

[First Reprint]

ASSEMBLY, No. 5225

STATE OF NEW JERSEY
220th LEGISLATURE

INTRODUCED FEBRUARY 23, 2023

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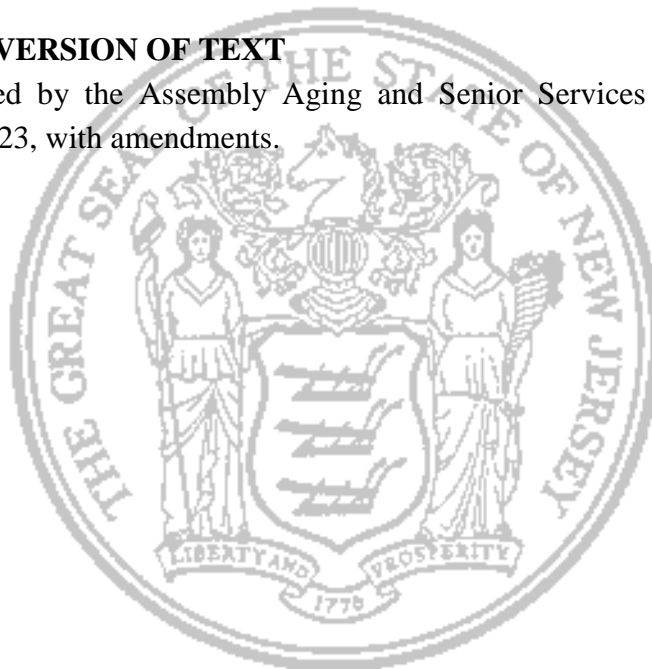
Assemblymen Stanley and Conaway

SYNOPSIS

Provides for coverage of community-based palliative care benefits under Medicaid.

CURRENT VERSION OF TEXT

As reported by the Assembly Aging and Senior Services Committee on March 20, 2023, with amendments.



(Sponsorship Updated As Of: 5/8/2023)

1 AN ACT concerning Medicaid community-based palliative care
2 benefits and amending P.L.1968, c.413.

3

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

6

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

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

14 (1) Inpatient hospital services;

15 (2) Outpatient hospital services;

16 (3) Other laboratory and X-ray services;

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

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

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

28 As used in this subsection, "laboratory and X-ray services"
29 includes HIV drug resistance testing, including, but not limited to,
30 genotype assays that have been cleared or approved by the federal
31 Food and Drug Administration, laboratory developed genotype
32 assays, phenotype assays, and other assays using phenotype
33 prediction with genotype comparison, for persons diagnosed with
34 HIV infection or AIDS.

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

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

43 (2) Home health care services;

44 (3) Clinic services;

45 (4) Dental services;

46 (5) Physical therapy and related services;

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:

¹Assembly ASE committee amendments adopted March 20, 2023.

- 1 (6) Prescribed drugs, dentures, and prosthetic devices; and
2 eyeglasses prescribed by a physician skilled in diseases of the eye
3 or by an optometrist, whichever the individual may select;
- 4 (7) Optometric services;
- 5 (8) Podiatric services;
- 6 (9) Chiropractic services;
- 7 (10) Psychological services;
- 8 (11) Inpatient psychiatric hospital services for individuals under
9 21 years of age, or under age 22 if they are receiving such services
10 immediately before attaining age 21;
- 11 (12) Other diagnostic, screening, preventive, and rehabilitative
12 services, and other remedial care;
- 13 (13) Inpatient hospital services, nursing facility services, and
14 intermediate care facility services for individuals 65 years of age or
15 over in an institution for mental diseases;
- 16 (14) Intermediate care facility services;
- 17 (15) Transportation services;
- 18 (16) Services in connection with the inpatient or outpatient
19 treatment or care of substance use disorder, when the treatment is
20 prescribed by a physician and provided in a licensed hospital or in a
21 narcotic and substance use disorder treatment center approved by
22 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
23 et seq.) and whose staff includes a medical director, and limited to
24 those services eligible for federal financial participation under Title
25 XIX of the federal Social Security Act;
- 26 (17) Any other medical care and any other type of remedial care
27 recognized under State law, specified by the Secretary of the federal
28 Department of Health and Human Services, and approved by the
29 commissioner;
- 30 (18) Comprehensive maternity care, which may include: the
31 basic number of prenatal and postpartum visits recommended by the
32 American College of Obstetricians and Gynecologists; additional
33 prenatal and postpartum visits that are medically necessary;
34 necessary laboratory, nutritional assessment and counseling, health
35 education, personal counseling, managed care, outreach, and
36 follow-up services; treatment of conditions which may complicate
37 pregnancy; doula care and physician or certified nurse-midwife
38 delivery services. For the purposes of this paragraph, "doula"
39 means a trained professional who provides continuous physical,
40 emotional, and informational support to a mother before, during,
41 and shortly after childbirth, to help her to achieve the healthiest,
42 most satisfying experience possible;
- 43 (19) Comprehensive pediatric care, which may include:
44 ambulatory, preventive, and primary care health services. The
45 preventive services shall include, at a minimum, the basic number
46 of preventive visits recommended by the American Academy of
47 Pediatrics;
- 48 (20) Services provided by a hospice which is participating in the
49 Medicare program established pursuant to Title XVIII of the Social

1 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
2 services shall be provided subject to approval of the Secretary of
3 the federal Department of Health and Human Services for federal
4 reimbursement;

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

13 (22) Upon referral by a physician, advanced practice nurse, or
14 physician assistant of a person who has been diagnosed with
15 diabetes, gestational diabetes, or pre-diabetes, in accordance with
16 standards adopted by the American Diabetes Association:

17 (a) Expenses for diabetes self-management education or training
18 to ensure that a person with diabetes, gestational diabetes, or pre-
19 diabetes can optimize metabolic control, prevent and manage
20 complications, and maximize quality of life. Diabetes self-
21 management education shall be provided by an in-State provider
22 who is:

23 (i) a licensed, registered, or certified health care professional
24 who is certified by the National Certification Board of Diabetes
25 Educators as a Certified Diabetes Educator, or certified by the
26 American Association of Diabetes Educators with a Board
27 Certified-Advanced Diabetes Management credential, including, but
28 not limited to: a physician, an advanced practice or registered nurse,
29 a physician assistant, a pharmacist, a chiropractor, a dietitian
30 registered by a nationally recognized professional association of
31 dietitians, or a nutritionist holding a certified nutritionist specialist
32 (CNS) credential from the Board for Certification of Nutrition
33 Specialists; or

34 (ii) an entity meeting the National Standards for Diabetes Self-
35 Management Education and Support, as evidenced by a recognition
36 by the American Diabetes Association or accreditation by the
37 American Association of Diabetes Educators;

38 (b) Expenses for medical nutrition therapy as an effective
39 component of the person's overall treatment plan upon a: diagnosis
40 of diabetes, gestational diabetes, or pre-diabetes; change in the
41 beneficiary's medical condition, treatment, or diagnosis; or
42 determination of a physician, advanced practice nurse, or physician
43 assistant that reeducation or refresher education is necessary.
44 Medical nutrition therapy shall be provided by an in-State provider
45 who is a dietitian registered by a nationally-recognized professional
46 association of dietitians, or a nutritionist holding a certified
47 nutritionist specialist (CNS) credential from the Board for
48 Certification of Nutrition Specialists, who is familiar with the
49 components of diabetes medical nutrition therapy;

1 (c) For a person diagnosed with pre-diabetes, items and services
2 furnished under an in-State diabetes prevention program that meets
3 the standards of the National Diabetes Prevention Program, as
4 established by the federal Centers for Disease Control and
5 Prevention; and

6 (d) Expenses for any medically appropriate and necessary
7 supplies and equipment recommended or prescribed by a physician,
8 advanced practice nurse, or physician assistant for the management
9 and treatment of diabetes, gestational diabetes, or pre-diabetes,
10 including, but not limited to: equipment and supplies for self-
11 management of blood glucose; insulin pens; insulin pumps and
12 related supplies; and other insulin delivery devices;

13 (23) Expenses incurred for the provision of group prenatal care
14 services to a pregnant woman, provided that:

15 (a) the provider of such services, which shall include, but not be
16 limited to, a federally qualified health center or a community health
17 center operating in the State :

18 (i) is a site accredited by the Centering Healthcare Institute, or
19 is a site engaged in an active implementation contract with the
20 Centering Healthcare Institute, that utilizes the Centering Pregnancy
21 model; and

22 (ii) incorporates the applicable information outlined in any best
23 practices manual for prenatal and postpartum maternal care
24 developed by the Department of Health into the curriculum for each
25 group prenatal visit;

26 (b) each group prenatal care visit is at least 1.5 hours in
27 duration, with a minimum of two women and a maximum of 20
28 women in participation; and

29 (c) no more than 10 group prenatal care visits occur per
30 pregnancy.

31 As used in this paragraph, "group prenatal care services"
32 means a series of prenatal care visits provided in a group setting
33 which are based upon the Centering Pregnancy model developed by
34 the Centering Healthcare Institute and which include health
35 assessments, social and clinical support, and educational activities;

36 (24) Expenses incurred for the provision of pasteurized donated
37 human breast milk, which shall include human milk fortifiers if
38 indicated in a medical order provided by a licensed medical
39 practitioner, to an infant under the age of six months; provided that
40 the milk is obtained from a human milk bank that meets quality
41 guidelines established by the Department of Health and a licensed
42 medical practitioner has issued a medical order for the infant under
43 at least one of the following circumstances:

44 (a) the infant is medically or physically unable to receive
45 maternal breast milk or participate in breast feeding, or the infant's
46 mother is medically or physically unable to produce maternal breast
47 milk in sufficient quantities or participate in breast feeding despite
48 optimal lactation support; or

49 (b) the infant meets any of the following conditions:

1 (i) a body weight below healthy levels, as determined by the
2 licensed medical practitioner issuing the medical order for the
3 infant;

4 (ii) the infant has a congenital or acquired condition that places
5 the infant at a high risk for development of necrotizing
6 enterocolitis; or

7 (iii) the infant has a congenital or acquired condition that may
8 benefit from the use of donor breast milk and human milk fortifiers,
9 as determined by the Department of Health; **[and]**

10 (25) Comprehensive tobacco cessation benefits to an individual
11 who is 18 years of age or older, or who is pregnant. Coverage shall
12 include: brief and high intensity individual counseling, brief and
13 high intensity group counseling, and telemedicine as defined by
14 section 1 of P.L.2017, c.117 (C.45:1-61); all medications approved
15 for tobacco cessation by the U.S. Food and Drug Administration;
16 and other tobacco cessation counseling recommended by the
17 Treating Tobacco Use and Dependence Clinical Practice Guideline
18 issued by the U.S. Public Health Service. Notwithstanding the
19 provisions of any other law, rule, or regulation to the contrary, and
20 except as otherwise provided in this section:

21 (a) Information regarding the availability of the tobacco
22 cessation services described in this paragraph shall be provided to
23 all individuals authorized to receive the tobacco cessation services
24 pursuant to this paragraph at the following times: no later than 90
25 days after the effective date of P.L.2019, c.473; upon the
26 establishment of an individual's eligibility for medical assistance;
27 and upon the redetermination of an individual's eligibility for
28 medical assistance;

29 (b) The following conditions shall not be imposed on any
30 tobacco cessation services provided pursuant to this paragraph:
31 copayments or any other forms of cost-sharing, including
32 deductibles; counseling requirements for medication; stepped care
33 therapy or similar restrictions requiring the use of one service prior
34 to another; limits on the duration of services; or annual or lifetime
35 limits on the amount, frequency, or cost of services, including, but
36 not limited to, annual or lifetime limits on the number of covered
37 attempts to quit; and

38 (c) Prior authorization requirements shall not be imposed on any
39 tobacco cessation services provided pursuant to this paragraph
40 except in the following circumstances where prior authorization
41 may be required: for a treatment that exceeds the duration
42 recommended by the most recently published United States Public
43 Health Service clinical practice guidelines on treating tobacco use
44 and dependence; or for services associated with more than two
45 attempts to quit within a 12-month period; and

46 (26) (a) Community-based palliative care benefits which shall
47 include, but not be limited to, all of the following:

48 (1) specialized medical care and emotional and spiritual support
49 for beneficiaries with serious advanced illnesses;

- 1 (2) relief of symptoms, pain, and stress of serious illness;
2 (3) improvement of quality of life for both the beneficiary and
3 the beneficiary's family; and
4 (4) appropriate care for any age and for any stage of serious
5 illness, along with curative treatment.

6 (b) Benefits provided under this paragraph shall include services
7 provided by a hospice pursuant to paragraph (20) of subsection b. of
8 this section, provided that:

9 (1) hospice services may be provided at the same time that
10 curative treatment is available, to the extent that services are not
11 duplicative;

12 (2) hospice services may be provided to beneficiaries whose
13 conditions may result in death, regardless of the estimated length of
14 the beneficiary's remaining period of life; and

15 (3) the Division of Medical Assistance and Health Services in
16 the Department of Human Services may include any other service
17 deemed appropriate under the benefits provided under the
18 paragraph.

19 (c) Providers authorized to deliver benefits provided under this
20 paragraph shall include Medicaid-approved licensed hospice
21 agencies and home health agencies licensed to provide hospice care.

22 (d) Nothing in this paragraph shall be construed to result in the
23 elimination or reduction of covered benefits or services under the
24 Medicaid program.

25 (e) This paragraph shall not affect a beneficiary's eligibility to
26 receive, concurrently with services provided for in this paragraph,
27 any services, including home health services, for which the
28 beneficiary would have been eligible in the absence of this
29 paragraph, to the extent that services are not duplicative.

30 c. Payments for the foregoing services, goods, and supplies
31 furnished pursuant to this act shall be made to the extent authorized
32 by this act, the rules and regulations promulgated pursuant thereto
33 and, where applicable, subject to the agreement of insurance
34 provided for under this act. The payments shall constitute payment
35 in full to the provider on behalf of the recipient. Every provider
36 making a claim for payment pursuant to this act shall certify in
37 writing on the claim submitted that no additional amount will be
38 charged to the recipient, the recipient's family, the recipient's
39 representative or others on the recipient's behalf for the services,
40 goods, and supplies furnished pursuant to this act.

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

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

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

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

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

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

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

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

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

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

- 1 g. The following services shall be provided to eligible
2 medically needy individuals as follows:
- 3 (1) Pregnant women shall be provided prenatal care and delivery
4 services and postpartum care, including the services cited in
5 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
6 (10), (12), (15), and (17) of this section, and nursing facility
7 services cited in subsection b.(13) of this section.
- 8 (2) Dependent children shall be provided with services cited in
9 subsections a.(3) and (5) of this section and subsections b.(1), (2),
10 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
11 nursing facility services cited in subsection b.(13) of this section.
- 12 (3) Individuals who are 65 years of age or older shall be
13 provided with services cited in subsections a.(3) and (5) of this
14 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
15 (7), (8), (10), (12), (15), and (17) of this section, and nursing
16 facility services cited in subsection b.(13) of this section.
- 17 (4) Individuals who are blind or disabled shall be provided with
18 services cited in subsections a.(3) and (5) of this section and
19 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
20 (12), (15), and (17) of this section, and nursing facility services
21 cited in subsection b.(13) of this section.
- 22 (5) (a) Inpatient hospital services, subsection a.(1) of this
23 section, shall only be provided to eligible medically needy
24 individuals, other than pregnant women, if the federal Department
25 of Health and Human Services discontinues the State's waiver to
26 establish inpatient hospital reimbursement rates for the Medicare
27 and Medicaid programs under the authority of section 601(c)(3) of
28 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
29 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
30 extended to other eligible medically needy individuals if the federal
31 Department of Health and Human Services directs that these
32 services be included.
- 33 (b) Outpatient hospital services, subsection a.(2) of this section,
34 shall only be provided to eligible medically needy individuals if the
35 federal Department of Health and Human Services discontinues the
36 State's waiver to establish outpatient hospital reimbursement rates
37 for the Medicare and Medicaid programs under the authority of
38 section 601(c)(3) of the Social Security Amendments of 1983,
39 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
40 services may be extended to all or to certain medically needy
41 individuals if the federal Department of Health and Human Services
42 directs that these services be included. However, the use of
43 outpatient hospital services shall be limited to clinic services and to
44 emergency room services for injuries and significant acute medical
45 conditions.
- 46 (c) The division shall monitor the use of inpatient and outpatient
47 hospital services by medically needy persons.
- 48 h. In the case of a qualified disabled and working individual
49 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the

1 only medical assistance provided under this act shall be the
2 payment of premiums for Medicare part A under 42 U.S.C.
3 ss.1395i-2 and 1395r.

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

9 j. In the case of a qualified individual pursuant to 42 U.S.C.
10 s.1396a(aa), the only medical assistance provided under this act
11 shall be payment for authorized services provided during the period
12 in which the individual requires treatment for breast or cervical
13 cancer, in accordance with criteria established by the commissioner.

14 k. In the case of a qualified individual pursuant to 42 U.S.C.
15 s.1396a(ii), the only medical assistance provided under this act shall
16 be payment for family planning services and supplies as described
17 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
18 treatment services that are provided pursuant to a family planning
19 service in a family planning setting.

20 (cf: P.L.2019, c.473, s.1)¹

21

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

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

29 (1) Inpatient hospital services

30 (2) Outpatient hospital services;

31 (3) Other laboratory and X-ray services;

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

33 (b) Early and periodic screening and diagnosis of individuals
34 who are eligible under the program and are under age 21, to
35 ascertain their physical or mental health status and the health care,
36 treatment, and other measures to correct or ameliorate defects and
37 chronic conditions discovered thereby, as may be provided in
38 regulation of the Secretary of the federal Department of Health and
39 Human Services and approved by the commissioner;

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

43 As used in this subsection, "laboratory and X-ray services"
44 includes HIV drug resistance testing, including, but not limited to,
45 genotype assays that have been cleared or approved by the federal
46 Food and Drug Administration, laboratory developed genotype
47 assays, phenotype assays, and other assays using phenotype
48 prediction with genotype comparison, for persons diagnosed with
49 HIV infection or AIDS.

- 1 b. Subject to the limitations imposed by federal law, by this
2 act, and by the rules and regulations promulgated pursuant thereto,
3 the medical assistance program may be expanded to include
4 authorized services within each of the following classifications:
- 5 (1) Medical care not included in subsection a.(5) above, or any
6 other type of remedial care recognized under State law, furnished
7 by licensed practitioners within the scope of their practice, as
8 defined by State law;
- 9 (2) Home health care services;
- 10 (3) Clinic services;
- 11 (4) Dental services;
- 12 (5) Physical therapy and related services;
- 13 (6) Prescribed drugs, dentures, and prosthetic devices; and
14 eyeglasses prescribed by a physician skilled in diseases of the eye
15 or by an optometrist, whichever the individual may select;
- 16 (7) Optometric services;
- 17 (8) Podiatric services;
- 18 (9) Chiropractic services;
- 19 (10) Psychological services;
- 20 (11) Inpatient psychiatric hospital services for individuals under
21 21 years of age, or under age 22 if they are receiving such services
22 immediately before attaining age 21;
- 23 (12) Other diagnostic, screening, preventative, and rehabilitative
24 services, and other remedial care;
- 25 (13) Inpatient hospital services, nursing facility services, and
26 immediate care facility services for individuals 65 years of age or
27 over in an institution for mental diseases;
- 28 (14) Intermediate care facility services;
- 29 (15) Transportation services;
- 30 (16) Services in connection with the inpatient or outpatient
31 treatment or care of substance use disorder, when the treatment is
32 prescribed by a physician and provided in a licensed hospital or in a
33 narcotic and substance use disorder treatment center approved by
34 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
35 et. seq.) and whose staff includes a medical director, and limited
36 those services eligible for federal financial participation under Title
37 XIX of the federal Social Security Act;
- 38 (17) Any other medical care and any other type of remedial care
39 recognized under State law, specified by the Secretary of the federal
40 Department of Health and Human Services, and approved by the
41 commissioner;
- 42 (18) Comprehensive maternity care, which may include: the
43 basic number of prenatal and postpartum visits recommended by the
44 American College of Obstetrics and Gynecology; additional
45 prenatal and postpartum visits that are medically necessary;
46 necessary laboratory, nutritional assessment and counseling, health
47 education, personal counseling, managed care, outreach, and
48 follow-up services; treatment of conditions which may complicate
49 pregnancy doula care; and physician or certified nurse midwife

1 delivery services. For the purposes of this paragraph, "doula"
2 means a trained professional who provides continuous physical,
3 emotional, and informational support to a mother before, during,
4 and shortly after childbirth, to help her to achieve the healthiest,
5 most satisfying experience possible;

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

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

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

25 (22) Upon referral by a physician, advanced practice nurse, or
26 physician assistant of a person who has been diagnosed with
27 diabetes, gestational diabetes, or pre-diabetes, in accordance with
28 standards adopted by the American Diabetes Association:

29 (a) Expenses for diabetes self-management education or training
30 to ensure that a person with diabetes, gestational diabetes, or pre-
31 diabetes can optimize metabolic control, prevent and manage
32 complications, and maximize quality of life. Diabetes self-
33 management education shall be provided by an in-State provider
34 who is:

35 (i) a licensed, registered, or certified health care professional
36 who is certified by the National Certification Board of Diabetes
37 Educators as a Certified Diabetes Educator, or certified by the
38 American Association of Diabetes Educators with a Board
39 Certified-Advanced Diabetes Management credential, including, but
40 not limited to: a physician, an advanced practice or registered nurse,
41 a physician assistant, a pharmacist, a chiropractor, a dietitian
42 registered by a nationally recognized professional association of
43 dietitians, or a nutritionist holding a certified nutritionist specialist
44 (CNS) credential from the Board for Certification of Nutrition
45 Specialists; or

46 (ii) an entity meeting the National Standards for Diabetes Self-
47 Management Education and Support, as evidenced by a recognition
48 by the American Diabetes Association or accreditation by the
49 American Association of Diabetes Educators;

1 (b) Expenses for medical nutrition therapy as an effective
2 component of the person's overall treatment plan upon a: diagnosis
3 of diabetes, gestational diabetes, or pre-diabetes; change in the
4 beneficiary's medical condition, treatment, or diagnosis; or
5 determination of a physician, advanced practice nurse, or physician
6 assistant that reeducation or refresher education is necessary.
7 Medical nutrition therapy shall be provided by an in-State provider
8 who is a dietitian registered by a nationally-recognized professional
9 association of dietitians, or a nutritionist holding a certified
10 nutritionist specialist (CNS) credential from the Board for
11 Certification of Nutrition Specialists, who is familiar with the
12 components of diabetes medical nutrition therapy;

13 (c) For a person diagnosed with pre-diabetes, items and services
14 furnished under an in-State diabetes prevention program that meets
15 the standards of the National Diabetes Prevention Program, as
16 established by the federal Centers for Disease Control and
17 Prevention; and

18 (d) Expenses for any medically appropriate and necessary
19 supplies and equipment recommended or prescribed by a physician,
20 advanced practice nurse, or physician assistant for the management
21 and treatment of diabetes, gestational diabetes, or pre-diabetes,
22 including, but not limited to: equipment and supplies for self-
23 management of blood glucose; insulin pens; insulin pumps and
24 related supplies; and other insulin delivery devices;

25 (23) Expenses incurred for the provision of group prenatal
26 services to a pregnant woman, provided that:

27 (a) the provider of such services, which shall include, but not be
28 limited to, a federally qualified health center or a community health
29 center operating in the State:

30 (i) is a site accredited by the Centering Healthcare Institute, or is
31 a site engaged in an active implementation contract with the
32 Centering Healthcare institute, that utilizes the Centering Pregnancy
33 model; and

34 (ii) incorporates the applicable information outlined in any best
35 practices manual for prenatal and postpartum maternal care
36 developed by the Department of Health into the curriculum for each
37 group prenatal visit;

38 (b) each group prenatal care visit is at least 1.5 hours in
39 duration, with a minimum of two women and a maximum of 20
40 women in participation; and

41 (c) no more than 10 group prenatal care visits occur per
42 pregnancy. As used in this paragraph, "group prenatal care
43 services" means a series of prenatal care visits provided in a group
44 setting which are based upon the Centering Pregnancy model
45 developed by the Centering Healthcare Institute and which include
46 health assessments, social and clinical support, and educational
47 activities;

48 (24) Expenses incurred for the provision of pasteurized donated
49 human breast milk, which shall include human milk fortifiers if

1 indicated in a medical order provided by a licensed medical
2 practitioner, to an infant under the age of six months; provided that
3 the milk is obtained from a human milk bank that meets quality
4 guidelines established by the Department of Health and a licensed
5 medical practitioner has issued a medical order for the infant under
6 at least one of the following circumstances:

7 (a) the infant is medically or physically unable to receive
8 maternal breast milk or participate in breast feeding, or the infant's
9 mother is medically or physically unable to produce maternal breast
10 milk in sufficient quantities or participate in breast feeding despite
11 optimal lactation support; or

12 (b) the infant meets any of the following conditions:

13 (i) a body weight below healthy levels, as determined by the
14 licensed medical practitioner issuing the medical order for the
15 infant;

16 (ii) the infant has a congenital or acquired condition that places
17 the infant at a high risk for development of necrotizing
18 enterocolitis; or

19 (iii) the infant has a congenital or acquired condition that may
20 benefit from the use of donor breast milk and human milk fortifiers,
21 as determined by the Department of Health;

22 (25) Comprehensive tobacco cessation benefits to an individual
23 who is 18 years of age or older, or who is pregnant. Coverage shall
24 include: brief and high intensity individual counseling, brief and
25 high intensity group counseling, and telemedicine as defined by
26 section 1 of P.L.2017, c.117 (C.45:1-61); all medications approved
27 for tobacco cessation by the U.S. Food and Drug Administration;
28 and other tobacco cessation counseling recommended by the
29 Treating Tobacco Use and Dependence Clinical Practice Guideline
30 issued by the U.S. Public Health Service. Notwithstanding the
31 provisions of any other law, rule, or regulation to the contrary, and
32 except as otherwise provided in this section:

33 (a) Information regarding the availability of the tobacco
34 cessation services described in this paragraph shall be provided to
35 all individuals authorized to receive the tobacco cessation services
36 pursuant to this paragraph at the following times: no later than 90
37 days after the effective date of P.L.2019, c.473: upon the
38 establishment of an individual's eligibility for medical assistance;
39 and upon the redetermination of an individual's eligibility for
40 medical assistance;

41 (b) The following conditions shall not be imposed on any
42 tobacco cessation services provided pursuant to this paragraph:
43 copayments or any other forms of cost-sharing, including
44 deductibles; counseling requirements for medication; stepped care
45 therapy or similar restrictions requiring the use of one service prior
46 to another; limits on the duration of services; or annual or lifetime
47 limits on the amount, frequency, or cost of services, including, but
48 not limited to, annual or lifetime limits on the number of covered
49 attempts to quit; and

1 (c) Prior authorization requirements shall not be imposed on any
2 tobacco cessation services provided pursuant to this paragraph
3 except in the following circumstances where prior authorization
4 may be required: for a treatment that exceeds the duration
5 recommended by the most recently published United States Public
6 Health Service clinical practice guidelines on treating tobacco use
7 and dependence; or for services associated with more than two
8 attempts to quit within a 12-month period; **[and]**

9 (26) Provided that there is federal financial participation
10 available, benefits for expenses incurred in conducting a colorectal
11 cancer screening in accordance with United States Preventive
12 Services Task Force recommendations. The method and frequency
13 of screening to be utilized shall be in accordance with the most
14 recent published recommendations of the United States Preventive
15 Services Task Force and as determined medically necessary by the
16 covered person's physician, in consultation with the covered person.

17 No deductible, coinsurance, copayment, or any other cost-
18 sharing requirement shall be imposed for a colonoscopy performed
19 following a positive result on a non-colonoscopy, colorectal cancer
20 screening test recommended by the United States Preventive
21 Services Task Force; and

22 (27) (a) Community-based palliative care benefits which shall
23 include, but not be limited to, all of the following:

24 (1) specialized medical care and emotional and spiritual support
25 for beneficiaries with serious advanced illnesses;

26 (2) relief of symptoms, pain, and stress of serious illness;

27 (3) improvement of quality of life for both the beneficiary and
28 the beneficiary's family; and

29 (4) appropriate care for any age and for any stage of serious
30 illness, along with curative treatment.

31 (b) Benefits provided under this paragraph shall include services
32 provided by a hospice pursuant to paragraph (20) of subsection b. of
33 this section, provided that:

34 (1) hospice services may be provided at the same time that
35 curative treatment is available, to the extent that services are not
36 duplicative;

37 (2) hospice services may be provided to beneficiaries whose
38 conditions may result in death, regardless of the estimated length of
39 the beneficiary's remaining period of life; and

40 (3) the Division of Medical Assistance and Health Services in
41 the Department of Human Services may include any other service
42 deemed appropriate under the benefits provided under the
43 paragraph.

44 (c) Providers authorized to deliver benefits provided under this
45 paragraph shall include Medicaid-approved licensed hospice
46 agencies and home health agencies licensed to provide hospice care.

47 (d) Nothing in this paragraph shall be construed to result in the
48 elimination or reduction of covered benefits or services under the
49 Medicaid program.

1 (e) This paragraph shall not affect a beneficiary's eligibility to
2 receive, concurrently with services provided for in this paragraph,
3 any services, including home health services, for which the
4 beneficiary would have been eligible in the absence of this
5 paragraph, to the extent that services are not duplicative.

6 c. Payments for the foregoing services, goods and supplies
7 furnished pursuant to this act shall be made to the extent authorized
8 by this act, the rules and regulations promulgated pursuant thereto
9 and, where applicable, subject to the agreement of insurance
10 provided for under this act. The payments shall constitute payment
11 in full to the provider on behalf of the recipient. Every provider
12 making a claim for payment pursuant to this act shall certify in
13 writing on the claim submitted that no additional amount will be
14 charged to the recipient, the recipient's family, the recipient's
15 representative or others on the recipient's behalf for the services,
16 goods, and supplies furnished pursuant to this act.

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

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

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

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

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

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

47 (3) Is over 21 years of age and who is receiving inpatient
48 psychiatric hospital services in a psychiatric facility; provided,
49 however, that an individual who was receiving such services

1 immediately prior to attaining age 21 may continue to receive such
2 services until the individual reaches age 22. Nothing in this
3 subsection shall prohibit the commissioner from extending medical
4 assistance to all eligible persons receiving inpatient psychiatric
5 services; provided that there is federal financial participation
6 available.

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

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

19 (3) Notwithstanding any provision of law to the contrary, the
20 provisions of paragraph (2) of this subsection shall not apply to a
21 trust agreement that is established pursuant to 42 U.S.C.
22 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
23 provided by government entities to a person who is disabled as
24 defined in section 1614(a)(3) of the federal Social Security Act (42
25 31 U.S.C. s.1382c (a)(3)).

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

28 (1) Pregnant women shall be provided prenatal care and delivery
29 services and postpartum care, including the services cited in
30 subsections a.(1), (3), and (5) of this section and subsections b.(1)-
31 (10), (12), (15), and (17) of this section, and nursing facility
32 services cited in subsection b.(13) of this section.

33 (2) Dependent children shall be provided with services cited in
34 subsections a.(3) and (5) of this section and subsections b.(1), (2),
35 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
36 nursing facility services cited in subsection b.(13) of this section.

37 (3) Individuals who are 65 years of age or older shall be
38 provided with services cited in subsections a.(3) and (5) of this
39 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
40 (7), (8), (10), (12), (15), and (17) of this section, and nursing
41 facility services cited in subsection b.(13) of this section.

42 (4) Individuals who are blind or disabled shall be provided with
43 services cited in subsections a.(3) and (5) of this section and
44 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
45 3 (12), (15), and (17) of this section, and nursing facility services
46 cited in subsection b.(13) of this section.

47 (5) (a) Inpatient hospital services, subsection a.(1) of this
48 section, shall only be provided to eligible medically needy
49 individuals, other than pregnant women, if the federal Department

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

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

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

24 h. In the case of a qualified disabled and working individual
25 pursuant to section h6408 of Pub.L.101-239 (42 U.S.C. s.1396d),
26 the only medical assistance provided under this act shall be the
27 payment of premiums for Medicare part A under 42 U.S.C.
28 ss.1395i-2 and 1395r.

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

34 j. In the case of a qualified individual pursuant to 42 U.S.C.
35 s.1396a(aa), the only medical assistance provided under this act
36 shall be payment for authorized services provided during the period
37 in which the individual requires treatment for breast or cervical
38 cancer, in accordance with criteria established by the commissioner.

39 k. In the case of a qualified individual pursuant to 42 U.S.C.
40 s.1396a(ii), the only medical assistance provided under this act shall
41 be payment for family planning services and supplies as described
42 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
43 treatment services that are provided pursuant to a family planning
44 service in a family planning setting.¹

45 (cf: P.L.2023, c.8, s.11)

46

47 2. (New section) The Commissioner of Human Services shall
48 apply for such State plan amendments or waivers as may be necessary
49 to implement the provisions of this act and to secure federal financial

1 participation for State Medicaid expenditures under the federal
2 Medicaid program.

3

4 3. (New section) The Commissioner of Human Services shall
5 adopt rules and regulations pursuant to the "Administrative Procedure
6 Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes
7 of this act including guidance on the medical conditions and prognoses
8 that render a beneficiary eligible for community-based palliative care
9 services.

10

11 4. This act shall take effect immediately.