CHAPTER 96

AN ACT concerning special needs trusts and amending P.L.1968, c.413 and supplementing Title 3B of the New Jersey Statutes.

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

C.3B:11-36 Findings, declarations regarding special needs trusts.

1. The Legislature finds and declares that:

a. It is in the public interest to encourage persons to set aside amounts to supplement and augment assistance provided by government entities to persons with severe chronic disabilities;

b. By enacting section 13611 of the federal Omnibus Budget Reconciliation Act of 1993, 42 U.S.C. s.1396p(d)(4), the United States Congress affirmed this view by permitting the establishment of a trust to supplement and augment assistance for a person who is disabled without disqualifying that person from benefits under the Medicaid program;

c. In some instances, trusts must be established by a court in order to comply with the provisions of 42 U.S.C. s.1396p(d)(4);

d. However, the current law in New Jersey does not specifically authorize the establishment of these trusts and subsection f. of section 6 of P.L.1968, c.413 (C.30:4D-6) may be construed as impeding their establishment; and

e. Therefore, legislation is appropriate to facilitate the establishment of trusts to supplement and augment assistance provided by government entities to persons with severe chronic disabilities and persons who are disabled under the federal Social Security Act.

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

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

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

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

(5) Physical therapy and related services;

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

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

(11) Inpatient psychiatric hospital services for individuals under 21 years of age, or under age

22 if they are receiving such services immediately before attaining age 21;

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

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

(14) Intermediate care facility services;

(15) Transportation services;

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

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

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

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

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

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

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

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

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

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

participation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C.3B:11-37 Establishing an OBRA '93 trust.

3. a. As used in this section "OBRA '93 trust" means a trust established pursuant to 42 U.S.C. s.1396p(d)(4)(A) or an account within a pooled trust pursuant to 42 U.S.C. s.1396p(d)(4)(C).

b. Upon the request of an interested party, a court may establish an OBRA '93 trust for a person who is disabled as defined in section 1614(a)(3) of the federal Social Security Act (42 U.S.C. s.1382c (a)(3)), whether or not the person is an incapacitated person as defined in N.J.S.3B:1-2, and may direct that the assets of the person with a disability be placed in the OBRA '93 trust.

c. Prior to establishing an OBRA '93 trust for a person with a disability who is incapacitated, the court shall consider the factors listed in N.J.S.3B:12-3.

d. Prior to establishing an OBRA '93 trust for a person who is a minor, the court shall consider the applicable Rules of Court and State law relating to the handling of funds for a minor, including, but not limited to, the provisions of N.J.S.3B:15-16 and N.J.S.3B:15-17.

e. Nothing in this section shall be construed to preclude an OBRA '93 trust from being created by any person in addition to a court as would be consistent with 42 U.S.C. s.1396p(d)(4).

f. Notwithstanding any provision or principle of law to the contrary, a beneficiary, grantor, trustee or other person shall not have authority to revoke an OBRA '93 trust. This provision shall apply whether or not an OBRA '93 trust instrument designates the trust as irrevocable or whether the OBRA '93 trust was created by a court or otherwise.

4. This act shall take effect immediately.

Approved August 29, 2000.