30:4D-3

LEGISLATIVE HISTORY CHECKLIST
Compiled by the NJ State Law Library

NJSA: 30:4D-3

(Medicaid--adjust time for disposal of resources)

LAWS OF: 1991 **CHAPTER:** 20

Bill No: S2971

Sponsor(s): Lipman

Date Introduced: October 4, 1990

Committee: Assembly: -----

Senate: Institutions, Health & Welfare

Amended during passage: Yes Amendments during passage denoted asterisks.

Date of Passage: Assembly: January 10, 1991

Senate: December 6, 1990

Date of Approval: February 1, 1991

Following statements are attached if available:

Sponsor statement: Yes

Committee Statement: Assembly: No

Senate: Yes

Fiscal Note: No

Veto Message: No

Message on signing: No

Following were printed:

Reports: No

Hearings: No

KBG/SLJ

[FIRST REPRINT]

SENATE, No. 2971

STATE OF NEW JERSEY

INTRODUCED OCTOBER 4, 1990

By Senator LIPMAN

AN ACT concerning the Medicaid program and amending P.L.1968, c.413.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Is an "ineligible spouse" of a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
1 Senate SIH committee amendments adopted December 3, 1990.

of the Social Security Act, as defined by the federal Social Security Administration;

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

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

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

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

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

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

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

(i) Pregnant women;

(ii) Dependent children under the age of 21;

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

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

(b) The following income standard shall be used to

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

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

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

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

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

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

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

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

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

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

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

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

welfare agencies with all information the division may have available on the individual.

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

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

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

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

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

(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. §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.

[1](12) Is a qualified disabled and working individual pursuant to section 6408 of Pub. L. 101-239 (42 U.S.C. §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.).[1]

An individual who has, within 30 months 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. §1396n(c)), disposed of resources 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. §1396n(c)). The period of the ineligibility shall be the lesser of 30 months or the number of months resulting from dividing the uncompensated value of the transferred resources by the average monthly private payment rate for nursing facility services in the State as determined annually 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, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

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

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

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

(cf: P.L.1987, c.349, s.1)

[1]2. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read as follows:

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

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

(5) Physical therapy and related services;

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

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

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

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

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

(14) Intermediate care facility services;

(15) Transportation services;

(16) Services in connection with the inpatient or outpatient treatment or care of drug abuse, when the treatment is prescribed by a physician and provided in a licensed hospital or in a narcotic and drug abuse treatment center approved by the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et seq.) and whose staff includes a medical director, and limited to those services eligible for federal financial participation under Title XIX of the federal Social Security Act;

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

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

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

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

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

No provider whose claim for payment pursuant to this act has been denied because the services, goods or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his

behalf for such services, goods and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.

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

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

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

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

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

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

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

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

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

(12), (15) and (17)).

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

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

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

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

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

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

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

§1395i-2 and §1395r.[1]
(cf: P.L.1989, c.251, s.1)

[1][2.] 3.[1] This act shall take effect immediately [1], except that section 2 shall take effect on April 1, 1991[1].

HUMAN SERVICES

Amends Medicaid law to adjust time limit for disposal of resources and to provide for payment of Medicare premiums for certain disabled persons.

rate for nursing facility services in the State as determined annually 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, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

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

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

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

(cf: P.L.1987, c.349, s.1)

2. This act shall take effect immediately.

STATEMENT

This bill amends section 3 of P.L.1968, c.413 (C.30:4D-3) to comply with changes in the Medicare Catastrophic Coverage Act of 1988, Pub.L.100-360 which mandates the increased Medicaid ineligibility period for institutionalized persons who transfer

resources for less than fair market value. This bill changes the period of ineligibility after resource transfer from a firm 24-month period to a sliding 30-month restriction.

HUMAN SERVICES

Amends Medicaid law to adjust time limit for disposal of resources.

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO

SENATE, No. 2971

with Senate committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 3, 1990

The Senate Institutions, Health and Welfare Committee favorably reports Senate Bill No. 2971 with committee amendments.

As amended by committee, this bill amends section 3 of P.L.1968, c.413 (C.30:4D-3), the law establishing the Medicaid program, to comply with changes in the "Medicare Catastrophic Coverage Act of 1988," Pub.L.100-360, which mandates an increased Medicaid ineligibility period for institutionalized persons who transfer resources for less than fair market value. This bill changes the period of ineligibility after resource transfer from a firm 24-month period to a sliding 30-month restriction.

Under the federal requirement, an individual who has, within 30 months of applying for Medicaid services in a nursing facility or a medical institution, or for certain home or community-based services, disposed of resources 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. The period of the ineligibility shall be the lesser of 30 months or the number of months resulting from dividing the uncompensated value of the transferred resources by the average monthly private payment rate for nursing facility services in the State, as determined annually by the commissioner.

The bill also amends section 6 of the Medicaid law (C.30:4D-6) to provide that the Medicaid program will pay the Medicare part A premium for certain disabled, working persons whose income does not exceed 200% of the poverty level and whose resources do not exceed 200% of the Supplemental Security Income resource standard. The State is required to adopt this provision by April 1, 1991 pursuant to the Omnibus Budget Reconciliation Act of 1989, Pub.L. 101-239.

The committee amended the bill to add the provision concerning payment of the Medicare premiums.