

**30:4D-6; 30:4D-6u and 30:4D-6v
LEGISLATIVE HISTORY CHECKLIST**

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LAWS OF: 2023 **CHAPTER:** 187

NJSA: 30:4D-6; 30:4D-6u and 30:4D-6v Provides for coverage of community-based palliative care benefits under Medicaid.

BILL NO: A5225 (Substituted for S3729 (2R))

SPONSOR(S) McKnight, Angela V. and others

DATE INTRODUCED: 2/23/2023

COMMITTEE: **ASSEMBLY:** Aging & Senior Services
Health
Appropriations

SENATE: --

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 12/07/2023

SENATE: 12/11/2023

DATE OF APPROVAL: 12/21/2023

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (A5225 AcaAca w/GR (3R) enacted)	Yes	
A5225		
INTRODUCED BILL: (Includes sponsor(s) statement)	Yes	
COMMITTEE STATEMENT: ASSEMBLY:	Yes	Aging & Senior Services Health Appropriations
SENATE:	No	

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, *may possibly* be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT:	No	
LEGISLATIVE FISCAL ESTIMATE:	Yes	
S3729 (2R)		
INTRODUCED BILL: (Includes sponsor(s) statement)	Yes	
COMMITTEE STATEMENT: ASSEMBLY:	No	
SENATE:	Yes	Health, Human Services & Sr. Citizens Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, **may possibly** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes 06/21/2023
07/06/2023

VETO MESSAGE: Yes

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: No

CL/JA

P.L. 2023, CHAPTER 187, *approved December 21, 2023*
Assembly, No. 5225 (*Third Reprint*)

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:

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.

³Assembly amendments adopted in accordance with Governor's recommendations November 30, 2023.

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

1 and shortly after childbirth, to help her to achieve the healthiest,
2 most satisfying experience possible;

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

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

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

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

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

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

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

47 (b) Expenses for medical nutrition therapy as an effective
48 component of the person's overall treatment plan upon a: diagnosis

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

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

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

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

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

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

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

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

39 (c) no more than 10 group prenatal care visits occur per
40 pregnancy.

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

46 (24) Expenses incurred for the provision of pasteurized donated
47 human breast milk, which shall include human milk fortifiers if
48 indicated in a medical order provided by a licensed medical

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (3) the Division of Medical Assistance and Health Services in
28 the Department of Human Services may include any other service
29 deemed appropriate under the benefits provided under the
30 paragraph.

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

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

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

42 c. Payments for the foregoing services, goods, and supplies
43 furnished pursuant to this act shall be made to the extent authorized
44 by this act, the rules and regulations promulgated pursuant thereto
45 and, where applicable, subject to the agreement of insurance
46 provided for under this act. The payments shall constitute payment
47 in full to the provider on behalf of the recipient. Every provider
48 making a claim for payment pursuant to this act shall certify in

1 writing on the claim submitted that no additional amount will be
2 charged to the recipient, the recipient's family, the recipient's
3 representative or others on the recipient's behalf for the services,
4 goods, and supplies furnished pursuant to this act.

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

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

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

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

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

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

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

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

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

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

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

18 (1) Pregnant women shall be provided prenatal care and delivery
19 services and postpartum care, including the services cited in
20 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
21 (10), (12), (15), and (17) of this section, and nursing facility
22 services cited in subsection b.(13) of this section.

23 (2) Dependent children shall be provided with services cited in
24 subsections a.(3) and (5) of this section and subsections b.(1), (2),
25 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
26 nursing facility services cited in subsection b.(13) of this section.

27 (3) Individuals who are 65 years of age or older shall be
28 provided with services cited in subsections a.(3) and (5) of this
29 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
30 (7), (8), (10), (12), (15), and (17) of this section, and nursing
31 facility services cited in subsection b.(13) of this section.

32 (4) Individuals who are blind or disabled shall be provided with
33 services cited in subsections a.(3) and (5) of this section and
34 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
35 (12), (15), and (17) of this section, and nursing facility services
36 cited in subsection b.(13) of this section.

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

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

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

16 h. In the case of a qualified disabled and working individual
17 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
18 only medical assistance provided under this act shall be the
19 payment of premiums for Medicare part A under 42 U.S.C.
20 ss.1395i-2 and 1395r.

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

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

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

37 (cf: P.L.2019, c.473, s.1) **1**

38

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

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

- 46 (1) Inpatient hospital services
- 47 (2) Outpatient hospital services;
- 48 (3) Other laboratory and X-ray services;

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

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

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

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

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

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

26 (2) Home health care services;

27 (3) Clinic services;

28 (4) Dental services;

29 (5) Physical therapy and related services;

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

33 (7) Optometric services;

34 (8) Podiatric services;

35 (9) Chiropractic services;

36 (10) Psychological services;

37 (11) Inpatient psychiatric hospital services for individuals under
38 21 years of age, or under age 22 if they are receiving such services
39 immediately before attaining age 21;

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

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

45 (14) Intermediate care facility services;

46 (15) Transportation services;

47 (16) Services in connection with the inpatient or outpatient
48 treatment or care of substance use disorder, when the treatment is

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

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

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

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

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

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

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

46 (a) Expenses for diabetes self-management education or training
47 to ensure that a person with diabetes, gestational diabetes, or pre-
48 diabetes can optimize metabolic control, prevent and manage

1 complications, and maximize quality of life. Diabetes self-
2 management education shall be provided by an in-State provider who
3 is:

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

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

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

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

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

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

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

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

1 (ii) incorporates the applicable information outlined in any best
2 practices manual for prenatal and postpartum maternal care developed
3 by the Department of Health into the curriculum for each group
4 prenatal visit;

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

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

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

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

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

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

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

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

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

46 (a) Information regarding the availability of the tobacco cessation
47 services described in this paragraph shall be provided to all individuals
48 authorized to receive the tobacco cessation services pursuant to this

1 paragraph at the following times: no later than 90 days after the
 2 effective date of P.L.2019, c.473: upon the establishment of an
 3 individual's eligibility for medical assistance; and upon the
 4 redetermination of an individual's eligibility for medical assistance;

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

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

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

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

34 (27) (a) ³**[Community-based]** Within 24 months of the effective
 35 date of P.L. , c. (C.) (pending before the Legislature as this
 36 bill), and conditional on the receipt of all necessary federal
 37 approvals and the securing of federal financial participation
 38 pursuant to section 2 of P.L. , c. (C.) (pending before the
 39 Legislature as this bill), community-based³ palliative care benefits
 40 which shall include, but not be limited to, all of the following:

41 ²**[(1)]** (i)² specialized medical care and emotional and spiritual
 42 support for beneficiaries with serious advanced illnesses;

43 ²**[(2)]** (ii)² relief of symptoms, pain, and stress of serious illness;

44 ²**[(3)]** (iii)² improvement of quality of life for both the beneficiary
 45 and the beneficiary's family; and

46 ²**[(4)]** (iv)² appropriate care for any age and for any stage of
 47 serious illness, along with curative treatment.

1 **(b) Benefits provided under this paragraph shall include ², but**
2 **shall not be limited to, ² services provided by a hospice pursuant to**
3 **paragraph (20) of subsection b. of this section, provided that:**

4 **²[(1)] (i) ² hospice services may be provided at the same time that**
5 **curative treatment is available, to the extent that services are not**
6 **duplicative;**

7 **²[(2)] (ii) ² hospice services may be provided to beneficiaries**
8 **whose conditions may result in death, regardless of the estimated**
9 **length of the beneficiary's remaining period of life; and**

10 **²[(3)] (iii) ² the Division of Medical Assistance and Health**
11 **Services in the Department of Human Services may include any other**
12 **service deemed appropriate under the benefits provided under ²[the]**
13 **this ² paragraph.**

14 **(c) Providers authorized to deliver benefits provided under this**
15 **paragraph shall include Medicaid-approved licensed hospice agencies**
16 **²[and] , Medicaid-approved ² home health agencies licensed to**
17 **provide hospice care ², and other Medicaid-approved licensed health**
18 **care providers ².**

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, any**
24 **services, including home health services, for which the beneficiary**
25 **would have been eligible in the absence of this paragraph, to the extent**
26 **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 by
29 this act, the rules and regulations promulgated pursuant thereto and,
30 where applicable, subject to the agreement of insurance provided for
31 under this act. The payments shall constitute payment in full to the
32 provider on behalf of the recipient. Every provider making a claim for
33 payment pursuant to this act shall certify in writing on the claim
34 submitted that no additional amount will be charged to the recipient,
35 the recipient's family, the recipient's representative or others on the
36 recipient's behalf for the services, goods, and supplies furnished
37 pursuant to this act.

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

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

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

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

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

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

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

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

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

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

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

1 (1) Pregnant women shall be provided prenatal care and delivery
2 services and postpartum care, including the services cited in
3 subsections a.(1), (3), and (5) of this section and subsections b.(1)-
4 (10), (12), (15), and (17) of this section, and nursing facility services
5 cited in subsection b.(13) of this section.

6 (2) Dependent children shall be provided with services cited in
7 subsections a.(3) and (5) of this section and subsections b.(1), (2), (3),
8 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing
9 facility services cited in subsection b.(13) of this section.

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

15 (4) Individuals who are blind or disabled shall be provided with
16 services cited in subsections a.(3) and (5) of this section and
17 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), 3
18 (12), (15), and (17) of this section, and nursing facility services cited
19 in subsection b.(13) of this section.

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

30 (b) Outpatient hospital services, subsection a.(2) of this section,
31 shall only be provided to eligible medically needy individuals if the
32 federal Department of Health and Human Services discontinues the
33 State's waiver to establish outpatient hospital reimbursement rates for
34 the Medicare and Medicaid programs under the authority of section
35 601(c)(3) of the Social Security Amendments of 1983, Pub.L.98-21
36 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital services may be
37 extended to all or to certain medically needy individuals if the federal
38 Department of Health and Human Services directs that these services
39 be included. However, the use of outpatient hospital services shall be
40 limited to clinic services and to emergency room services for injuries
41 and significant acute medical conditions.

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

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

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

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

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

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

18
19 2. (New section) The Commissioner of Human Services shall
20 apply for such State plan amendments or waivers as may be
21 necessary to implement the provisions of this act and to secure
22 federal financial participation for State Medicaid expenditures
23 under the federal Medicaid program. ³Coverage to eligible
24 beneficiaries of the community-based palliative care benefit
25 established by the amendments made by section 1 of P.L. _____, c.
26 (C. _____) (pending before the Legislature as this bill) to section 6 of
27 P.L.1968, c.413 (C.30:4D-6) shall be contingent on securing federal
28 financial participation pursuant to this section.³

29
30 3. (New section) The Commissioner of Human Services shall
31 adopt rules and regulations pursuant to the "Administrative Procedure
32 Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes
33 of this act including guidance on the medical conditions and prognoses
34 that render a beneficiary eligible for community-based palliative care
35 services.

36
37 4. This act shall take effect immediately.

38
39
40 _____
41
42 Provides for coverage of community-based palliative care
43 benefits under Medicaid.

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)

Assemblywoman CAROL A. MURPHY

District 7 (Burlington)

Co-Sponsored by:

Assemblyman Stanley

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 2/23/2023)

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. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
8 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;

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.

- 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, preventive, and rehabilitative
13 services, and other remedial care;
- 14 (13) Inpatient hospital services, nursing facility services, and
15 intermediate 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 to
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 Obstetricians and Gynecologists; 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) Services provided by a hospice which is participating in the
2 Medicare program established pursuant to Title XVIII of the Social
3 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
4 services shall be provided subject to approval of the Secretary of
5 the federal Department of Health and Human Services for federal
6 reimbursement;

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

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

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

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

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

40 (b) Expenses for medical nutrition therapy as an effective
41 component of the person's overall treatment plan upon a: diagnosis
42 of diabetes, gestational diabetes, or pre-diabetes; change in the
43 beneficiary's medical condition, treatment, or diagnosis; or
44 determination of a physician, advanced practice nurse, or physician
45 assistant that reeducation or refresher education is necessary.
46 Medical nutrition therapy shall be provided by an in-State provider
47 who is a dietitian registered by a nationally-recognized professional
48 association of dietitians, or a nutritionist holding a certified
49 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 care
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
21 is 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
29 duration, with a minimum of two women and a maximum of 20
30 women in participation; and

31 (c) no more than 10 group prenatal care visits occur per
32 pregnancy.

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

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; and

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

1 this act; provided, however, a provider may seek reimbursement
2 from a recipient for services, goods, or supplies not authorized by
3 this act, if the recipient elected to receive the services, goods or
4 supplies with the knowledge that they were not authorized.

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

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

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

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

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

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

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

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

47 (3) Notwithstanding any provision of law to the contrary, the
48 provisions of paragraph (2) of this subsection shall not apply to a
49 trust agreement that is established pursuant to 42 U.S.C.

1 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
2 provided by government entities to a person who is disabled as
3 defined in section 1614(a)(3) of the federal Social Security Act (42
4 U.S.C. s.1382c (a)(3)).

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

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

12 (2) Dependent children shall be provided with services cited in
13 subsections a.(3) and (5) of this section and subsections b.(1), (2),
14 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
15 nursing facility services cited in subsection b.(13) of this section.

16 (3) Individuals who are 65 years of age or older shall be
17 provided with services cited in subsections a.(3) and (5) of this
18 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
19 (7), (8), (10), (12), (15), and (17) of this section, and nursing
20 facility services cited in subsection b.(13) of this section.

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

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

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

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

3 h. In the case of a qualified disabled and working individual
4 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
5 only medical assistance provided under this act shall be the
6 payment of premiums for Medicare part A under 42 U.S.C.
7 ss.1395i-2 and 1395r.

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

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

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

24 (cf: P.L.2019, c.473, s.1)

25
26 2. (New section) The Commissioner of Human Services shall
27 apply for such State plan amendments or waivers as may be necessary
28 to implement the provisions of this act and to secure federal financial
29 participation for State Medicaid expenditures under the federal
30 Medicaid program.

31
32 3. (New section) The Commissioner of Human Services shall
33 adopt rules and regulations pursuant to the "Administrative Procedure
34 Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes
35 of this act including guidance on the medical conditions and prognoses
36 that render a beneficiary eligible for community-based palliative care
37 services.

38
39 4. This act shall take effect immediately.
40
41

42 STATEMENT

43
44 This bill provides coverage for community-based palliative care
45 benefits under the Medicaid program. The purpose of palliative
46 care is to bring comfort and relief from a serious, progressive
47 illness that may or may not be life-limiting.

48 Currently, Medicaid covers services provided by a hospice. As
49 defined in regulation, a hospice is primarily engaged in providing

1 supportive or palliative care and services, as well as any other item
2 or service specified in the beneficiary's plan of care. Hospice
3 providers in New Jersey may be hospital-based, home health
4 agencies, or hospice agencies.

5 However, in order to be eligible for hospice services, a Medicaid
6 beneficiary, among other things, must be certified with a medical
7 prognosis that provides a life expectancy of six months or less and,
8 for Medicaid beneficiaries 21 years of age or older, must waive all
9 rights to curative treatment, or services that are related to the
10 treatment of that terminal condition.

11 The purpose of this bill is to provide Medicaid beneficiaries
12 palliative care services outside of hospice, and without a six-month
13 time requirement of a terminal illness or a requirement to forgo
14 curative care. Thus, this benefit can reimburse for interdisciplinary
15 palliative care teams to support individuals with serious illness
16 throughout the continuum of care and not only at end of life. In
17 recent years, several states, such as California, Hawaii, Maine,
18 Oregon, and Colorado, have developed a Medicaid community-
19 based palliative care benefit to promote positive outcomes, and
20 avoid costly, unnecessary, and often unwanted treatment, for people
21 with serious illness.

22 Specifically, under the bill, the Medicaid community-based
23 palliative care benefit is to include, but not be limited to, all of the
24 following:

- 25 1) specialized medical care and emotional and spiritual support
26 for beneficiaries with serious advanced illnesses;
- 27 2) relief of symptoms, pain, and stress of serious illness;
- 28 3) improvement of quality of life for both the beneficiary and
29 the beneficiary's family; and
- 30 4) appropriate care for any age and for any stage of serious
31 illness, along with curative treatment.

32 The Medicaid community-based palliative care benefit is to
33 include services provided by a hospice pursuant to existing law,
34 provided that:

- 35 1) hospice services may be provided at the same time that
36 curative treatment is available, to the extent that services are not
37 duplicative;
- 38 2) hospice services may be provided to beneficiaries whose
39 conditions may result in death, regardless of the estimated length of
40 the beneficiary's remaining period of life; and
- 41 3) the Division of Medical Assistance and Health Services in
42 the Department of Human Services may include any other service
43 deemed appropriate under the benefits provided under the
44 paragraph.

45 Providers authorized to deliver the Medicaid community-based
46 palliative care benefit include Medicaid-approved licensed hospice
47 agencies and home health agencies licensed to provide hospice care.
48 Nothing in the bill is to be construed to result in the elimination or
49 reduction of covered benefits or services under Medicaid.

1 Moreover, the bill explicitly states that its provisions are not to
2 affect a beneficiary's eligibility to receive, concurrently with
3 community-based palliative care services, any services, including
4 home health services, for which the beneficiary would have been
5 eligible in the absence of the bill, to the extent that services are not
6 duplicative.

7 The bill directs the Commissioner of Human Services to: 1) apply
8 for such State plan amendments or waivers as may be necessary to
9 implement the provisions of the bill and to secure federal financial
10 participation for State Medicaid expenditures under the federal
11 Medicaid program; and 2) adopt rules and regulations to effectuate the
12 purposes of the bill, including guidance on the medical conditions and
13 prognoses that render a beneficiary eligible for the community-based
14 palliative care benefit.

ASSEMBLY AGING AND SENIOR SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 5225

STATE OF NEW JERSEY

with committee amendments

DATED: MARCH 30, 2023

The Assembly Aging and Senior Services Committee reports favorably and with committee amendments Assembly Bill No. 5225.

This bill provides coverage for community-based palliative care benefits under the Medicaid program. Currently, Medicaid covers services provided by a hospice. However, in order to be eligible for hospice services, a Medicaid beneficiary, among other things, must be certified with a medical prognosis that provides a life expectancy of six months or less and, for Medicaid beneficiaries 21 years of age or older, must waive all rights to curative treatment, or services that are related to the treatment of that terminal condition.

Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

The Medicaid community-based palliative care benefit is to include services provided by a hospice pursuant to existing law, provided that:

- 1) hospice services may be provided at the same time that curative treatment is available, to the extent that services are not duplicative;
- 2) hospice services may be provided to beneficiaries whose conditions may result in death, regardless of the estimated length of the beneficiary's remaining period of life; and
- 3) the Division of Medical Assistance and Health Services in the Department of Human Services may include any other service deemed appropriate under the benefits provided under the paragraph.

Providers authorized to deliver the Medicaid community-based palliative care benefit include Medicaid-approved licensed hospice agencies and home health agencies licensed that provide hospice care. Nothing in the bill is to be construed to result in the elimination or reduction of covered benefits or services under Medicaid. Moreover, the bill explicitly states that its provisions are not to affect a

beneficiary's eligibility to receive, concurrently with community-based palliative care services, any services, including home health services, for which the beneficiary would have been eligible in the absence of the bill, to the extent that services are not duplicative.

COMMITTEE AMENDMENTS:

The committee amendments make technical changes to the bill to update the underlying law to reflect current statutes.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 5225

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 18, 2023

The Assembly Health Committee reports favorably and with committee amendments Assembly Bill No. 5225 (1R).

As amended by the committee, this bill provides coverage for community-based palliative care benefits under the Medicaid program. Currently, Medicaid covers services provided by a hospice. However, in order to be eligible for hospice services, a Medicaid beneficiary, among other things, must be certified with a medical prognosis that provides a life expectancy of six months or less and, for Medicaid beneficiaries 21 years of age or older, must waive all rights to curative treatment, or services that are related to the treatment of that terminal condition.

Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

The Medicaid community-based palliative care benefit is to include services provided by a hospice pursuant to existing law, provided that:

- 1) hospice services may be provided at the same time that curative treatment is available, to the extent that services are not duplicative;
- 2) hospice services may be provided to beneficiaries whose conditions may result in death, regardless of the estimated length of the beneficiary's remaining period of life; and
- 3) the Division of Medical Assistance and Health Services in the Department of Human Services may include any other service deemed appropriate under the benefits provided in the bill.

Providers authorized to deliver the Medicaid community-based palliative care benefit include Medicaid-approved licensed hospice agencies and home health agencies licensed that provide hospice care.

Nothing in the bill is to be construed to result in the elimination or reduction of covered benefits or services under Medicaid. Moreover, the bill explicitly states that its provisions are not to affect a beneficiary's eligibility to receive, concurrently with community-based palliative care services, any services, including home health services, for which the beneficiary would have been eligible in the absence of the bill, to the extent that services are not duplicative.

COMMITTEE AMENDMENTS:

The committee amendments provide that community-based palliative benefits are to include services provided by Medicaid-approved licensed hospice agencies, Medicaid-approved home health agencies licensed to provide hospice care, and other Medicaid-approved licensed health care providers. The amendments also make technical changes to the bill involving numbering and usage.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[Second Reprint]
ASSEMBLY, No. 5225

STATE OF NEW JERSEY

DATED: JUNE 22, 2023

The Assembly Appropriations Committee reports favorably Assembly Bill No, 5225 (2R).

This bill provides coverage for community-based palliative care benefits under the Medicaid program. Currently, Medicaid covers services provided by a hospice. However, in order to be eligible for hospice services, a Medicaid beneficiary, among other things, must be certified with a medical prognosis that provides a life expectancy of six months or less and, for Medicaid beneficiaries 21 years of age or older, must waive all rights to curative treatment, or services that are related to the treatment of that terminal condition.

Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

The Medicaid community-based palliative care benefit is to include services provided by a hospice pursuant to existing law, provided that:

- 1) hospice services may be provided at the same time that curative treatment is available, to the extent that services are not duplicative;
- 2) hospice services may be provided to beneficiaries whose conditions may result in death, regardless of the estimated length of the beneficiary's remaining period of life; and
- 3) the Division of Medical Assistance and Health Services in the Department of Human Services may include any other service deemed appropriate under the benefits provided in the bill.

Providers authorized to deliver the Medicaid community-based palliative care benefit include Medicaid-approved licensed hospice agencies and home health agencies licensed that provide hospice care. Nothing in the bill is to be construed to result in the elimination or reduction of covered benefits or services under Medicaid. Moreover, the bill explicitly states that its provisions are not to affect a

beneficiary's eligibility to receive, concurrently with community-based palliative care services, any services, including home health services, for which the beneficiary would have been eligible in the absence of the bill, to the extent that services are not duplicative.

FISCAL IMPACT:

The Office of Legislative Services (OLS) determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million.

The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures.

This estimate assumes the annual uptake of the benefit will be 56,062 Medicaid beneficiaries, or 2.5 percent of Medicaid enrollment, with a net combined State and federal cost savings per beneficiary between \$6,696 and \$9,936 per year.

LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

ASSEMBLY, No. 5225

STATE OF NEW JERSEY 220th LEGISLATURE

DATED: JUNE 21, 2023

SUMMARY

- Synopsis:** Provides for coverage of community-based palliative care benefits under Medicaid.
- Type of Impact:** Countervailing impact on State expenditures and revenue; General Fund.
- Agencies Affected:** Department of Human Services.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State Cost Savings	\$375.7 million to \$563.5 million
State Revenue Loss	\$244.2 million to \$366.3 million

- The Office of Legislative Services (OLS) determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million.
- The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures.
- This estimate assumes the annual uptake of the benefit will be 56,062 Medicaid beneficiaries, or 2.5 percent of Medicaid enrollment, with a net combined State and federal cost savings per beneficiary between \$6,696 and \$9,936 per year.

BILL DESCRIPTION

This bill provides coverage for community-based palliative care benefits under the Medicaid program. Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

Providers authorized to deliver the Medicaid community-based palliative care benefit will include Medicaid-approved licensed hospice agencies, Medicaid-approved home health agencies, and other Medicaid-approved licensed health care providers.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million. The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures. This estimate assumes an aggregate federal Medicaid matching rate across all Medicaid eligibility groups of 65 percent.

This estimate is based upon a study prepared by the National Academy for State Health Policy, which indicated that the effective administration of a Medicaid palliative care benefit for the highest service utilizers could produce cost avoidance savings ranging between \$231 and \$1,165 per Medicaid beneficiary per month. For the purposes of this estimate, the OLS assumes 20 percent above and below the midpoint of this range, or \$558 to \$828, as the cost avoidance savings. This study concludes that cost savings under the palliative care benefit is associated with a reduced number of hospital readmissions experienced by those utilizing the palliative care services. Preliminary analysis of California's implementation of a community-based palliative care benefit affirms the National Academy for State Health Policy's study and shows that when comparing a member's total cost of care prior to and after enrollment in the palliative care benefit, reductions in costs are between 42 and 51 percent, with the majority of the cost reduction occurring for hospital-related expenditures.

At present, four percent of all Americans have a serious illness. For reference, examples of serious illness include, but are not limited to: cancer, heart failure, chronic obstructive pulmonary disease, Alzheimer's disease, Parkinson's disease, multiple sclerosis, AIDS, and amyotrophic lateral sclerosis (ALS). Assuming seven percent of the existing State Medicaid population, an increase to the base national rate due to the higher prevalence of chronic illness among Medicaid beneficiaries, provides that 160,176 Medicaid beneficiaries in the State have a serious illness. This estimate further assumes that only 35 percent of these beneficiaries, or 56,062, would seek community-based palliative care services under this bill as the National Academy for State Health Policy indicates that successful home-based palliative care programs cite an engagement rate of 35 percent.

The OLS further notes several variables that may affect this estimate, such as: the administrative costs associated with implementing the benefit; the unpredictability of benefit uptake; the reimbursement rate established for the benefit following enactment; the length of time services are provided per beneficiary; and provider capacity to deliver community-based palliative care services to beneficiaries.

Section: Human Services

*Analyst: Sarah Schmidt
Lead Research Analyst*

*Approved: Thomas Koenig
Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

SENATE, No. 3729

STATE OF NEW JERSEY
220th LEGISLATURE

INTRODUCED MARCH 16, 2023

Sponsored by:

Senator RICHARD J. CODEY

District 27 (Essex and Morris)

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.



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. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
8 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;

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.

S3729 CODEY

- 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, preventive, and rehabilitative
13 services, and other remedial care;
- 14 (13) Inpatient hospital services, nursing facility services, and
15 intermediate 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 to
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 Obstetricians and Gynecologists; 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) Services provided by a hospice which is participating in the
2 Medicare program established pursuant to Title XVIII of the Social
3 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
4 services shall be provided subject to approval of the Secretary of
5 the federal Department of Health and Human Services for federal
6 reimbursement;

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

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

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

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

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

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

1 nutritionist specialist (CNS) credential from the Board for
2 Certification of Nutrition Specialists, who is familiar with the
3 components of diabetes medical nutrition therapy;

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

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

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

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

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

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

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

32 (c) no more than 10 group prenatal care visits occur per
33 pregnancy.

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

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

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

1 mother is medically or physically unable to produce maternal breast
2 milk in sufficient quantities or participate in breast feeding despite
3 optimal lactation support; or

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

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

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

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

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

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

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

42 (c) Prior authorization requirements shall not be imposed on any
43 tobacco cessation services provided pursuant to this paragraph
44 except in the following circumstances where prior authorization
45 may be required: for a treatment that exceeds the duration
46 recommended by the most recently published United States Public
47 Health Service clinical practice guidelines on treating tobacco use

1 and dependence; or for services associated with more than two
2 attempts to quit within a 12-month period; and

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

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

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

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

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

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

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

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

21 (3) the Division of Medical Assistance and Health Services in
22 the Department of Human Services may include any other service
23 deemed appropriate under the benefits provided under the
24 paragraph.

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

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

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

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

47 No provider whose claim for payment pursuant to this act has
48 been denied because the services, goods, or supplies were

1 determined to be medically unnecessary shall seek reimbursement
2 from the recipient, his family, his representative or others on his
3 behalf for such services, goods, and supplies provided pursuant to
4 this act; provided, however, a provider may seek reimbursement
5 from a recipient for services, goods, or supplies not authorized by
6 this act, if the recipient elected to receive the services, goods or
7 supplies with the knowledge that they were not authorized.

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

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

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

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

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

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

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

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

1 and void, and no payments shall be made under this act as a result
2 of any such 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
5 trust agreement that is established pursuant to
6 42 U.S.C. s.1396p(d)(4)(A) or (C) to supplement and augment
7 assistance provided by government entities to a person who is
8 disabled as defined in section 1614(a)(3) of the federal Social
9 Security Act (42 U.S.C. s.1382c (a)(3)).

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

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

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

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

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

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

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

1 services may be extended to all or to certain medically needy
2 individuals if the federal Department of Health and Human Services
3 directs that these services be included. However, the use of
4 outpatient hospital services shall be limited to clinic services and to
5 emergency room services for injuries and significant acute medical
6 conditions.

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

9 h. In the case of a qualified disabled and working individual
10 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
11 only medical assistance provided under this act shall be the
12 payment of premiums for Medicare part A under 42 U.S.C.
13 ss.1395i-2 and 1395r.

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

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

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

30 (cf: P.L.2019, c.473, s.1)

31

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

37

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

44

45 4. This act shall take effect immediately.

STATEMENT

1

2

3 This bill provides coverage for community-based palliative care
4 benefits under the Medicaid program. The purpose of palliative
5 care is to bring comfort and relief from a serious, progressive
6 illness that may or may not be life-limiting.

7 Currently, Medicaid covers services provided by a hospice. As
8 defined in regulation, a hospice is primarily engaged in providing
9 supportive or palliative care and services, as well as any other item
10 or service specified in the beneficiary's plan of care. Hospice
11 providers in New Jersey may be hospital-based, home health
12 agencies, or hospice agencies.

13 However, in order to be eligible for hospice services, a Medicaid
14 beneficiary, among other things, must be certified with a medical
15 prognosis that provides a life expectancy of six months or less and,
16 for Medicaid beneficiaries 21 years of age or older, must waive all
17 rights to curative treatment, or services that are related to the
18 treatment of that terminal condition.

19 The purpose of this bill is to provide Medicaid beneficiaries
20 palliative care services outside of hospice, and without a six-month
21 time requirement of a terminal illness or a requirement to forgo
22 curative care. Thus, this benefit can reimburse for interdisciplinary
23 palliative care teams to support individuals with serious illness
24 throughout the continuum of care and not only at end of life. In
25 recent years, several states, such as California, Hawaii, Maine,
26 Oregon, and Colorado, have developed a Medicaid community-
27 based palliative care benefit to promote positive outcomes, and
28 avoid costly, unnecessary, and often unwanted treatment, for people
29 with serious illness.

30 Specifically, under the bill, the Medicaid community-based
31 palliative care benefit is to include, but not be limited to, all of the
32 following:

- 33 1) specialized medical care and emotional and spiritual support
34 for beneficiaries with serious advanced illnesses;
35 2) relief of symptoms, pain, and stress of serious illness;
36 3) improvement of quality of life for both the beneficiary and
37 the beneficiary's family; and
38 4) appropriate care for any age and for any stage of serious
39 illness, along with curative treatment.

40 The Medicaid community-based palliative care benefit is to
41 include services provided by a hospice pursuant to existing law,
42 provided that:

- 43 1) hospice services may be provided at the same time that
44 curative treatment is available, to the extent that services are not
45 duplicative;
46 2) hospice services may be provided to beneficiaries whose
47 conditions may result in death, regardless of the estimated length of
48 the beneficiary's remaining period of life; and

1 3) the Division of Medical Assistance and Health Services in
2 the Department of Human Services may include any other service
3 deemed appropriate under the benefits provided under the
4 paragraph.

5 Providers authorized to deliver the Medicaid community-based
6 palliative care benefit include Medicaid-approved licensed hospice
7 agencies and home health agencies licensed to provide hospice care.
8 Nothing in the bill is to be construed to result in the elimination or
9 reduction of covered benefits or services under Medicaid.
10 Moreover, the bill explicitly states that its provisions are not to
11 affect a beneficiary's eligibility to receive, concurrently with
12 community-based palliative care services, any services, including
13 home health services, for which the beneficiary would have been
14 eligible in the absence of the bill, to the extent that services are not
15 duplicative.

16 The bill directs the Commissioner of Human Services to: 1) apply
17 for such State plan amendments or waivers as may be necessary to
18 implement the provisions of the bill and to secure federal financial
19 participation for State Medicaid expenditures under the federal
20 Medicaid program; and 2) adopt rules and regulations to effectuate the
21 purposes of the bill, including guidance on the medical conditions and
22 prognoses that render a beneficiary eligible for the community-based
23 palliative care benefit.

SENATE HEALTH, HUMAN SERVICES AND SENIOR
CITIZENS COMMITTEE

STATEMENT TO
SENATE, No. 3729

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 11, 2023

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 3729.

This bill provides coverage for community-based palliative care benefits under the Medicaid program. Currently, Medicaid covers services provided by a hospice. However, in order to be eligible for hospice services, a Medicaid beneficiary, among other things, must be certified with a medical prognosis that provides a life expectancy of six months or less and, for Medicaid beneficiaries 21 years of age or older, must waive all rights to curative treatment, or services that are related to the treatment of that terminal condition.

Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

The Medicaid community-based palliative care benefit is to include services provided by a hospice pursuant to existing law, provided that:

- 1) hospice services may be provided at the same time that curative treatment is available, to the extent that services are not duplicative;
- 2) hospice services may be provided to beneficiaries whose conditions may result in death, regardless of the estimated length of the beneficiary's remaining period of life; and
- 3) the Division of Medical Assistance and Health Services in the Department of Human Services may include any other service deemed appropriate under the community-based palliative care benefit.

Providers authorized to deliver the Medicaid community-based palliative care benefit will include Medicaid-approved licensed hospice agencies and home health agencies licensed to provide hospice

care. Nothing in the bill is to be construed to result in the elimination or reduction of covered benefits or services under Medicaid. Moreover, the bill explicitly states that its provisions are not to affect a beneficiary's eligibility to receive, concurrently with community-based palliative care services, any services, including home health services, for which the beneficiary would have been eligible in the absence of the bill, to the extent that services are not duplicative.

COMMITTEE AMENDMENTS:

The committee amendments make technical changes to the bill to update the underlying law to reflect current statutes, correct a numbering issue, and fix a typographical error.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 3729

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 27, 2023

The Senate Budget and Appropriations Committee reports favorably and with committee amendments Senate Bill No. 3729 (1R).

As amended by the committee, this bill provides coverage for community-based palliative care benefits under the Medicaid program. Currently, Medicaid covers services provided by a hospice. However, in order to be eligible for hospice services, a Medicaid beneficiary, among other things, must be certified with a medical prognosis that provides a life expectancy of six months or less and, for Medicaid beneficiaries 21 years of age or older, must waive all rights to curative treatment, or services that are related to the treatment of that terminal condition.

Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

The Medicaid community-based palliative care benefit is to include, but is not to be limited to, services provided by a hospice pursuant to existing law, provided that:

- 1) hospice services may be provided at the same time that curative treatment is available, to the extent that services are not duplicative;
- 2) hospice services may be provided to beneficiaries whose conditions may result in death, regardless of the estimated length of the beneficiary's remaining period of life; and
- 3) the Division of Medical Assistance and Health Services in the Department of Human Services may include any other service deemed appropriate under the benefits provided in the bill.

Providers authorized to deliver the Medicaid community-based palliative care benefit include Medicaid-approved licensed hospice agencies and home health agencies licensed that provide hospice care.

Nothing in the bill is to be construed to result in the elimination or reduction of covered benefits or services under Medicaid. Moreover, the bill explicitly states that its provisions are not to affect a beneficiary's eligibility to receive, concurrently with community-based palliative care services, any services, including home health services, for which the beneficiary would have been eligible in the absence of the bill, to the extent that services are not duplicative.

COMMITTEE AMENDMENTS:

The committee amendments clarify that the Medicaid community-based palliative care benefit is not be limited to services provided by a hospice pursuant to existing law, under certain circumstances.

The committee amendments provide that community-based palliative benefits are to include services provided by Medicaid-approved licensed hospice agencies, Medicaid-approved home health agencies licensed to provide hospice care, and other Medicaid-approved licensed health care providers.

FISCAL IMPACT:

The Office of Legislative Services determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million. The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures. This estimate assumes the annual uptake of the benefit will be 56,062 Medicaid beneficiaries, or 2.5 percent of Medicaid enrollment, with a net combined State and federal cost savings per beneficiary between \$6,696 and \$9,936 per year.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

SENATE, No. 3729

STATE OF NEW JERSEY

220th LEGISLATURE

DATED: JUNE 21, 2023

SUMMARY

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

Type of Impact: Countervailing impact on State expenditures and revenue; General Fund.

Agencies Affected: Department of Human Services.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State Cost Savings	\$375.7 million to \$563.5 million
State Revenue Loss	\$244.2 million to \$366.3 million

- The Office of Legislative Services (OLS) determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million.
- The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures.
- This estimate assumes the annual uptake of the benefit will be 56,062 Medicaid beneficiaries, or 2.5 percent of Medicaid enrollment, with a net combined State and federal cost savings per beneficiary between \$6,696 and \$9,936 per year.

BILL DESCRIPTION

This bill provides coverage for community-based palliative care benefits under the Medicaid program. Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

Providers authorized to deliver the Medicaid community-based palliative care benefit will include Medicaid-approved licensed hospice agencies, Medicaid-approved home health agencies, and other Medicaid-approved licensed health care providers.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million. The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures. This estimate assumes an aggregate federal Medicaid matching rate across all Medicaid eligibility groups of 65 percent.

This estimate is based upon a study prepared by the National Academy for State Health Policy, which indicated that the effective administration of a Medicaid palliative care benefit for the highest service utilizers could produce cost avoidance savings ranging between \$231 and \$1,165 per Medicaid beneficiary per month. For the purposes of this estimate, the OLS assumes 20 percent above and below the midpoint of this range, or \$558 to \$828, as the cost avoidance savings. This study concludes that cost savings under the palliative care benefit is associated with a reduced number of hospital readmissions experienced by those utilizing the palliative care services. Preliminary analysis of California's implementation of a community-based palliative care benefit affirms the National Academy for State Health Policy's study and shows that when comparing a member's total cost of care prior to and after enrollment in the palliative care benefit, reductions in costs are between 42 and 51 percent, with the majority of the cost reduction occurring for hospital-related expenditures.

At present, four percent of all Americans have a serious illness. For reference, examples of serious illness include, but are not limited to: cancer, heart failure, chronic obstructive pulmonary disease, Alzheimer's disease, Parkinson's disease, multiple sclerosis, AIDS, and amyotrophic lateral sclerosis (ALS). Assuming seven percent of the existing State Medicaid population, an increase to the base national rate due to the higher prevalence of chronic illness among Medicaid beneficiaries, provides that 160,176 Medicaid beneficiaries in the State have a serious illness. This estimate further assumes that only 35 percent of these beneficiaries, or 56,062, would seek community-based palliative care services under this bill as the National Academy for State Health Policy indicates that successful home-based palliative care programs cite an engagement rate of 35 percent.

The OLS further notes several variables that may affect this estimate, such as: the administrative costs associated with implementing the benefit; the unpredictability of benefit uptake; the reimbursement rate established for the benefit following enactment; the length of time services are provided per beneficiary; and provider capacity to deliver community-based palliative care services to beneficiaries.

Section: Human Services

*Analyst: Sarah Schmidt
Lead Research Analyst*

*Approved: Thomas Koenig
Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

SENATE, No. 3729

STATE OF NEW JERSEY 220th LEGISLATURE

DATED: JULY 6, 2023

SUMMARY

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

Type of Impact: Countervailing impact on State expenditures and revenue; General Fund.

Agencies Affected: Department of Human Services.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State Cost Savings	\$375.7 million to \$563.5 million
State Revenue Loss	\$244.2 million to \$366.3 million

- The Office of Legislative Services (OLS) determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million.
- The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures.
- This estimate assumes the annual uptake of the benefit will be 56,062 Medicaid beneficiaries, or 2.5 percent of Medicaid enrollment, with a net combined State and federal cost savings per beneficiary between \$6,696 and \$9,936 per year.

BILL DESCRIPTION

This bill provides coverage for community-based palliative care benefits under the Medicaid program. Under the bill, the Medicaid community-based palliative care benefit is to include, but not be limited to, all of the following:

- 1) specialized medical care and emotional and spiritual support for beneficiaries with serious advanced illnesses;
- 2) relief of symptoms, pain, and stress of serious illness;
- 3) improvement of quality of life for both the beneficiary and the beneficiary's family; and
- 4) appropriate care for any age and for any stage of serious illness, along with curative treatment.

Providers authorized to deliver the Medicaid community-based palliative care benefit will include Medicaid-approved licensed hospice agencies, Medicaid-approved home health agencies, and other Medicaid-approved licensed health care providers.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS determines that providing for coverage of community-based palliative care benefits under Medicaid will result in countervailing impacts on State expenditures and revenue resulting in a State cost savings of between \$375.7 million to \$563.5 million, partially offset by a loss of \$244.2 million to \$366.3 million in federal Medicaid reimbursements, for a net State cost savings of \$131.5 million to \$197.2 million. The costs associated with this bill will result from an increase in Medicaid expenditures due to reimbursement for the new benefit. Alternatively, cost savings will be achieved as a function of community-based palliative care services being associated with the prevention of health crises and more expensive hospital-based services. Revenues under the bill will be realized as the loss or gain of federal Medicaid reimbursements, which will be incurred in correspondence to the increase or decrease of State Medicaid expenditures. This estimate assumes an aggregate federal Medicaid matching rate across all Medicaid eligibility groups of 65 percent.

This estimate is based upon a study prepared by the National Academy for State Health Policy, which indicated that the effective administration of a Medicaid palliative care benefit for the highest service utilizers could produce cost avoidance savings ranging between \$231 and \$1,165 per Medicaid beneficiary per month. For the purposes of this estimate, the OLS assumes 20 percent above and below the midpoint of this range, or \$558 to \$828, as the cost avoidance savings. This study concludes that cost savings under the palliative care benefit is associated with a reduced number of hospital readmissions experienced by those utilizing the palliative care services. Preliminary analysis of California's implementation of a community-based palliative care benefit affirms the National Academy for State Health Policy's study and shows that when comparing a member's total cost of care prior to and after enrollment in the palliative care benefit, reductions in costs are between 42 and 51 percent, with the majority of the cost reduction occurring for hospital-related expenditures.

At present, four percent of all Americans have a serious illness. For reference, examples of serious illness include, but are not limited to: cancer, heart failure, chronic obstructive pulmonary disease, Alzheimer's disease, Parkinson's disease, multiple sclerosis, AIDS, and amyotrophic lateral sclerosis (ALS). Assuming seven percent of the existing State Medicaid population, an increase to the base national rate due to the higher prevalence of chronic illness among Medicaid beneficiaries, provides that 160,176 Medicaid beneficiaries in the State have a serious illness. This estimate further assumes that only 35 percent of these beneficiaries, or 56,062, would seek community-based palliative care services under this bill as the National Academy for State Health Policy indicates that successful home-based palliative care programs cite an engagement rate of 35 percent.

The OLS further notes several variables that may affect this estimate, such as: the administrative costs associated with implementing the benefit; the unpredictability of benefit uptake; the reimbursement rate established for the benefit following enactment; the length of time services are provided per beneficiary; and provider capacity to deliver community-based palliative care services to beneficiaries.

Section: Human Services

*Analyst: Sarah Schmidt
Lead Research Analyst*

*Approved: Thomas Koenig
Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

ASSEMBLY BILL NO. 5225
(Second Reprint)

To the General Assembly:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Assembly Bill No. 5225 (Second Reprint) with my recommendations for reconsideration.

Assembly Bill No. 5225 (Second Reprint) requires the State Medicaid program, administered by the Department of Human Services ("DHS"), to provide coverage to eligible beneficiaries for community-based palliative care. The bill defines community-based palliative care to include specialized medical care, along with emotional and spiritual support, for individuals with serious advanced illnesses; relief of symptoms, pain, and stress of serious illness; improvement of quality of life for beneficiaries and their families; and age-appropriate care for any stage of a serious illness, alongside curative treatment. The palliative care benefit would include hospice services, to be provided simultaneously with curative treatment, to the extent that the services are not duplicative, and to be made available to beneficiaries with fatal conditions, regardless of the estimated remaining period of life. The bill also clarifies which types of providers would be authorized to provide community-based palliative care services. Beneficiaries receiving palliative care would still be eligible to concurrently receive any already-covered non-duplicative services.

I applaud the bill's sponsors for working to make a community-based palliative care benefit available to New Jersey's roughly two million Medicaid beneficiaries. There is far more to caring for individuals with serious illnesses than curative treatment, and this bill will create the opportunity for more community-based, quality-of-life-centered options for patients and their families dealing with an immeasurably painful experience. Adding

coverage for palliative care reflects the value our State places in patient choice, emphasizes autonomy around end-of-life treatment, and recognizes that no person should be defined by their illness. And as community-based palliative treatment continues to garner recognition as a vital component of end-of-life care, this bill provides Medicaid with the opportunity to be at the forefront of the conversation and set an example for private insurers in the State. For these reasons, I fully support adding community-based palliative care as a State Medicaid benefit.

My only concern with this bill is that it takes effect immediately, presupposing that DHS would be able to offer the benefit in a very short time frame. Adding any new form of coverage to Medicaid takes a substantial commitment of time and resources, including investigating and designing the benefit, building out the information technology infrastructure, and, critically, securing the federal approvals and financial participation necessary to reduce State costs. And with respect to this circumstance in particular, studies have revealed racial disparities in who receives quality end-of-life care and shown that New Jersey has room to improve when it comes to transitions between the hospital, rehabilitation centers and other facilities, and home for individuals with serious illnesses. Accordingly, to design a comprehensive, equitable system of coverage, DHS will need to carefully study the current palliative care landscape and engage thoughtfully with our communities. For that reason, I am recommending that Assembly Bill No. 5225 (Second Reprint) be amended to provide DHS with two years to conduct the work necessary to design a quality benefit, and – to optimize reach while protecting State financial resources – make clear that coverage would be contingent on receiving all necessary federal approvals.

With these amendments, I am confident that the State will develop the best possible coverage for our Medicaid recipients.

Therefore, I herewith return Assembly Bill No. 5225 (Second Reprint) and recommend that it be amended as follows:

Page 15, Section 1, Line 4:

Delete "Community-based" and insert "Within twenty-four months of the effective date of P.L. , c. (pending before the Legislature as this bill), and conditional on the receipt of all necessary federal approvals and the securing of federal financial participation pursuant to section 2 of P.L. , c. (pending before the Legislature as this bill), community-based"

Page 18, Section 2, Line 31:

After "program." insert "Coverage to eligible beneficiaries of the community-based palliative care benefit established by the amendments made by section 1 of P.L. , c. (C.) (pending before the Legislature as this bill) to section 6 of P.L.1968, c.413 (C.30:4D-6) shall be contingent on securing federal financial participation pursuant to this section."

[seal]

Respectfully,

/s/ Philip D. Murphy

Governor

Attest:

/s/ Parimal Garg

Chief Counsel to the Governor

Governor Murphy Takes Action on Legislation

12/21/2023

TRENTON – Today, Governor Murphy signed the following bills into law:

A-4752wGR/S-3210 (Tully, Benson, Chaparro/Gopal, Pou) - Promotes small business Internet presence

A-5179wGR/SCS for S-3516 (Verrelli, Murphy, Benson/Cruz-Perez, Turner) - "Fire Life Safety Damper and Smoke Control System Inspection Verification Act"; Requires routine maintenance and periodic testing of smoke dampers, fire dampers, and smoke control systems in certain buildings by qualified personnel

A-5225wGR/S-3729 (McKnight, Speight, Murphy/Codey, Pou) - Provides for coverage of community-based palliative care benefits under Medicaid