

[Second Reprint]

ASSEMBLY, No. 5225

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED FEBRUARY 23, 2023

Sponsored by:

Assemblywoman ANGELA V. MCKNIGHT

District 31 (Hudson)

Assemblywoman SHANIQUE SPEIGHT

District 29 (Essex)

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District 7 (Burlington)

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District 27 (Essex and Morris)

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District 35 (Bergen and Passaic)

Co-Sponsored by:

Assemblymen Stanley, Conaway, Assemblywomen Jaffer, Lampitt, Jasey,

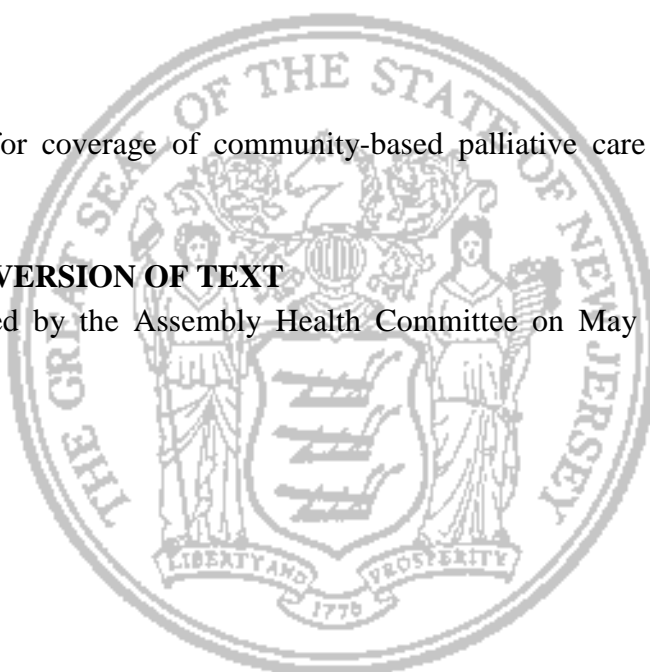
Assemblyman Wimberly, Assemblywoman Lopez and Senator Durr

SYNOPSIS

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

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on May 18, 2023, with amendments.



(Sponsorship Updated As Of: 6/30/2023)

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.

²Assembly AHE committee amendments adopted May 18, 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
- 50 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice

1 services shall be provided subject to approval of the Secretary of
2 the federal Department of Health and Human Services for federal
3 reimbursement;

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

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

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

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

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

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

49 (c) For a person diagnosed with pre-diabetes, items and services
50 furnished under an in-State diabetes prevention program that meets

1 the standards of the National Diabetes Prevention Program, as
2 established by the federal Centers for Disease Control and
3 Prevention; and

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

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

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

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

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

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

27 (c) no more than 10 group prenatal care visits occur per
28 pregnancy.

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

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

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

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

48 (i) a body weight below healthy levels, as determined by the
49 licensed medical practitioner issuing the medical order for the
50 infant;

1 (ii) the infant has a congenital or acquired condition that places
2 the infant at a high risk for development of necrotizing
3 enterocolitis; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47 d. Any individual eligible for medical assistance (including
48 drugs) may obtain such assistance from any person qualified to
49 perform the service or services required (including an organization
50 which provides such services, or arranges for their availability on a

1 prepayment basis), who undertakes to provide the individual such
2 services.

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

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

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

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

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

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

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

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

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

48 (1) Pregnant women shall be provided prenatal care and delivery
49 services and postpartum care, including the services cited in
50 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 subsections a.(3) and (5) of this section and subsections 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 subsections a.(3) and (5) of this section and subsections 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 subsections a.(3) and (5) of this section and subsections 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. s.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. s.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. s.1396d), the only medical assistance provided under this act shall be the payment of premiums for Medicare part A under 42 U.S.C. ss.1395i-2 and 1395r.

i. In the case of a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)(10)(E)iii, the only medical assistance provided under this act shall be the payment of premiums

1 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
2 U.S.C. s.1396d(p)(3)(A)(ii).

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

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

14 (cf: P.L.2019, c.473, s.1) **1**¹

15
16 ¹1. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read as
17 follows:

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

23 (1) Inpatient hospital services

24 (2) Outpatient hospital services;

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

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

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

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

36 As used in this subsection, "laboratory and X-ray services"
37 includes HIV drug resistance testing, including, but not limited to,
38 genotype assays that have been cleared or approved by the federal
39 Food and Drug Administration, laboratory developed genotype assays,
40 phenotype assays, and other assays using phenotype prediction with
41 genotype comparison, for persons diagnosed with HIV infection or
42 AIDS.

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

47 (1) Medical care not included in subsection a.(5) above, or any
48 other type of remedial care recognized under State law, furnished by

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

1 preventive visits recommended by the American Academy of
2 Pediatrics;

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

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

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

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

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

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

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

1 Specialists, who is familiar with the components of diabetes medical
2 nutrition therapy;

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

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

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

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

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

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

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

29 (c) no more than 10 group prenatal care visits occur per
30 pregnancy. As used in this paragraph, "group prenatal care services"
31 means a series of prenatal care visits provided in a group setting which
32 are based upon the Centering Pregnancy model developed by the
33 Centering Healthcare Institute and which include health assessments,
34 social and clinical support, and educational activities;

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

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

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

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

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

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

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

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

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

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

40 (26) Provided that there is federal financial participation available,
41 benefits for expenses incurred in conducting a colorectal cancer
42 screening in accordance with United States Preventive Services Task
43 Force recommendations. The method and frequency of screening to
44 be utilized shall be in accordance with the most recent published
45 recommendations of the United States Preventive Services Task Force
46 and as determined medically necessary by the covered person's
47 physician, in consultation with the covered person.

48 No deductible, coinsurance, copayment, or any other cost-sharing
49 requirement shall be imposed for a colonoscopy performed following a

- 1 positive result on a non-colonoscopy, colorectal cancer screening test
2 recommended by the United States Preventive Services Task Force;
3 and
- 4 (27) (a) Community-based palliative care benefits which shall
5 include, but not be limited to, all of the following:
- 6 ²[(1)] (i)² specialized medical care and emotional and spiritual
7 support for beneficiaries with serious advanced illnesses;
- 8 ²[(2)] (ii)² relief of symptoms, pain, and stress of serious illness;
- 9 ²[(3)] (iii)² improvement of quality of life for both the beneficiary
10 and the beneficiary's family; and
- 11 ²[(4)] (iv)² appropriate care for any age and for any stage of
12 serious illness, along with curative treatment.
- 13 (b) Benefits provided under this paragraph shall include ², but
14 shall not be limited to, ² services provided by a hospice pursuant to
15 paragraph (20) of subsection b. of this section, provided that:
- 16 ²[(1)] (i)² hospice services may be provided at the same time that
17 curative treatment is available, to the extent that services are not
18 duplicative;
- 19 ²[(2)] (ii)² hospice services may be provided to beneficiaries
20 whose conditions may result in death, regardless of the estimated
21 length of the beneficiary's remaining period of life; and
- 22 ²[(3)] (iii)² the Division of Medical Assistance and Health
23 Services in the Department of Human Services may include any other
24 service deemed appropriate under the benefits provided under ²[the]
25 this² paragraph.
- 26 (c) Providers authorized to deliver benefits provided under this
27 paragraph shall include Medicaid-approved licensed hospice agencies
28 ²[and] , Medicaid-approved² home health agencies licensed to
29 provide hospice care ², and other Medicaid-approved licensed health
30 care providers².
- 31 (d) Nothing in this paragraph shall be construed to result in the
32 elimination or reduction of covered benefits or services under the
33 Medicaid program.
- 34 (e) This paragraph shall not affect a beneficiary's eligibility to
35 receive, concurrently with services provided for in this paragraph, any
36 services, including home health services, for which the beneficiary
37 would have been eligible in the absence of this paragraph, to the extent
38 that services are not duplicative.
- 39 c. Payments for the foregoing services, goods and supplies
40 furnished pursuant to this act shall be made to the extent authorized by
41 this act, the rules and regulations promulgated pursuant thereto and,
42 where applicable, subject to the agreement of insurance provided for
43 under this act. The payments shall constitute payment in full to the
44 provider on behalf of the recipient. Every provider making a claim for
45 payment pursuant to this act shall certify in writing on the claim
46 submitted that no additional amount will be charged to the recipient,
47 the recipient's family, the recipient's representative or others on the

1 recipient's behalf for the services, goods, and supplies furnished
2 pursuant to this act.

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

12 d. Any individual eligible for medical assistance (including
13 drugs) may obtain such assistance from any person qualified to 33
14 perform the service or services required (including an organization
15 which provides such services, or arranges for their availability on a
16 prepayment basis), who undertakes to provide the individual such
17 services.

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

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

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

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

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

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

44 (2) In addition, any provision in a contract of insurance, health
45 benefits plan, or other health care coverage document, will, trust,
46 agreement, court order, or other instrument which reduces or excludes
47 coverage or payment for health care-related goods and services to or
48 for an individual because of that individual's actual or potential
49 eligibility for or receipt of Medicaid benefits shall be null and void,

1 and no payments shall be made under this act as a result of any such
2 provision.

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

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

11 (1) Pregnant women shall be provided prenatal care and delivery
12 services and postpartum care, including the services cited in
13 subsections a.(1), (3), and (5) of this section and subsections b.(1)-
14 (10), (12), (15), and (17) of this section, and nursing facility services
15 cited in subsection b.(13) of this section.

16 (2) Dependent children shall be provided with services cited in
17 subsections a.(3) and (5) of this section and subsections b.(1), (2), (3),
18 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing
19 facility services cited in subsection b.(13) of this section.

20 (3) Individuals who are 65 years of age or older shall be provided
21 with services cited in subsections a.(3) and (5) of this section and
22 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
23 (12), (15), and (17) of this section, and nursing facility services cited
24 in subsection b.(13) of this section.

25 (4) Individuals who are blind or disabled shall be provided with
26 services cited in subsections a.(3) and (5) of this section and
27 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), 3
28 (12), (15), and (17) of this section, and nursing facility services cited
29 in subsection b.(13) of this section.

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

40 (b) Outpatient hospital services, subsection a.(2) of this section,
41 shall only be provided to eligible medically needy individuals if the
42 federal Department of Health and Human Services discontinues the
43 State's waiver to establish outpatient hospital reimbursement rates for
44 the Medicare and Medicaid programs under the authority of section
45 601(c)(3) of the Social Security Amendments of 1983, Pub.L.98-21
46 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital services may be
47 extended to all or to certain medically needy individuals if the federal
48 Department of Health and Human Services directs that these services
49 be included. However, the use of outpatient hospital services shall be

- 1 limited to clinic services and to emergency room services for injuries
- 2 and significant acute medical conditions.
- 3 (c) The division shall monitor the use of inpatient and outpatient
- 4 hospital services by medically needy persons.
- 5 h. In the case of a qualified disabled and working individual
- 6 pursuant to section h6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
- 7 only medical assistance provided under this act shall be the payment of
- 8 premiums for Medicare part A under 42 U.S.C. ss.1395i-2 and 1395r.
- 9 i. In the case of a specified low-income Medicare beneficiary
- 10 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical assistance
- 11 provided under this act shall be the payment of premiums for Medicare
- 12 part B under 42 U.S.C. s.1395r as provided for in 42 U.S.C.
- 13 s.1396d(p)(3)(A)(ii).
- 14 j. In the case of a qualified individual pursuant to 42 U.S.C.
- 15 s.1396a(aa), the only medical assistance provided under this act shall
- 16 be payment for authorized services provided during the period in
- 17 which the individual requires treatment for breast or cervical cancer, in
- 18 accordance with criteria established by the commissioner.
- 19 k. In the case of a qualified individual pursuant to 42 U.S.C.
- 20 s.1396a(ii), the only medical assistance provided under this act shall be
- 21 payment for family planning services and supplies as described at 42
- 22 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and treatment
- 23 services that are provided pursuant to a family planning service in a
- 24 family planning setting.¹
- 25 (cf: P.L.2023, c.8, s.11)
- 26
- 27 2. (New section) The Commissioner of Human Services shall
- 28 apply for such State plan amendments or waivers as may be necessary
- 29 to implement the provisions of this act and to secure federal financial
- 30 participation for State Medicaid expenditures under the federal
- 31 Medicaid program.
- 32
- 33 3. (New section) The Commissioner of Human Services shall
- 34 adopt rules and regulations pursuant to the "Administrative Procedure
- 35 Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes
- 36 of this act including guidance on the medical conditions and prognoses
- 37 that render a beneficiary eligible for community-based palliative care
- 38 services.
- 39
- 40 4. This act shall take effect immediately.