 35 percent with State funds. Funding requirements cannot be estimated because the number of uninsured persons and the cost and duration of the breast and cervical cancer-related treatment services are unknown.

P.L. 2001, CHAPTER 186, ***approved July 27, 2001***
Assembly, No. 3218

AN ACT concerning Medicaid coverage for breast and cervical cancer-related treatment services for certain persons and amending P.L.1968, c.413.

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

1. 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 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 either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, and who:

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

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

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

(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 Supplemental Security Income under Title XVI of the federal Social Security Act or, without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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) (Deleted by amendment, P.L.2000, c.71).

(6) Is an individual under 21 years of age who, without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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 developmental centers for the developmentally disabled, or in psychiatric hospitals;

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

(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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996; 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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996.

(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.s.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.s.1382(2)(B);

(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; and

(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 and other entities designated by the commissioner 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 child who is at least one year of age and under 19 years of age and, if older than six years but under 19 years of age, is uninsured; and

(b) Is a member of a family whose income does not exceed 133% of 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. s.1396a);

(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. s.1396a(a));

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

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

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of 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. s.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;

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

(15) (a) Is a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1, 1993 do not exceed 200% of the resource standard used to determine eligibility under the Supplemental Security Income program, P.L.1973,

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

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

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

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

waivers;

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner; or

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds; **[**or**]**

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

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

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

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

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

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

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

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

(d) meets all other Medicaid eligibility requirements; and

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

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, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. s.1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or 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-6).

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. s.9902(2)).

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

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

(a) a lawful permanent resident;

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

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

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

(e) an alien who has been granted parole for less than one year by the federal Immigration and Naturalization Service pursuant to section

212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C. s.1182(d)(5));

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

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

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

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

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

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

(cf: P.L.2000, c.116, s.1)

2. 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, to 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, 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 and Senior Services 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;

(20) Services provided by a hospice which is participating in the Medicare program established pursuant to Title XVIII of the Social Security Act, Pub.L.89-97 (42 U.S.C.1395 et seq.). Hospice services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement;

(21) Mammograms, subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement, including one baseline mammogram for women who are at least 35 but less than 40 years of age; one mammogram examination every two years or more frequently, if recommended by a physician, for women who are at least 40 but less than 50 years of age; and one mammogram examination every year for women age 50 and over.

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

(2) In addition, any provision in a contract of insurance, health benefits plan or other health care coverage document, will, trust agreement, court order or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or potential 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.

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

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 this section and subsection b.(1)-(10), (12), (15) and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

(3) Individuals who are 65 years of age or older shall be provided with services cited in subsection a.(3) and (5) of this section and

subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15) and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

(5) (a) Inpatient hospital services, subsection a.(1) of this section, 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 this section, 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.

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

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

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

(cf: P.L.2000, c.96, s.2)

3. The Commissioner of Human Services shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act; except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

4. This act shall take effect immediately.

STATEMENT

This bill permits the State Medicaid program, in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000," Pub.L.106-354, to provide coverage for breast and cervical cancer-related treatment services for uninsured persons who have been screened for these cancers under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and are presumptively eligible for Medicaid. This coverage would be limited to the period during which a person requires treatment for breast or cervical cancer.

This bill enables the State to exercise its option under Pub.L.106-354 (which was signed into law on October 24, 2000) to provide the coverage stipulated thereunder for these persons who would not otherwise be eligible for the Medicaid program.

Provides Medicaid coverage for certain breast and cervical cancer-related treatment services for presumptively eligible persons under federal law.

CHAPTER 186

AN ACT concerning Medicaid coverage for breast and cervical cancer-related treatment services for certain persons and amending P.L.1968, c.413.

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

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

C.30:4D-3 Definitions.

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 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 either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, with respect to whom the period for which eligibility to be a recipient is determined shall be the maximum period permitted under federal law, and who:

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

(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 Supplemental Security Income under Title XVI of the federal Social Security Act or, without regard to resources, would be eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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) (Deleted by amendment, P.L.2000, c.71).

(6) Is an individual under 21 years of age who, without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, 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 developmental centers for the developmentally disabled, or in psychiatric hospitals;

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

(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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996; 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 under the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act in effect as of July 16, 1996.

(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.s.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.s.1382(2)(B);

(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; and

(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 and other entities designated by the commissioner 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 child who is at least one year of age and under 19 years of age and, if older than six years of age but under 19 years of age, is uninsured; and

(b) Is a member of a family whose income does not exceed 133% of 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. s.1396a);

(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. s.1396a(a));

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

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

(13) Is a pregnant woman or is a child who is under one year of age and is a member of a family whose income does not exceed 185% of 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. s.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;

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

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

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

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

facility services or home or community-based services.

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

(16) Subject to federal approval under Title XIX of the federal Social Security Act, is a dependent child, parent or specified caretaker relative of a child who is a qualified applicant, who would be eligible, without regard to resources, for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, except for the income eligibility requirements of that program, and whose family earned income does not exceed 133% of the poverty level plus such earned income disregards as shall be determined according to a methodology to be established by regulation of the commissioner;

(17) Is an individual from 18 through 20 years of age who is not a dependent child and would be eligible for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), without regard to income or resources, who, on the individual's 18th birthday was in foster care under the care and custody of the Division of Youth and Family Services and whose maintenance was being paid in whole or in part from public funds;

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

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

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

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

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

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

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

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

(d) meets all other Medicaid eligibility requirements; and

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

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, group health plan as defined in section 607(1) of the federal "Employee Retirement and Income Security Act of 1974," 29 U.S.C. s.1167(1), service benefit plan, health maintenance organization, or other prepaid health plan, or 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-6).

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. s.9902(2)).

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

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

(a) a lawful permanent resident;

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

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

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

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

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

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

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

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

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

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

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

C.30:4D-6 Basic medical care and services.

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, to 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, 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 and Senior Services 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;

(20) Services provided by a hospice which is participating in the Medicare program established pursuant to Title XVIII of the Social Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement;

(21) Mammograms, subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement, including one baseline mammogram for women who are at least 35 but less than 40 years of age; one mammogram examination every two years or more frequently, if recommended by a physician, for women who are at least 40 but less than 50 years of age; and one mammogram examination every year for women age 50 and over.

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

(2) In addition, any provision in a contract of insurance, health benefits plan or other health care coverage document, will, trust agreement, court order or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or potential 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.

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

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 this section and subsection b.(1)-(10), (12), (15) and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

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

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

(5) (a) Inpatient hospital services, subsection a.(1) of this section, 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. s.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 this section, 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. s.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.

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

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

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

3. The Commissioner of Human Services shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act; except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

4. This act shall take effect immediately.

Approved July 27, 2001.

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NEWS RELEASE

RELEASE: July 27 , 2001

DiFRANCESCO SIGNS LEGISLATION GIVING MEDICAID COVERAGE TO UNINSURED WOMEN FOR BREAST AND CERVICAL CANCER TREATMENT

Bill Enables State to Access Federal Funds

Acting Governor Donald T. DiFrancesco signed the Breast and Cervical Cancer Treatment Act today, to provide coverage for medical treatments related to breast and cervical cancer under the state's Medicaid program.

"Uninsured women diagnosed with breast or cervical cancer have very limited access to treatment. These women can either pay for treatment themselves, receive treatment through a state, local, or privately funded program, go through charity care or simply go without. Even with these options not ALL costs of treatment such as prescriptions or conditions caused by drug side effects are covered," said the acting Governor.

The Breast and Cervical Cancer Treatment Act enables the State to access federal matching funds in accordance with the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000" in order to provide necessary medical treatment for uninsured women with breast and cervical cancer.

Women who have been previously screened for these cancers under the Federal Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program and who are within 250 percent of the federal poverty level are eligible for coverage.

Women who receive coverage through the Breast and Cervical Cancer Early Detection Program will now have access to the Medicaid network of providers and receive coverage for prescriptions throughout the entire course of cancer treatment. During the course of treatment they will also have access to other medical services through Medicaid.

"I want to take this opportunity to stress the importance of early detection and treatment. One of the greatest acts of love is to encourage a friend or family member to get tested -- and then, if necessary, get treatment as soon as possible," said DiFrancesco.

New Jersey currently has 25 screening sites for breast and cervical cancer, which were established in 1996 as part of New Jersey's Cancer Education Early Detection program. In the past five years, these centers have screened almost 25,000 women, with approximately 1 percent diagnosed with cancer.

A-3218 is sponsored by Senators Jack Sinagra (R-Middlesex) and Joe Vitale (D-Middlesex) and Assembly members Frank Blee (R-Atlantic) and Charlotte Vandervalk (R-Bergen).