

CHAPTER 306

AN ACT concerning presumptive eligibility for Medicaid home and community-based services and services provided through programs of all-inclusive care for the elderly, and supplementing Title 30 of the Revised Statutes.

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

C.30:4D-3d1 Presumptive eligibility, Medicaid, home, community-based services, long-term services, supports program; definitions.

1. a. Within 30 months of enactment of P.L.2023, c.306 (C.30:4D-3d1), and conditional on the receipt of all necessary approvals and the securing of federal financial participation pursuant to subsection g. of this section, the Department of Human Services shall provide presumptive eligibility for Medicaid, including, where appropriate, eligibility for the managed long-term services and supports program, for an individual who is: seeking home and community-based services or PACE enrollment; awaiting an eligibility determination for Medicaid or for the managed long-term services and supports program or services provided through PACE; and likely to be financially and clinically eligible for Medicaid and where necessary the managed long-term services and supports program or services provided through PACE, as determined by the department.

b. Conditional on federal financial participation, the department shall provide Medicaid coverage for eligible home and community-based services or services provided through PACE to an individual who is granted presumptive eligibility pursuant to this section. Coverage provided under this subsection shall begin upon the receipt of an individual's request for services, pursuant to subsection c. of this section, and shall be terminated if the individual is determined clinically or financially ineligible for home and community-based services or services provided through PACE under Medicaid during the eligibility determination process.

c. An individual seeking presumptive eligibility for home and community-based services or services provided through PACE under Medicaid shall submit a request to the department in a manner and form as determined by the commissioner.

d. An individual granted presumptive eligibility pursuant to this section shall be required to submit a completed application for Medicaid and any applicable Medicaid waiver program offering home and community-based services or services provided through PACE no later than the end of the month following the month in which presumptive eligibility is granted.

e. Conditional on federal financial participation, a home and community-based services provider or PACE center shall be reimbursed for all Medicaid-eligible services rendered to an individual who has been granted presumptive eligibility pursuant to this section, regardless of whether the individual granted presumptive eligibility is determined clinically or financially ineligible for home and community-based services or services provided through PACE under Medicaid during the eligibility determination process.

f. The department shall provide each individual granted presumptive eligibility pursuant to this section a written notice explaining the terms and conditions of presumptive eligibility and the home and community-based services or services provided through PACE the individual will be eligible to receive.

g. The commissioner shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this section and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program. The provision of presumptive eligibility pursuant to this section shall be contingent on securing all necessary federal approvals and federal financial participation as may be necessary to implement the provisions of this section.

h. In designing the program required pursuant to subsection a. of this section, the Department shall assess the success of other jurisdictions in providing for presumptive eligibility for home and community-based services and related services for Medicaid recipients; consider methods for minimizing costs due to determinations of clinical or financial ineligibility; and engage with relevant stakeholders to determine how to best tailor the benefit to the needs of the Medicaid population.

i. As used in this section:

“Commissioner” means the Commissioner of Human Services.

“Department” means Department of Human Services.

“Eligibility determination” means the administrative process by which the Division of Medical Assistance and Health Services in the Department of Human Services or a county welfare agency reviews a beneficiary’s income, financial resources, and circumstances relating to the beneficiary’s application for benefits received under Medicaid or any applicable Medicaid waiver program offering home and community-based services or services provided through PACE.

“Home and community-based services” means community-based services provided under the managed long term services and supports program or personal care assistant services provided in the home under New Jersey’s Medicaid State Plan.

“Medicaid” means the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

“PACE” means the program of all-inclusive care for the elderly as defined in section 1 of P.L.1997, c.296 (C.26:2H-88).

2. The Commissioner of Human Services, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as the commissioner deems necessary to carry out the provisions of this act.

3. This act shall take effect immediately.

Approved January 16, 2024.