SENATE, No. 2920

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED MARCH 7, 2024

Sponsored by:
Senator JON M. BRAMNICK
District 21 (Middlesex, Morris, Somerset and Union)

SYNOPSIS

Requires parity in Medicaid reimbursement rates for certain routine inpatient hospice room and board services.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning Medicaid reimbursement for inpatient hospice care and amending P.L.1968, c.413.

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

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

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

(1) Inpatient hospital services

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

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

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

(5) Physical therapy and related services;

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

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

(11) Inpatient psychiatric hospital services for individuals under 21 years of age, or under age 22 if they are receiving such services immediately before attaining age 21;

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

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

(14) Intermediate care facility services;

(15) Transportation services;

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

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

(18) Comprehensive maternity care, which may include: the basic number of prenatal and postpartum visits recommended by the American College of Obstetrics and Gynecology; additional prenatal and postpartum visits that are medically necessary; necessary laboratory, nutritional assessment and counseling, health education, personal counseling, managed care, outreach, and follow-up services; treatment of conditions which may complicate pregnancy doula care; and physician or certified nurse midwife delivery services. For the purposes of this paragraph, "doula" means a trained professional who provides continuous physical, emotional, and informational support to a mother before, during, and shortly after childbirth, to help her to achieve the healthiest, most satisfying experience possible;

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

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

(b) Notwithstanding any other provision of law to the contrary, the reimbursement rate for inpatient room and board services provided in an inpatient unit by a hospice care program licensed pursuant to P.L.1997, c.78 (C.26:2H-79 et seq.) shall be no less than the reimbursement rate for room and board services provided by a nursing home licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) to a resident receiving hospice services from the nursing home.

(c) The reimbursement rate provided in subparagraph (b) of this paragraph shall not apply to hospice benefit coverage for hospice medical services otherwise provided in a patient's home or for days of inpatient care otherwise covered by the hospice medical benefit under 42 CFR 418.108 and 42 CFR 418.110.

(d) For patients admitted to the inpatient unit of an inpatient hospice care program licensed pursuant to P.L.1997, c.78 (C.26:2H-79 et seq.), the reimbursement rate provided in subparagraph (b) of this paragraph shall apply to days of care during which the patient is on the routine level of hospice care, as that level of care is defined for the purposes of the federal Medicaid program, as well as to any days during which the patient is no longer receiving hospice care services from the program but continues to reside with the program pending transfer to another facility;

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

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

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

(i) a licensed, registered, or certified health care professional who is certified by the National Certification Board of Diabetes

Educators as a Certified Diabetes Educator, or certified by the American Association of Diabetes Educators with a Board Certified-Advanced Diabetes Management credential, including, but not limited to: a physician, an advanced practice or registered nurse, a physician assistant, a pharmacist, a chiropractor, a dietitian registered by a nationally recognized professional association of dietitians, or a nutritionist holding a certified nutritionist specialist (CNS) credential from the Board for Certification of Nutrition Specialists; or

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

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

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

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

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

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

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

(ii) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care

developed by the Department of Health into the curriculum for each group prenatal visit;

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

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

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

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

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

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

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

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

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

(a) Information regarding the availability of the tobacco cessation services described in this paragraph shall be provided to

all individuals authorized to receive the tobacco cessation services pursuant to this paragraph at the following times: no later than 90 days after the effective date of P.L.2019, c.473: upon the establishment of an individual's eligibility for medical assistance; and upon the redetermination of an individual's eligibility for medical assistance;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) In addition, any provision in a contract of insurance, health benefits plan, or other health care coverage document, will, trust, agreement, court order, or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or

potential eligibility for or receipt of Medicaid benefits shall be null and void, and no payments shall be made under this act as a result of any such provision.

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

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

(1) Pregnant women shall be provided prenatal care and delivery services and postpartum care, including the services cited in subsections a.(1), (3), and (5) of this section and subsections 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), 3 (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 h6408 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 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42 U.S.C. s.1396d(p)(3)(A)(ii).

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

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

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

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

3. This act shall take effect immediately.

STATEMENT

This bill requires that the Medicaid reimbursement rate for inpatient room and board hospice services provided in an inpatient unit by a licensed hospice care program be equal to the Medicaid reimbursement rate for room and board hospice services provided by a nursing home. The reimbursement rate provided under the bill

will not apply to medical hospice care provided in a patient's home or for days of inpatient care otherwise covered by the hospice medical benefit under 42 CFR 418.108 and 42 CFR 418.110.

For patients admitted to the inpatient unit of an inpatient hospice care program, the reimbursement rate will apply to days of care when the patient is at the routine level of care, as that level of care is defined for the purposes of the federal Medicaid program, as well as to any days during which the patient is no longer receiving hospice care services from the program but continues to reside with the program pending transfer to another facility.