

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

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

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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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:

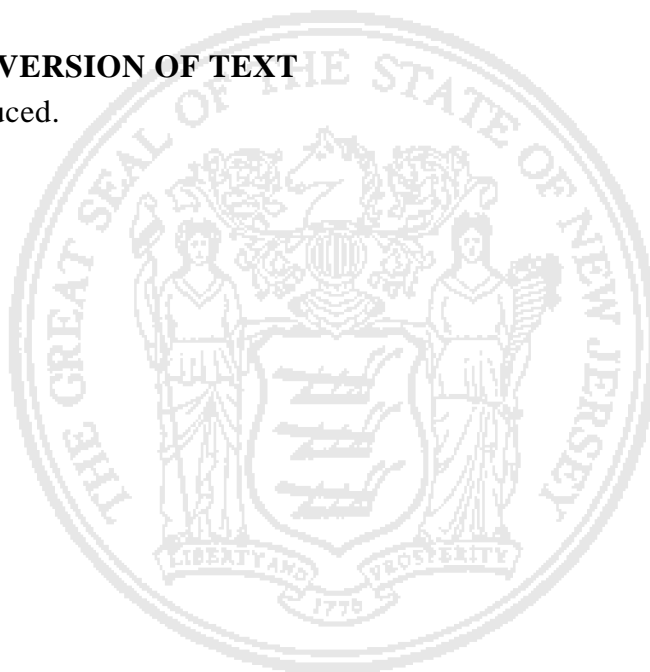
**Assemblywoman Gill, Assemblyman Bagger, Assemblywoman Weinberg,
Assemblymen Pennacchio, Geist, Asselta, Zisa, Conaway, Assemblywoman
Greenstein, Assemblyman Greenwald, Assemblywomen Heck, Previte,
Senators Vitale, Sinagra, Ciesla, Lesniak, Turner and O'Toole**

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)

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

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

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

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

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

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

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

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

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

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

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

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

31 i. "Qualified applicant" means a person who is a resident of this
32 State, and either a citizen of the United States or an eligible alien, and
33 is determined to need medical care and services as provided under this
34 act, and who:

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

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

41 (3) Is an "ineligible spouse" of a recipient of Supplemental Security
42 Income for the Aged, Blind and Disabled under Title XVI of the Social
43 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 thus is new matter.

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

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

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

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

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

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

29 (i) Pregnant women;

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

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

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

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

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

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

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

3 (i) For one person households, the resource standard shall be
4 200% of the resource standard for recipients of Supplemental Security
5 Income pursuant to 42 U.S.C.s.1382(1)(B);

6 (ii) For two person households, the resource standard shall be
7 200% of the resource standard for recipients of Supplemental Security
8 Income pursuant to 42 U.S.C.s.1382(2)(B);

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

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

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

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

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

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

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

40 The division shall notify all eligible recipients of the Pharmaceutical
41 Assistance to the Aged and Disabled program, P.L.1975, c.194
42 (C.30:4D-20 et seq.) on an annual basis of the medically needy
43 program and the program's general requirements. The division shall
44 take all reasonable administrative actions to ensure that
45 Pharmaceutical Assistance to the Aged and Disabled recipients, who
46 notify the division that they may be eligible for the program, have their

1 applications processed expeditiously, at times and locations convenient
2 to the recipients; and

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

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

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

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

18 (11) Is an individual 65 years of age and older, or an individual
19 who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42
20 U.S.C. s.1382c), whose income does not exceed 100% of the poverty
21 level, adjusted for family size, and whose resources do not exceed
22 100% of the resource standard used to determine medically needy
23 eligibility pursuant to paragraph (8) of this subsection;

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

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

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

40 (15) (a) Is a specified low-income Medicare beneficiary pursuant to
41 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
42 1993 do not exceed 200% of the resource standard used to determine
43 eligibility under the Supplemental Security Income program, P.L.1973,
44 c.256 (C.44:7-85 et seq.) and whose income beginning January 1,
45 1993 does not exceed 110% of the poverty level, and beginning
46 January 1, 1995 does not exceed 120% of the poverty level.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (e) in accordance with Pub.L.106-354, is determined by a qualified
35 entity to be presumptively eligible for medical assistance pursuant to
36 42 U.S.C. s.1396a(aa), based upon criteria established by the
37 commissioner pursuant to section 1920B of the federal Social Security
38 Act (42 U.S.C. s.1396r-1b).

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

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

46 l. "State Medicaid Commission" means the Governor, the

1 Commissioner of Human Services, the President of the Senate and the
2 Speaker of the General Assembly, hereby constituted a commission to
3 approve and direct the means and method for the payment of claims
4 pursuant to this act.

5 m. "Third party" means any person, institution, corporation,
6 insurance company, group health plan as defined in section 607(1) of
7 the federal "Employee Retirement and Income Security Act of 1974,"
8 29 U.S.C. s.1167(1), service benefit plan, health maintenance
9 organization, or other prepaid health plan, or public, private or
10 governmental entity who is or may be liable in contract, tort, or
11 otherwise by law or equity to pay all or part of the medical cost of
12 injury, disease or disability of an applicant for or recipient of medical
13 assistance payable under this act.

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

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

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

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

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

34 (a) a lawful permanent resident;

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

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

39 (d) an alien who has had deportation withheld pursuant to section
40 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
41 s.1253 (h));

42 (e) an alien who has been granted parole for less than one year by
43 the federal Immigration and Naturalization Service pursuant to section
44 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
45 s.1182(d)(5));

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

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

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

6 (2) An alien who entered the United States on or after August 22,
7 1996, who is:

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

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

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

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

17

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

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

25 (1) Inpatient hospital services;

26 (2) Outpatient hospital services;

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

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

29 (b) Such early and periodic screening and diagnosis of individuals
30 who are eligible under the program and are under age 21, to ascertain
31 their physical or mental defects and such health care, treatment, and
32 other measures to correct or ameliorate defects and chronic conditions
33 discovered thereby, as may be provided in regulations of the Secretary
34 of the federal Department of Health and Human Services and approved
35 by the commissioner;

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

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

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

46 (2) Home health care services;

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

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

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

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

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

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

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

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

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

1 subject to the limitations imposed by federal law and regulations, or

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

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

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

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

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

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

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

38 (2) Dependent children shall be provided with services cited in
39 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
40 (4), (5), (6), (7), (10), (12), (15) and (17) of this section, and nursing
41 facility services cited in subsection b.(13) of this section.

42 (3) Individuals who are 65 years of age or older shall be provided
43 with services cited in subsection a.(3) and (5) of this section and
44 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
45 (12), (15) and (17) of this section, and nursing facility services cited
46 in subsection b.(13) of this section.

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

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

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

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

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

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

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

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

45
46 3. The Commissioner of Human Services shall adopt rules and

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

10
11 4. This act shall take effect immediately.
12
13

14 STATEMENT
15

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

25 This bill enables the State to exercise its option under Pub.L.106-
26 354 (which was signed into law on October 24, 2000) to provide the
27 coverage stipulated thereunder for these persons who would not
28 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.

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)

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

4

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

7

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

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

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

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

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

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

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

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

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

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

31 i. "Qualified applicant" means a person who is a resident of this
32 State, and either a citizen of the United States or an eligible alien, and
33 is determined to need medical care and services as provided under this
34 act, and who:

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

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

41 (3) Is an "ineligible spouse" of a recipient of Supplemental Security
42 Income for the Aged, Blind and Disabled under Title XVI of the Social
43 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 thus is new matter.

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

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

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

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

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

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

29 (i) Pregnant women;

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

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

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

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

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

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

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

3 (i) For one person households, the resource standard shall be
4 200% of the resource standard for recipients of Supplemental Security
5 Income pursuant to 42 U.S.C.s.1382(1)(B);

6 (ii) For two person households, the resource standard shall be
7 200% of the resource standard for recipients of Supplemental Security
8 Income pursuant to 42 U.S.C.s.1382(2)(B);

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

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

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

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

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

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

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

40 The division shall notify all eligible recipients of the Pharmaceutical
41 Assistance to the Aged and Disabled program, P.L.1975, c.194
42 (C.30:4D-20 et seq.) on an annual basis of the medically needy
43 program and the program's general requirements. The division shall
44 take all reasonable administrative actions to ensure that
45 Pharmaceutical Assistance to the Aged and Disabled recipients, who
46 notify the division that they may be eligible for the program, have their

1 applications processed expeditiously, at times and locations convenient
2 to the recipients; and

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

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

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

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

18 (11) Is an individual 65 years of age and older, or an individual
19 who is blind or disabled pursuant to section 301 of Pub.L.92-603 (42
20 U.S.C. s.1382c), whose income does not exceed 100% of the poverty
21 level, adjusted for family size, and whose resources do not exceed
22 100% of the resource standard used to determine medically needy
23 eligibility pursuant to paragraph (8) of this subsection;

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

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

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

40 (15) (a) Is a specified low-income Medicare beneficiary pursuant to
41 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
42 1993 do not exceed 200% of the resource standard used to determine
43 eligibility under the Supplemental Security Income program, P.L.1973,
44 c.256 (C.44:7-85 et seq.) and whose income beginning January 1,
45 1993 does not exceed 110% of the poverty level, and beginning
46 January 1, 1995 does not exceed 120% of the poverty level.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (e) in accordance with Pub.L.106-354, is determined by a qualified
35 entity to be presumptively eligible for medical assistance pursuant to
36 42 U.S.C. s.1396a(aa), based upon criteria established by the
37 commissioner pursuant to section 1920B of the federal Social Security
38 Act (42 U.S.C. s.1396r-1b).

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

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

46 l. "State Medicaid Commission" means the Governor, the

1 Commissioner of Human Services, the President of the Senate and the
2 Speaker of the General Assembly, hereby constituted a commission to
3 approve and direct the means and method for the payment of claims
4 pursuant to this act.

5 m. "Third party" means any person, institution, corporation,
6 insurance company, group health plan as defined in section 607(1) of
7 the federal "Employee Retirement and Income Security Act of 1974,"
8 29 U.S.C. s.1167(1), service benefit plan, health maintenance
9 organization, or other prepaid health plan, or public, private or
10 governmental entity who is or may be liable in contract, tort, or
11 otherwise by law or equity to pay all or part of the medical cost of
12 injury, disease or disability of an applicant for or recipient of medical
13 assistance payable under this act.

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

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

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

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

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

34 (a) a lawful permanent resident;

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

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

39 (d) an alien who has had deportation withheld pursuant to section
40 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
41 s.1253 (h));

42 (e) an alien who has been granted parole for less than one year by
43 the federal Immigration and Naturalization Service pursuant to section
44 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
45 s.1182(d)(5));

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

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

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

6 (2) An alien who entered the United States on or after August 22,
7 1996, who is:

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

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

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

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

17

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

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

25 (1) Inpatient hospital services;

26 (2) Outpatient hospital services;

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

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

29 (b) Such early and periodic screening and diagnosis of individuals
30 who are eligible under the program and are under age 21, to ascertain
31 their physical or mental defects and such health care, treatment, and
32 other measures to correct or ameliorate defects and chronic conditions
33 discovered thereby, as may be provided in regulations of the Secretary
34 of the federal Department of Health and Human Services and approved
35 by the commissioner;

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

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

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

46 (2) Home health care services;

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

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

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

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

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

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

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

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

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

1 subject to the limitations imposed by federal law and regulations, or

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

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

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

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

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

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

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

38 (2) Dependent children shall be provided with services cited in
39 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
40 (4), (5), (6), (7), (10), (12), (15) and (17) of this section, and nursing
41 facility services cited in subsection b.(13) of this section.

42 (3) Individuals who are 65 years of age or older shall be provided
43 with services cited in subsection a.(3) and (5) of this section and
44 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
45 (12), (15) and (17) of this section, and nursing facility services cited
46 in subsection b.(13) of this section.

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

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

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

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

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

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

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

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

45
46 3. The Commissioner of Human Services shall adopt rules and

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

10
11 4. This act shall take effect immediately.

12
13
14 STATEMENT

15
16 This bill permits the State Medicaid program, in accordance with
17 the provisions of the federal "Breast and Cervical Cancer Prevention
18 and Treatment Act of 2000," Pub.L.106-354, to provide coverage for
19 breast and cervical cancer-related treatment services for uninsured
20 persons who have been screened for these cancers under the federal
21 Centers for Disease Control and Prevention breast and cervical cancer
22 early detection program and are presumptively eligible for Medicaid.
23 This coverage would be limited to the period during which a person
24 requires treatment for breast or cervical cancer.

25 This bill enables the State to exercise its option under Pub.L.106-
26 354 (which was signed into law on October 24, 2000) to provide the
27 coverage stipulated thereunder for these persons who would not
28 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.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

Potential savings or costs cannot be determined:

- C 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.
- C 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

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

4

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

7

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

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

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

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

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

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

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

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

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

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

31 i. "Qualified applicant" means a person who is a resident of this
32 State, and either a citizen of the United States or an eligible alien, and
33 is determined to need medical care and services as provided under this
34 act, and who:

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

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

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

Matter underlined thus is new matter.

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

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

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

6 (i) For one person households, the resource standard shall be
7 200% of the resource standard for recipients of Supplemental Security
8 Income pursuant to 42 U.S.C.s.1382(1)(B);

9 (ii) For two person households, the resource standard shall be
10 200% of the resource standard for recipients of Supplemental Security
11 Income pursuant to 42 U.S.C.s.1382(2)(B);

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

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

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

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

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

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

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

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

1 take all reasonable administrative actions to ensure that
2 Pharmaceutical Assistance to the Aged and Disabled recipients, who
3 notify the division that they may be eligible for the program, have their
4 applications processed expeditiously, at times and locations convenient
5 to the recipients; and

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

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

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

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

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

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

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

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

43 (15) (a) Is a specified low-income Medicare beneficiary pursuant to
44 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1,
45 1993 do not exceed 200% of the resource standard used to determine
46 eligibility under the Supplemental Security Income program, P.L.1973,

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

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

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

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

1 waivers;

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

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

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

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

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

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

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

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

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

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

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

37 (e) in accordance with Pub.L.106-354, is determined by a qualified
38 entity to be presumptively eligible for medical assistance pursuant to
39 42 U.S.C. s.1396a(aa), based upon criteria established by the
40 commissioner pursuant to section 1920B of the federal Social Security
41 Act (42 U.S.C. s.1396r-1b).

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

44 k. "Resident" means a person who is living in the State voluntarily
45 with the intention of making his home here and not for a temporary
46 purpose. Temporary absences from the State, with subsequent returns

1 to the State or intent to return when the purposes of the absences have
2 been accomplished, do not interrupt continuity of residence.

3 1. "State Medicaid Commission" means the Governor, the
4 Commissioner of Human Services, the President of the Senate and the
5 Speaker of the General Assembly, hereby constituted a commission to
6 approve and direct the means and method for the payment of claims
7 pursuant to this act.

8 m. "Third party" means any person, institution, corporation,
9 insurance company, group health plan as defined in section 607(1) of
10 the federal "Employee Retirement and Income Security Act of 1974,"
11 29 U.S.C. s.1167(1), service benefit plan, health maintenance
12 organization, or other prepaid health plan, or public, private or
13 governmental entity who is or may be liable in contract, tort, or
14 otherwise by law or equity to pay all or part of the medical cost of
15 injury, disease or disability of an applicant for or recipient of medical
16 assistance payable under this act.

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

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

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

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

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

37 (a) a lawful permanent resident;

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

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

42 (d) an alien who has had deportation withheld pursuant to section
43 243(h) of the federal "Immigration and Nationality Act" (8 U.S.C.
44 s.1253 (h));

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

1 212(d)(5) of the federal "Immigration and Nationality Act" (8 U.S.C.
2 s.1182(d)(5));

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

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

9 (2) An alien who entered the United States on or after August 22,
10 1996, who is:

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

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

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

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

20

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

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

28 (1) Inpatient hospital services;

29 (2) Outpatient hospital services;

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

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

32 (b) Such early and periodic screening and diagnosis of individuals
33 who are eligible under the program and are under age 21, to ascertain
34 their physical or mental defects and such health care, treatment, and
35 other measures to correct or ameliorate defects and chronic conditions
36 discovered thereby, as may be provided in regulations of the Secretary
37 of the federal Department of Health and Human Services and approved
38 by the commissioner;

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

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

45 (1) Medical care not included in subsection a.(5) above, or any
46 other type of remedial care recognized under State law, furnished by

- 1 licensed practitioners within the scope of their practice, as defined by
2 State law;
- 3 (2) Home health care services;
- 4 (3) Clinic services;
- 5 (4) Dental services;
- 6 (5) Physical therapy and related services;
- 7 (6) Prescribed drugs, dentures, and prosthetic devices; and
8 eyeglasses prescribed by a physician skilled in diseases of the eye or by
9 an optometrist, whichever the individual may select;
- 10 (7) Optometric services;
- 11 (8) Podiatric services;
- 12 (9) Chiropractic services;
- 13 (10) Psychological services;
- 14 (11) Inpatient psychiatric hospital services for individuals under 21
15 years of age, or under age 22 if they are receiving such services
16 immediately before attaining age 21;
- 17 (12) Other diagnostic, screening, preventive, and rehabilitative
18 services, and other remedial care;
- 19 (13) Inpatient hospital services, nursing facility services and
20 intermediate care facility services for individuals 65 years of age or
21 over in an institution for mental diseases;
- 22 (14) Intermediate care facility services;
- 23 (15) Transportation services;
- 24 (16) Services in connection with the inpatient or outpatient
25 treatment or care of drug abuse, when the treatment is prescribed by
26 a physician and provided in a licensed hospital or in a narcotic and
27 drug abuse treatment center approved by the Department of Health
28 and Senior Services pursuant to P.L.1970, c.334 (C.26:2G-21 et seq.)
29 and whose staff includes a medical director, and limited to those
30 services eligible for federal financial participation under Title XIX of
31 the federal Social Security Act;
- 32 (17) Any other medical care and any other type of remedial care
33 recognized under State law, specified by the Secretary of the federal
34 Department of Health and Human Services, and approved by the
35 commissioner;
- 36 (18) Comprehensive maternity care, which may include: the basic
37 number of prenatal and postpartum visits recommended by the
38 American College of Obstetrics and Gynecology; additional prenatal
39 and postpartum visits that are medically necessary; necessary
40 laboratory, nutritional assessment and counseling, health education,
41 personal counseling, managed care, outreach and follow-up services;
42 treatment of conditions which may complicate pregnancy; and
43 physician or certified nurse-midwife delivery services;
- 44 (19) Comprehensive pediatric care, which may include: ambulatory,
45 preventive and primary care health services. The preventive services
46 shall include, at a minimum, the basic number of preventive visits

1 recommended by the American Academy of Pediatrics;

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

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

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

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

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

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

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

45 (1) Is an inmate of a public institution (except as a patient in a
46 medical institution); provided, however, that an individual who is

1 otherwise eligible may continue to receive services for the month in
2 which he becomes an inmate, should the commissioner determine to
3 expand the scope of Medicaid eligibility to include such an individual,
4 subject to the limitations imposed by federal law and regulations, or

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

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

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

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

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

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

36 (1) Pregnant women shall be provided prenatal care and delivery
37 services and postpartum care, including the services cited in subsection
38 a.(1), (3) and (5) of this section and subsection b.(1)-(10), (12), (15)
39 and (17) of this section, and nursing facility services cited in
40 subsection b.(13) of this section.

41 (2) Dependent children shall be provided with services cited in
42 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
43 (4), (5), (6), (7), (10), (12), (15) and (17) of this section, and nursing
44 facility services cited in subsection b.(13) of this section.

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

1 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
2 (12), (15) and (17) of this section, and nursing facility services cited
3 in subsection b.(13) of this section.

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

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

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

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

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

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

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

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

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

11

12 4. This act shall take effect immediately.

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14

15

STATEMENT

16

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

26 This bill enables the State to exercise its option under Pub.L.106-
27 354 (which was signed into law on October 24, 2000) to provide the
28 coverage stipulated thereunder for these persons who would not
29 otherwise be eligible for the Medicaid program.

30

31

32

33

34 Provides Medicaid coverage for certain breast and cervical cancer-
35 related treatment services for presumptively eligible persons under
36 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 Act 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.

Office of the Governor

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NEWS RELEASE

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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).