

[First Reprint]

**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 reported by the Senate Health, Human Services and Senior Citizens Committee on June 6, 2024, with amendments.



1 AN ACT concerning Medicaid reimbursement for inpatient hospice  
2 care 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 <sup>1</sup>[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 regulation 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;

**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:

<sup>1</sup>Senate SHH committee amendments adopted June 6, 2024.

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

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

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

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

20 (d) For patients admitted to the inpatient unit of an inpatient  
21 hospice care program licensed pursuant to P.L.1997, c.78 (C.26:2H-  
22 79 et seq.), the reimbursement rate provided in subparagraph (b) of  
23 this paragraph shall apply to days of care during which the patient is  
24 on the routine level of hospice care, as that level of care is defined  
25 for the purposes of the federal Medicaid program, as well as to any  
26 days during which the patient is no longer receiving hospice care  
27 services from the program but continues to reside with the program  
28 pending transfer to another facility;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (3) Is over 21 years of age and who is receiving inpatient  
32 psychiatric hospital services in a psychiatric facility; provided,  
33 however, that an individual who was receiving such services  
34 immediately prior to attaining age 21 may continue to receive such  
35 services until the individual reaches age 22. Nothing in this  
36 subsection shall prohibit the commissioner from extending medical  
37 assistance to all eligible persons receiving inpatient psychiatric  
38 services; provided that there is federal financial participation  
39 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  
47 excludes coverage or payment for health care-related goods and  
48 services to or for an individual because of that individual's actual or



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

4 (3) Notwithstanding any provision of law to the contrary, the  
5 provisions of paragraph (2) of this subsection shall not apply to a  
6 trust agreement that is established pursuant to 42 U.S.C.  
7 s.1396p(d)(4)(A) or (C) to supplement and augment assistance  
8 provided by government entities to a person who is disabled as  
9 defined in section 1614(a)(3) of the federal Social Security Act (42  
10 31 U.S.C. s.1382c (a)(3)).

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

13 (1) Pregnant women shall be provided prenatal care and delivery  
14 services and postpartum care, including the services cited in  
15 subsections a.(1), (3), and (5) of this section and subsections b.(1)-  
16 (10), (12), (15), and (17) of this section, and nursing facility  
17 services cited in subsection b.(13) of this section.

18 (2) Dependent children shall be provided with services cited in  
19 subsections a.(3) and (5) of this section and subsections b.(1), (2),  
20 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and  
21 nursing facility services cited in subsection b.(13) of this section.

22 (3) Individuals who are 65 years of age or older shall be  
23 provided with services cited in subsections a.(3) and (5) of this  
24 section and subsections b.(1)-(5), (6) excluding prescribed drugs,  
25 (7), (8), (10), (12), (15), and (17) of this section, and nursing  
26 facility services cited in subsection b.(13) of this section.

27 (4) Individuals who are blind or disabled shall be provided with  
28 services cited in subsections a.(3) and (5) of this section and  
29 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),  
30 (12), (15), and (17) of this section, and nursing facility services  
31 cited in subsection b.(13) of this section.

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

43 (b) Outpatient hospital services, subsection a.(2) of this section,  
44 shall only be provided to eligible medically needy individuals if the  
45 federal Department of Health and Human Services discontinues the  
46 State's waiver to establish outpatient hospital reimbursement rates  
47 for the Medicare and Medicaid programs under the authority of  
48 section 601(c)(3) of the Social Security Amendments of 1983,

1 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital  
2 services may be extended to all or to certain medically needy  
3 individuals if the federal Department of Health and Human Services  
4 directs that these services be included. However, the use of  
5 outpatient hospital services shall be limited to clinic services and to  
6 emergency room services for injuries and significant acute medical  
7 conditions.

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

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

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

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

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

31 (cf: P.L.2023, c.8, s.11)】<sup>1</sup>

32

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

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

40 (1) Inpatient hospital services

41 (2) Outpatient hospital services;

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

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

44 (b) Early and periodic screening and diagnosis of individuals  
45 who are eligible under the program and are under age 21, to  
46 ascertain their physical or mental health status and the health care,  
47 treatment, and other measures to correct or ameliorate defects and  
48 chronic conditions discovered thereby, as may be provided in

1 regulation of the Secretary of the federal Department of Health and  
2 Human Services and approved by the commissioner;

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

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

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

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

21 (2) Home health care services;

22 (3) Clinic services;

23 (4) Dental services;

24 (5) Physical therapy and related services;

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

28 (7) Optometric services;

29 (8) Podiatric services;

30 (9) Chiropractic services;

31 (10) Psychological services;

32 (11) Inpatient psychiatric hospital services for individuals under  
33 21 years of age, or under age 22 if they are receiving such services  
34 immediately before attaining age 21;

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

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

40 (14) Intermediate care facility services;

41 (15) Transportation services;

42 (16) Services in connection with the inpatient or outpatient  
43 treatment or care of substance use disorder, when the treatment is  
44 prescribed by a physician and provided in a licensed hospital or in a  
45 narcotic and substance use disorder treatment center approved by  
46 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21  
47 et. seq.) and whose staff includes a medical director, and limited

1 those services eligible for federal financial participation under Title  
2 XIX of the federal Social Security Act;

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

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

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

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

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

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

44 (d) For patients admitted to the inpatient unit of an inpatient  
45 hospice care program licensed pursuant to P.L.1997, c.78 (C.26:2H-  
46 79 et seq.), the reimbursement rate provided in subparagraph (b) of  
47 this paragraph shall apply to days of care during which the patient is  
48 on the routine level of hospice care, as that level of care is defined

1 for the purposes of the federal Medicaid program, as well as to any  
2 days during which the patient is no longer receiving hospice care  
3 services from the program but continues to reside with the program  
4 pending transfer to another facility;

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

1 Certification of Nutrition Specialists, who is familiar with the  
2 components of diabetes medical 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  
5 the standards of the National Diabetes Prevention Program, as  
6 established by the federal Centers for Disease Control and  
7 Prevention; and

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

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

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

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

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

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

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

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

46 (a) the infant is medically or physically unable to receive  
47 maternal breast milk or participate in breast feeding, or the infant's  
48 mother is medically or physically unable to produce maternal breast

1 milk in sufficient quantities or participate in breast feeding despite  
2 optimal lactation support; or

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

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

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

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

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

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

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

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

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

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

14 (27) (a) Within 24 months of the effective date of P.L.2023,  
15 c.187 (C.30:4D-6u et al.), and conditional on the receipt of all  
16 necessary federal approvals and the securing of federal financial  
17 participation pursuant to section 2 of P.L.2023, c.187 (C.30:4D-6u),  
18 community-based palliative care benefits which shall include, but  
19 not be limited to, all of the following:

20 (i) specialized medical care and emotional and spiritual support  
21 for beneficiaries with serious advanced illnesses;

22 (ii) relief of symptoms, pain, and stress of serious illness;

23 (iii) improvement of quality of life for both the beneficiary and  
24 the beneficiary's family; and

25 (iv) appropriate care for any age and for any stage of serious  
26 illness, along with curative treatment.

27 (b) Benefits provided under this paragraph shall include, but  
28 shall not be limited to, services provided by a hospice pursuant to  
29 paragraph (20) of subsection b. of this section, provided that:

30 (i) hospice services may be provided at the same time that  
31 curative treatment is available, to the extent that services are not  
32 duplicative;

33 (ii) hospice services may be provided to beneficiaries whose  
34 conditions may result in death, regardless of the estimated length of  
35 the beneficiary's remaining period of life; and

36 (iii) the Division of Medical Assistance and Health Services in  
37 the Department of Human Services may include any other service  
38 deemed appropriate under the benefits provided under this  
39 paragraph.

40 (c) Providers authorized to deliver benefits provided under this  
41 paragraph shall include Medicaid-approved licensed hospice  
42 agencies, Medicaid-approved home health agencies licensed to  
43 provide hospice care, and other Medicaid-approved licensed health  
44 care providers.

45 (d) Nothing in this paragraph shall be construed to result in the  
46 elimination or reduction of covered benefits or services under the  
47 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,

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

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

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

20 (3) Notwithstanding any provision of law to the contrary, the  
21 provisions of paragraph (2) of this subsection shall not apply to a  
22 trust agreement that is established pursuant to 42 U.S.C.  
23 s.1396p(d)(4)(A) or (C) to supplement and augment assistance  
24 provided by government entities to a person who is disabled as  
25 defined in section 1614(a)(3) of the federal Social Security Act (42  
26 31 U.S.C. s.1382c (a)(3)).

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

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

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

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

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

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

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

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

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

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

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

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

48 (cf: P.L.2023, c.187, s.1)

**S2920 [1R] BRAMNICK**

20

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

6

7       3. This act shall take effect immediately.