ASSEMBLY, No. 4934

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED JANUARY 17, 2019

Sponsored by:
Assemblywoman VERLINA REYNOLDS-JACKSON
District 15 (Hunterdon and Mercer)
Assemblywoman PATRICIA EGAN JONES
District 5 (Camden and Gloucester)
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District 37 (Bergen)

Co-Sponsored by:
Assemblywomen Lampitt, Murphy, Tucker and Mosquera

SYNOPSIS

Provides Medicaid coverage to eligible pregnant women for 365-day period beginning on last day of pregnancy.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 3/19/2019)

AN ACT concerning Medicaid coverage for pregnant women 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 P.L.1968, c.413 (C.30:4D-1 et seq.), 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 P.L.1968, c.413.

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 P.L.1968, c.413, 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 P.L.1968, c.413, 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;

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

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

(3) Is an "ineligible spouse" of a recipient of Supplemental Security Income for the Aged, Blind and Disabled under Title XVI of the Social Security Act, as defined by the federal Social Security Administration;

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

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

(6) Is an individual under 21 years of age who, without regard to resources, would be, except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the federal Social Security Act as of July 16, 1996, or groups of such individuals, including but not limited to, children in resource family placement under supervision of the Division of Child Protection and Permanency in the Department of Children and Families whose maintenance is being paid in whole or in part from public funds, children placed in a resource family 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**[**%**]** <u>percent</u> 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[%] percent 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[%] percent 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[%] percent 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[%] percent 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[%] percent 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**[**%**]** percent 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**[**%**]** percent of the poverty level, adjusted for family size, and whose resources do not exceed 100**[**%**]** percent 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**[**%**]** percent of the poverty level and whose resources do not exceed 200**[**%**]** percent 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**[**%**]** percent of the poverty level, or is a pregnant woman who is a member of a family whose income does not exceed the highest income eligibility level for pregnant women established under the State plan under Title XIX of the federal Social Security Act, 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] 365-day period beginning on the last day of her pregnancy;

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

(15) (a) Is a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii whose resources beginning January 1, 1993 do not exceed 200[%] percent 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[%] percent of the poverty level, and beginning January 1, 1995 does not exceed 120[%] percent 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,

(a) if a dependent child, does not exceed 133**[**%**]** percent of the poverty level; and

(b) if a parent or specified caretaker relative, beginning September 1, 2005 does not exceed 100**[**%**]** percent of the poverty level, beginning September 1, 2006 does not exceed 115**[**%**]** percent of the poverty level and beginning September 1, 2007 does not exceed 133**[**%**]** percent 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;

The commissioner may increase the income eligibility limits for children and parents and specified caretaker relatives, as funding permits;

(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 resource family care under the care and custody of the Division of Child Protection and Permanency in the Department of Children and Families and whose maintenance was being paid in whole or in part from public funds;

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

(a) whose income is at or below 250**[**%**]** percent 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;

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

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

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

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

(d) meets all other Medicaid eligibility requirements; and

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

(20) Subject to federal approval under Title XIX of the federal Social Security Act, is a single adult or couple, without dependent children, whose income in 2006 does not exceed 50**[**%**]** percent of the poverty level, in 2007 does not exceed 75**[**%**]** percent of the poverty level and in 2008 and each year thereafter does not exceed 100**[**%**]** percent of the poverty level; except that a person who is a recipient of Work First New Jersey general public assistance, pursuant to P.L.1947, c.156 (C.44:8-107 et seq.), shall not be a qualified applicant; or

(21) is an individual who:

(a) has an income that does not exceed the highest income eligibility level for pregnant women established under the State plan under Title XIX or Title XXI of the federal Social Security Act;

(b) is not pregnant; and

(c) is eligible to receive family planning services provided under the Medicaid program pursuant to subsection k. of section 6 of P.L.1968, c.413 (C.30:4D-6) and in accordance with 42 U.S.C. s.1396a(ii).

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 P.L.1968, c.413.

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 P.L.1968, c.413.

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 U.S. Citizenship and Immigration Services 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.2018, c.1, s.1)

2. The Commissioner of Human Services shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program.

3. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to implement the provisions of this act.

4. This act shall take effect on the first day of the fourth month next following the date of enactment, but the Commissioner of Human Services may take such anticipatory administrative action in advance thereof as may be necessary for the implementation of this act.

STATEMENT

This bill provides Medicaid coverage to eligible pregnant women for a 365-day period beginning on the last day of a pregnant woman’s pregnancy. Under current State law, Medicaid coverage for this population is extended for a 60-day period beginning on the last day of the pregnancy.

Specifically, the bill extends coverage of Medicaid services to pregnant individuals whose income does not exceed the highest income eligibility level established for pregnant women under the State Medicaid plan - currently 194 percent of the federal poverty (FPL) - for a 365-day period beginning on the last day of a pregnant woman’s pregnancy.

Under federal law, all states must provide Medicaid coverage for pregnancy-related services to pregnant women with incomes up to 138 percent of the FPL through the end of the month in which a 60-day period ends following the termination of the pregnancy. New Jersey has expanded this provision to included full Medicaid coverage for pregnant women with incomes at or below 194 percent of the FPL. This bill would further broaden coverage for low-

income pregnant women to include services in the first year following the last day of the pregnancy.

Since many low-income women of reproductive age do not have health insurance coverage, changes related to Medicaid coverage to reach more low-income women of childbearing age could have significant impacts on improving the health of women and children. In 2006, the Centers for Disease Control and Prevention published ten recommendations to improve health and health care for women in the United States before and after pregnancy. Some of these recommendations included preventative care, intervention for identified risks, and interconception care. Without extended access to Medicaid, low-income women would not receive this recommended level of care between pregnancies.

The bill takes effect on the first day of the fourth month following its enactment, but authorizes the Commissioner of Human Services to take such prior administrative action as may be necessary for implementation.