30:4D-3

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 122

NJSA: 30:4D-3 (Medicaid/NJKidCare - eligibility)

BILL NO: A2209 (Substituted for S1177)

SPONSOR(S): Murphy and Thompson

DATE INTRODUCED: March 16, 2000

COMMITTEE: **ASSEMBLY:** Health; Appropriations

SENATE: Budget

AMENDED DURING PASSAGE: No

DATE OF PASSAGE: **ASSEMBLY:** June 29, 2000

SENATE: May 14, 2001

DATE OF APPROVAL: June 26, 2001

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL Original version of bill enacted

(Amendments during passage denoted by superscript numbers)

A2209

SPONSORS STATEMENT: (Begins on page 11 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes 5-1-2000 (Health)

6-8-2000 (Approp.)

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: Yes

S1177

SPONSORS STATEMENT: (Begins on page 11 of original bill) Yes

Bill and Sponsors Statement identical to A2209

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes 5/11/00 (Health)

Identical to Assembly Health Committee Statement for A2209

11/9/00 (Budget)

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or mailto:refdesk@njstatelib.org

REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: No

ASSEMBLY, No. 2209

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 16, 2000

Sponsored by:
Assemblywoman CAROL J. MURPHY
District 26 (Essex, Morris and Passaic)
Assemblyman SAMUEL D. THOMPSON
District 13 (Middlesex and Monmouth)

Co-Sponsored by:
Assemblywoman Crecco, Assemblymen LeFevre, Gusciora, Senators Sinagra, Vitale, Allen and Turner

SYNOPSIS

Requires period for which eligibility for Medicaid and NJ KidCare are determined be maximum permitted under federal law.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 5/15/2001)

AN ACT concerning the determination of eligibility for benefits under Medicaid and the Children's Health Care Coverage Program and amending P.L.1968, c.413 and P.L.1997, c.272.

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

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

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

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

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

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

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

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

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

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

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

i. "Qualified applicant" means a person who is a resident of this State, and either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, <u>with respect to whom the period for which eligibility to be a recipient is determined shall be the maximum period permitted under federal law,</u> and who:

(1) Is a dependent child or parent or caretaker relative of a dependent child and a recipient of benefits under the Work First New Jersey program established pursuant to P.L.1997, c.38 (C.44:10-55 et seq.) 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,

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

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

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, using the resource standards of the Work First New Jersey program, 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) Is a child between 18 and 21 years of age who, using the resource standards of the Work First New Jersey program, 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, living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training;

(6) Is an individual under 21 years of age who, using the resource standards of the Work First New Jersey program, 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) Using the resource standards of the Work First New Jersey program, 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 in effect as of July 16, 1996 or 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

(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; **[**or**]**

(14) (Deleted by amendment, P.L.1997, c.272)**[**.**]** or

(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.

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

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

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

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

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

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

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

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

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

(a) a lawful permanent resident;

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

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

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

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

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

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

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

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

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

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

(cf: P.L.1997, c.352, s.1)

2. Section 4 of P.L.1997, c.272 (C.30:4I-4) is amended to read as follows:

4. a. The Children's Health Care Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, to children from birth through 18 years of age within the limits of funds appropriated or otherwise made available for the program. The program shall require copayments and a premium contribution from

families with incomes which exceed 150% of the official poverty level, which shall be based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall take such actions as are necessary to implement and operate the program in accordance with the provisions governing the State Children's Health Insurance Program in Title XXI of the federal Social Security Act, as provided in Subtitle J of Title IV of the federal "Balanced Budget Act of 1997," Pub.L.105-33.

c. The commissioner shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities to assist in administering the program. <u>The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.</u> The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

d. Subject to federal approval, a child with a family gross income that does not exceed 200% of the official poverty level shall not be determined ineligible for the program solely because the child was previously covered under an individual health benefits plan during any period preceding application to the program if the child was not voluntarily disenrolled from employer-sponsored group insurance coverage during the six-month period prior to application to the program.

e. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall provide by regulation for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at an acute care hospital or a federally qualified health center or local health department that provides primary care shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center or local health department staff indicates that the child meets program eligibility standards established by regulation of the commissioner and is a member of a household with an income which does not exceed 200% of the official poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is presumed eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) If a child is determined to be presumptively eligible for the program, the child's parent, guardian or caretaker relative shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined; and

(4) During the period in which the child is presumptively eligible for the program, the child shall be eligible to receive all services covered by the program.

f. The commissioner, in consultation with the Commissioner of Education and the Commissioner of Health and Senior Services, shall establish a partnership initiative between the program and public elementary and secondary schools, licensed child care centers, registered family day care homes, and unified child care agencies in this State, federally qualified health centers and local health departments that provide primary care to provide outreach to children throughout the State who are potentially eligible for the program. Under this partnership, the commissioner shall arrange for:

(1) the provision by the department to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of informational materials about the program, including the potential costs and benefits for a participating household, as well as program application forms and postage-paid envelopes to submit completed applications to the department, which the school, child care center, registered family day care home, unified child care agency, health center or local health department, as applicable, shall make available to persons wishing to apply for the program;

(2) the provision to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of a notice to be distributed at least annually to the households of children attending the school or child care center, or being cared for by the registered family day care home, or assisted by the unified child care agency or receiving health care services from the health center or local health department, as applicable, informing them about the availability of the informational materials, application forms and postage-paid envelopes provided by the department pursuant to paragraph (1) of this subsection, with respect to which distribution the department shall reimburse the school or child care center, or registered family day care home, or unified child care agency or health center or local health department for the costs thereof in accordance with procedures established by the commissioner; and

(3) a payment to be made by the department in the amount of $25 to a school, child care center, registered family day care home, unified

child care agency, federally qualified health center or local health department that provides primary care for each household enrolled in the program which was referred by that respective entity, and to which household the entity has provided assistance with enrollment in the program. The payment shall be made upon the determination of eligibility for the program by the department with respect to that household, including the receipt of any initial premium contribution from the household as required by the commissioner pursuant to this section.

g. Subject to federal approval, the commissioner shall by regulation establish that in determining income eligibility for the program, any gross family income above 200% of the official poverty level, up to a maximum of 350% of the official poverty level, shall be disregarded.

(cf: P.L.1999, c.172, s.1)

3. This act shall take effect immediately.

STATEMENT

This bill amends the Medicaid statute (N.J.S.A.30:4D-1 et seq.) and the statute governing the Children's Health Care Coverage Program, known as NJ KidCare (N.J.S.A.30:4I-1 et seq.), to provide that the period for which eligibility for benefits under both programs is determined shall be the maximum permitted under federal law (i.e., currently 12 months).

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2209

STATE OF NEW JERSEY

DATED: JUNE 8, 2000

The Assembly Appropriations Committee reports favorably Assembly Bill No. 2209.

Assembly Bill No. 2209 amends the Medicaid statute (N.J.S.A.30:4D-1 et seq.) and the statute governing the Children's Health Care Coverage Program, known as NJ KidCare (N.J.S.A.30:4I-1 et seq.), to provide that the period for which eligibility for benefits under both programs is determined (currently 6 months) shall be the maximum permitted under federal law (currently 12 months).

FISCAL IMPACT:

The bill, by increasing the period of eligibility, increases the possibility that some children would remain eligible for as much as six months after their family income/resources increased to a point that disqualified them from program coverage. Information provided by the Executive Branch estimates the total cost of such coverage at approximately $15.7 million annually, of which less than half, or $7.65 million, is the State share of State/federal matches.

It is likely that some children disqualified from Medicaid coverage would remain qualified for some benefits under NJ Kidcare, at a continuing cost, and that some children disqualified from Medicare and NJ Kidcare would be the recipients of hospital emergency award treatment "uncompensated care", at a continuing cost. The *net* coverage expenditures of extending the eligibility period under bill are not known. Administrative cost savings resulting from cutting the number of eligibility reviews by half are also not known.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2209

STATE OF NEW JERSEY

DATED: NOVEMBER 9, 2000

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 2209.

This bill extends the period of time for which eligibility for Medicaid and NJ KidCare is determined. The bill amends New Jersey's Medicaid statute (N.J.S.A.30:4D-1 et seq.) and the statute governing the Children's Health Care Coverage Program, known as NJ KidCare (N.J.S.A.30:4I-1 et seq.), to provide that the period for which eligibility for benefits under both programs is determined (currently six months) shall be the maximum permitted under federal law (currently 12 months).

The provisions of this bill are identical to those of Senate Bill No. 1177, which the committee also reports this day.

FISCAL IMPACT

The bill, by increasing the period of eligibility, increases the possibility that some children would remain eligible for as much as six months after their family income/resources increased to a point that disqualified them from program coverage. Information provided by the Executive Branch estimates the total cost of such coverage at approximately $15.7 million annually, of which less than half, or $7.65 million, is the State share of State/federal matches.

It is likely that some children disqualified from Medicaid coverage would remain qualified for some benefits under NJ Kidcare, at a continuing cost, and that some children disqualified from Medicare and NJ Kidcare would be the recipients of hospital emergency award treatment "uncompensated care", at a continuing cost. The *net* coverage expenditures of extending the eligibility period under bill are not known. Administrative cost savings resulting from cutting the number of eligibility reviews by half are also not known.

LEGISLATIVE FISCAL ESTIMATE
ASSEMBLY, No. 2209
STATE OF NEW JERSEY
209th LEGISLATURE

DATED: MAY 23, 2001

SUMMARY

Synopsis: Requires period for which eligibility for Medicaid and NJ KidCare are determined be maximum permitted under federal law.

Type of Impact: Possible increase in State Medicaid/NJ KidCare expenditures; possible decrease in State Medicaid/NJ KidCare administrative costs.

Agencies Affected: Department of Human Services (DHS) and county welfare agencies (CWAs).

Office of Legislative Services Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost	Indeterminate	Indeterminate	Indeterminate
Local Cost	Indeterminate	Indeterminate	Indeterminate

! Fifteen states provide 12-month continuous coverage to children in Medicaid and 23 states offer children 12 months of continuous eligibility in their State Children's Health Insurance Program.

BILL DESCRIPTION

Assembly Bill No. 2209 of 2000 amends the Medicaid and the Children's Health Care Coverage Program (NJ KidCare) statutes to provide that the period for which eligibility for benefits under both programs is determined shall be the maximum permitted under federal law (i.e., currently 12 months).

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

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OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services (OLS) is unable to determine the net fiscal impact of extending the period of eligibility for benefits under the Medicaid and NJ KidCare programs to the maximum permitted under federal law (i.e., currently 12 months). The Office of Legislative Services (OLS) has no information as to the amount of Medicaid/NJ KidCare benefits that may be inappropriately provided to persons who are eligible for benefits solely because of the 12 month eligibility redetermination requirement. Similarly, OLS has no information as to how much Medicaid administrative expenditures might be reduced as a result of fewer eligibility redeterminations.

It is noted that 15 states provide 12-months continuous coverage to children in their Medicaid programs and that 23 states offer children 12 months of continuous eligibility in their separate State Children's Health Insurance Programs.

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, No. 1177

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MARCH 27, 2000

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

Co-Sponsored by:
Senators Allen and Turner

SYNOPSIS

Requires period for which eligibility for Medicaid and NJ KidCare are determined be maximum permitted under federal law.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 5/15/2001)

AN ACT concerning the determination of eligibility for benefits under Medicaid and the Children's Health Care Coverage Program and amending P.L.1968, c.413 and P.L.1997, c.272.

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

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

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

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

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

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

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

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

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

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

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

i. "Qualified applicant" means a person who is a resident of this State, and either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, <u>with respect to whom the period for which eligibility to be a recipient is determined shall be the maximum period permitted under federal law,</u> and who:

(1) Is a dependent child or parent or caretaker relative of a dependent child and a recipient of benefits under the Work First New Jersey program established pursuant to P.L.1997, c.38 (C.44:10-55 et seq.) 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,

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

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

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, using the resource standards of the Work First New Jersey program, 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) Is a child between 18 and 21 years of age who, using the resource standards of the Work First New Jersey program, 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, living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training;

(6) Is an individual under 21 years of age who, using the resource standards of the Work First New Jersey program, 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) Using the resource standards of the Work First New Jersey program, 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 in effect as of July 16, 1996 or 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

(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; **[**or**]**

(14) (Deleted by amendment, P.L.1997, c.272)**[**.**]** or

(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.

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

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

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

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

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

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

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

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

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

(a) a lawful permanent resident;

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

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

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

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

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

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

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

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

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

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

(cf: P.L.1997, c.352, s.1)

2. Section 4 of P.L.1997, c.272 (C.30:4I-4) is amended to read as follows:

4. a. The Children's Health Care Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, to children from birth through 18 years of age within the limits of funds appropriated or otherwise made available for the program. The program shall require copayments and a premium contribution from

families with incomes which exceed 150% of the official poverty level, which shall be based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall take such actions as are necessary to implement and operate the program in accordance with the provisions governing the State Children's Health Insurance Program in Title XXI of the federal Social Security Act, as provided in Subtitle J of Title IV of the federal "Balanced Budget Act of 1997," Pub.L.105-33.

c. The commissioner shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities to assist in administering the program. <u>The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.</u> The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

d. Subject to federal approval, a child with a family gross income that does not exceed 200% of the official poverty level shall not be determined ineligible for the program solely because the child was previously covered under an individual health benefits plan during any period preceding application to the program if the child was not voluntarily disenrolled from employer-sponsored group insurance coverage during the six-month period prior to application to the program.

e. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall provide by regulation for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at an acute care hospital or a federally qualified health center or local health department that provides primary care shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center or local health department staff indicates that the child meets program eligibility standards established by regulation of the commissioner and is a member of a household with an income which does not exceed 200% of the official poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is presumed eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) If a child is determined to be presumptively eligible for the program, the child's parent, guardian or caretaker relative shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined; and

(4) During the period in which the child is presumptively eligible for the program, the child shall be eligible to receive all services covered by the program.

f. The commissioner, in consultation with the Commissioner of Education and the Commissioner of Health and Senior Services, shall establish a partnership initiative between the program and public elementary and secondary schools, licensed child care centers, registered family day care homes, and unified child care agencies in this State, federally qualified health centers and local health departments that provide primary care to provide outreach to children throughout the State who are potentially eligible for the program. Under this partnership, the commissioner shall arrange for:

(1) the provision by the department to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of informational materials about the program, including the potential costs and benefits for a participating household, as well as program application forms and postage-paid envelopes to submit completed applications to the department, which the school, child care center, registered family day care home, unified child care agency, health center or local health department, as applicable, shall make available to persons wishing to apply for the program;

(2) the provision to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of a notice to be distributed at least annually to the households of children attending the school or child care center, or being cared for by the registered family day care home, or assisted by the unified child care agency or receiving health care services from the health center or local health department, as applicable, informing them about the availability of the informational materials, application forms and postage-paid envelopes provided by the department pursuant to paragraph (1) of this subsection, with respect to which distribution the department shall reimburse the school or child care center, or registered family day care home, or unified child care agency or health center or local health department for the costs thereof in accordance with procedures established by the commissioner; and

(3) a payment to be made by the department in the amount of $25 to a school, child care center, registered family day care home, unified

child care agency, federally qualified health center or local health department that provides primary care for each household enrolled in the program which was referred by that respective entity, and to which household the entity has provided assistance with enrollment in the program. The payment shall be made upon the determination of eligibility for the program by the department with respect to that household, including the receipt of any initial premium contribution from the household as required by the commissioner pursuant to this section.

g. Subject to federal approval, the commissioner shall by regulation establish that in determining income eligibility for the program, any gross family income above 200% of the official poverty level, up to a maximum of 350% of the official poverty level, shall be disregarded.

(cf: P.L.1999, c.172, s.1)

3. This act shall take effect immediately.

STATEMENT

This bill amends the Medicaid statute (N.J.S.A.30:4D-1 et seq.) and the statute governing the Children's Health Care Coverage Program, known as NJ KidCare (N.J.S.A.30:4I-1 et seq.), to provide that the period for which eligibility for benefits under both programs is determined shall be the maximum permitted under federal law (i.e., currently 12 months).

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 1177

STATE OF NEW JERSEY

DATED: MAY 11, 2000

The Senate Health Committee reports favorably Senate Bill No. 1177.

This bill amends the Medicaid statute (N.J.S.A.30:4D-1 et seq.) and the statute governing the Children's Health Care Coverage Program, known as NJ KidCare (N.J.S.A.30:4I-1 et seq.), to provide that the period for which eligibility for benefits under both programs is determined shall be the maximum permitted under federal law (i.e., currently 12 months).

The bill is identical to Assembly Bill No. 2209 (Murphy/Thompson), which is currently pending in the Assembly Appropriations Committee.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE, No. 1177

STATE OF NEW JERSEY

DATED: NOVEMBER 9, 2000

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 1177.

This bill extends the period of time for which eligibility for Medicaid and NJ KidCare is determined. The bill amends New Jersey's Medicaid statute (N.J.S.A.30:4D-1 et seq.) and the statute governing the Children's Health Care Coverage Program, known as NJ KidCare (N.J.S.A.30:4I-1 et seq.), to provide that the period for which eligibility for benefits under both programs is determined (currently six months) shall be the maximum permitted under federal law (currently 12 months).

The provisions of this bill are identical to those of Assembly Bill No. 2209, which the committee also reports this day.

FISCAL IMPACT

The bill, by increasing the period of eligibility, increases the possibility that some children would remain eligible for as much as six months after their family income/resources increased to a point that disqualified them from program coverage. Information provided by the Executive Branch estimates the total cost of such coverage at approximately $15.7 million annually, of which less than half, or $7.65 million, is the State share of State/federal matches.

It is likely that some children disqualified from Medicaid coverage would remain qualified for some benefits under NJ Kidcare, at a continuing cost, and that some children disqualified from Medicare and NJ Kidcare would be the recipients of hospital emergency award treatment "uncompensated care", at a continuing cost. The *net* coverage expenditures of extending the eligibility period under bill are not known. Administrative cost savings resulting from cutting the number of eligibility reviews by half are also not known.

P.L. 2001, CHAPTER 122, ***approved June 26, 2001***
Assembly Bill No. 2209

AN ACT concerning the determination of eligibility for benefits under Medicaid and the Children's Health Care Coverage Program and amending P.L.1968, c.413 and P.L.1997, c.272.

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

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

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

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

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

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

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

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

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

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

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

i. "Qualified applicant" means a person who is a resident of this State, and either a citizen of the United States or an eligible alien, and is determined to need medical care and services as provided under this act, <u>with respect to whom the period for which eligibility to be a recipient is determined shall be the maximum period permitted under federal law,</u> and who:

(1) Is a dependent child or parent or caretaker relative of a dependent child and a recipient of benefits under the Work First New Jersey program established pursuant to P.L.1997, c.38 (C.44:10-55 et seq.) who would be, except for resources, eligible for the aid to families with dependent children program under the State Plan for

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

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

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, using the resource standards of the Work First New Jersey program, 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) Is a child between 18 and 21 years of age who, using the resource standards of the Work First New Jersey program, 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, living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training;

(6) Is an individual under 21 years of age who, using the resource standards of the Work First New Jersey program, 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) Using the resource standards of the Work First New Jersey program, 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 in effect as of July 16, 1996 or 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

(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; **[**or**]**

(14) (Deleted by amendment, P.L.1997, c.272)**[**.**]** or

(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.

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

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

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

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

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

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

(C.30:4D-6).

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

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

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

(a) a lawful permanent resident;

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

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

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

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

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

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

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

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

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

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

(cf: P.L.1997, c.352, s.1)

2. Section 4 of P.L.1997, c.272 (C.30:4I-4) is amended to read as follows:

4. a. The Children's Health Care Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, to children from birth through 18 years of age within the limits of funds appropriated or otherwise made available for the program. The

program shall require copayments and a premium contribution from families with incomes which exceed 150% of the official poverty level, which shall be based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall take such actions as are necessary to implement and operate the program in accordance with the provisions governing the State Children's Health Insurance Program in Title XXI of the federal Social Security Act, as provided in Subtitle J of Title IV of the federal "Balanced Budget Act of 1997," Pub.L.105-33.

c. The commissioner shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities to assist in administering the program. <u>The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.</u> The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

d. Subject to federal approval, a child with a family gross income that does not exceed 200% of the official poverty level shall not be determined ineligible for the program solely because the child was previously covered under an individual health benefits plan during any period preceding application to the program if the child was not voluntarily disenrolled from employer-sponsored group insurance coverage during the six-month period prior to application to the program.

e. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall provide by regulation for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at an acute care hospital or a federally qualified health center or local health department that provides primary care shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center or local health department staff indicates that the child meets program eligibility standards established by regulation of the commissioner and is a member of a household with an income which does not exceed 200% of the official poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is presumed eligible for Medicaid coverage

pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) If a child is determined to be presumptively eligible for the program, the child's parent, guardian or caretaker relative shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined; and

(4) During the period in which the child is presumptively eligible for the program, the child shall be eligible to receive all services covered by the program.

f. The commissioner, in consultation with the Commissioner of Education and the Commissioner of Health and Senior Services, shall establish a partnership initiative between the program and public elementary and secondary schools, licensed child care centers, registered family day care homes, and unified child care agencies in this State, federally qualified health centers and local health departments that provide primary care to provide outreach to children throughout the State who are potentially eligible for the program. Under this partnership, the commissioner shall arrange for:

(1) the provision by the department to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of informational materials about the program, including the potential costs and benefits for a participating household, as well as program application forms and postage-paid envelopes to submit completed applications to the department, which the school, child care center, registered family day care home, unified child care agency, health center or local health department, as applicable, shall make available to persons wishing to apply for the program;

(2) the provision to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of a notice to be distributed at least annually to the households of children attending the school or child care center, or being cared for by the registered family day care home, or assisted by the unified child care agency or receiving health care services from the health center or local health department, as applicable, informing them about the availability of the informational materials, application forms and postage-paid envelopes provided by the department pursuant to paragraph (1) of this subsection, with respect to which distribution the department shall reimburse the school or child care center, or registered family day care home, or unified child care agency or health center or local health department for the costs thereof in accordance with procedures established by the commissioner; and

(3) a payment to be made by the department in the amount of $25

to a school, child care center, registered family day care home, unified child care agency, federally qualified health center or local health department that provides primary care for each household enrolled in the program which was referred by that respective entity, and to which household the entity has provided assistance with enrollment in the program. The payment shall be made upon the determination of eligibility for the program by the department with respect to that household, including the receipt of any initial premium contribution from the household as required by the commissioner pursuant to this section.

g. Subject to federal approval, the commissioner shall by regulation establish that in determining income eligibility for the program, any gross family income above 200% of the official poverty level, up to a maximum of 350% of the official poverty level, shall be disregarded.

(cf: P.L.1999, c.172, s.1)

3. This act shall take effect immediately.

STATEMENT

This bill amends the Medicaid statute (N.J.S.A.30:4D-1 et seq.) and the statute governing the Children's Health Care Coverage Program, known as NJ KidCare (N.J.S.A.30:4I-1 et seq.), to provide that the period for which eligibility for benefits under both programs is determined shall be the maximum permitted under federal law (i.e., currently 12 months).

Requires period for which eligibility for Medicaid and NJ KidCare are determined be maximum permitted under federal law.

CHAPTER 122

AN ACT concerning the determination of eligibility for benefits under Medicaid and the Children's Health Care Coverage Program and amending P.L.1968, c.413 and P.L.1997, c.272.

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) or

(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; or

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

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

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

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

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 4 of P.L.1997, c.272 (C.30:4I-4) is amended to read as follows:

C.30:4I-4 Children's Health Care Coverage program established.

4. a. The Children's Health Care Coverage Program is established in the Department of Human Services. The purpose of the program shall be to provide subsidized private health insurance coverage, and other health care benefits as determined by the commissioner, to children from birth through 18 years of age within the limits of funds appropriated or otherwise made available for the program. The program shall require copayments and a premium contribution from families with incomes which exceed 150% of the official poverty level, which shall be based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall take such actions as are necessary to implement and operate the program in accordance with the provisions governing the State Children's Health Insurance Program in Title XXI of the federal Social Security Act, as provided in Subtitle J of Title IV of the federal "Balanced Budget Act of 1997," Pub.L.105-33.

c. The commissioner shall by regulation establish standards for determining eligibility and other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities to assist in administering the program. The period for which eligibility for the program is determined shall be the maximum period permitted under federal law. The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year.

d. Subject to federal approval, a child with a family gross income that does not exceed 200% of the official poverty level shall not be determined ineligible for the program solely because the child was previously covered under an individual health benefits plan during any period preceding application to the program if the child was not voluntarily disenrolled from employer-sponsored group insurance coverage during the six-month period prior to application to the program.

e. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall provide by regulation for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at an acute care hospital or a federally qualified health center or local health department that provides primary care shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center or local health department staff indicates that the child meets program eligibility standards established by regulation of the commissioner and is a member of a household with an income which does not exceed 200% of the official poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is presumed eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) If a child is determined to be presumptively eligible for the program, the child's parent, guardian or caretaker relative shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined; and

(4) During the period in which the child is presumptively eligible for the program, the child shall be eligible to receive all services covered by the program.

f. The commissioner, in consultation with the Commissioner of Education and the Commissioner of Health and Senior Services, shall establish a partnership initiative between the program and public elementary and secondary schools, licensed child care centers, registered family day care homes, and unified child care agencies in this State, federally qualified health centers and local health departments that provide primary care to provide outreach to children throughout the State who are potentially eligible for the program. Under this partnership, the commissioner shall arrange for:

(1) the provision by the department to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of informational materials about the program, including the potential costs and benefits for a participating household, as well as program application forms and postage-paid envelopes to submit completed applications to the department, which the school, child care center, registered family day care home, unified child care agency, health center or local health department, as applicable, shall make available to persons wishing to apply for the program;

(2) the provision to each public elementary and secondary school, licensed child care center, registered family day care home, and unified child care agency in the State, federally qualified health center and local health department that provides primary care of a notice to be distributed at least annually to the households of children attending the school or child care center, or being cared for by the registered family day care home, or assisted by the unified child care agency or receiving health care services from the health center or local health department, as applicable, informing them about the availability of the informational materials, application forms and postage-paid envelopes provided by the department pursuant to paragraph (1) of this subsection, with respect to which distribution the department shall reimburse the school or child care center, or registered family day care home, or unified child care agency or health center or local health department for the costs thereof in accordance with procedures established by the commissioner; and

(3) a payment to be made by the department in the amount of $25 to a school, child care center, registered family day care home, unified child care agency, federally qualified health center or local health department that provides primary care for each household enrolled in the program which was referred by that respective entity, and to which household the entity has provided assistance with enrollment in the program. The payment shall be made upon the determination of eligibility for the program by the department with respect to that household, including the receipt of any initial premium contribution from the household as required by the commissioner pursuant to this section.

g. Subject to federal approval, the commissioner shall by regulation establish that in determining income eligibility for the program, any gross family income above 200% of the official poverty level, up to a maximum of 350% of the official poverty level, shall be disregarded.

3. This act shall take effect immediately.

Approved June 26, 2001.

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Office of the Governor
NEWS RELEASE

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RELEASE: June 27 , 2001

Acting Governor Donald T. DiFrancesco has signed the following legislation:

S-621, sponsored by Senators John Matheussen (R-Camden/Gloucester), Norman Robertson (Essex/Passaic) and Anthony Bucco (R-Morris) and Assemblymembers John Kelly (R-Bergen/Essex/Passaic) and Arline Friscia (D-Middlesex), allows parents, children, spouses and siblings of illegal drug users, as well as employers of illegal drug users, medical facilities, insurers and persons injured by the drug users' actions to sue drug dealers for civil damages.

S-647, sponsored by Senator Joseph Kyrillos (R-Middlesex/Monmouth) and Assemblyman Joseph Azzolina (R-Middlesex/Monmouth) and Guy Gregg (R-Sussex/Hunterdon/Morris) permits the Director of the Division of Alcoholic Beverage Control to issue a special auction permit to a nonprofit organization operating solely for civic, religious, education, charitable, fraternal, social or recreational purposes.

The permit will cost $100 and would entitle the nonprofit organization to sell at auction alcoholic beverages donated to it by a licensee.

S-1382, sponsored by Senator Robert Martin (R-Essex/Morris/Passaic) and Assemblymen Wilfredo Caraballo (D-Essex) and Kip Bateman (R-Morris/Somerset), revises rules concerning secured transactions by replacing Chapter 9 of the Uniform Commercial Code (UCC) with revised Chapter 9, as well as, conforming amendments to Chapters 1,2,2A,4,5,7 and 8 of the UCC.

S-2123, sponsored by Senator Raymond Lesniak (D-Union) and Assemblymen Neil Cohen(D-Union) and Joseph Impreveduto (D-Bergen/Hudson), increases the term of office of the mayor and the members of council from two years to four years in municipalities. Provides for a transitional three-year term of office for the mayor and members of council elected at the 2002 general election.

This bill also alters the term of office of mayor and member so council from three years to four years in towns.

A-1325, sponsored by Senator William Schluter (R-Warren/Hunterdon/Mercer) and Assemblymembers Richard Bagger (R-Middlesex/Morris/Somerset/Union) and the late Alan Augustine (R-Middlesex/Morris/Somerset/Union), allows a municipality or county to install pedestrian crossing right-of-way signs at a marked or unmarked crosswalk or at an intersection.

A-1342, sponsored by late Assemblyman Alan Augustine (R-Middlesex/Morris/ Somerset/Union), provides that, as a fifth option, a Teachers' Pension and Annuity Fund (TPAF) or Public Employees' Retirement System (PERS) member may choose a retirement allowance actuarially reduced to provide to a beneficiary an allowance equivalent to the full amount, three-quarters, one-half or one-quarter of that reduced allowance, but if the beneficiary dies before the retiree, the retiree's allowance will increase to a maximum amount.

A-2185, sponsored by Senator Louis Bassano (R-Essex/Union) and John Singer (R-Burlington/Monmouth/Ocean) and Assembymembers Leonard Lance (R-Warren/ Hunterdon/Mercer) and Rose Maria Heck (R-Bergen), appropriates $28,695,000 from the Developmental Disabilities' Waiting List Reduction and Human Services Facilities Construction Fund for the Department of Human Services. This money will be used for various projects within the divisions, including reducing the community services waiting list.

A-2209, sponsored by Senators Jack Sinagra (R-Middlesex) and Joseph Vitale (D-Middlesex) and Assemblymembers Carol Murphy (R-Essex/Morris/Passaic) and Samuel Thompson (R-Middlesex/Monmouth), provides that the period for which eligibility for Medicaid and KidCare benefits is determined shall be the maximum permitted under federal law, currently 12 months.

A-2449, sponsored by Assemblymen Michael Arnone (R-Monmouth) and Joseph Azzolina (R-Middlesex/Monmouth), permits sewerage authority or a utilities authority to rename itself as a "water reclamation authority" to more accurately reflect its activities and purposes.

A-2523, sponsored by Senators William Gormley (R-Atlantic) and Edward O'Connor (D-Hudson) and Assemblymen James Holzapfel (R-Monmouth/Ocean) and Peter Barnes (D-Middlesex), increases the penalty for persons who produce and sell false motor vehicle identification cards from a crime of the fourth degree to a crime of the third degree which is punishable by imprisonment for three to five years, a fine of up to $15,000, or both.

A-3622, sponsored by Senators Walter Kavanaugh (R-Morris/Somerset) and Raymond Lesniak (D-Union) and Assemblymen John Wisniewski (D-Middlesex) and Samuel Thompson (R-Middlesex/Monmouth, provides that for the year 2001, 1) the day on which members of the State, county or municipal committee of a political party will take office, and the day on which the terms of members previously elected to each such committee will terminate, will be the day immediately following the day of the primary election for the general election and 2)the holding of the annual meeting of the State, county and municipal committees of a political party will occur no earlier than the day immediately following the day of the primary election and no later than the 21st day following such election.