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

§§2,3
C.30:4D-6u
and 30:4D-6v

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

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

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

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

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

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

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

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly ASE committee amendments adopted March 20, 2023.
[2]Assembly AHE committee amendments adopted May 18, 2023.
[3]Assembly amendments adopted in accordance with Governor's recommendations November 30, 2023.

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

(5) Physical therapy and related services;

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

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

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

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

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

(14) Intermediate care facility services;

(15) Transportation services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) (a) Community–based palliative care benefits which shall 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Inpatient hospital services

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

(5) Physical therapy and related services;

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

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

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

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

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

(14) Intermediate care facility services;

(15) Transportation services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(27) (a) [3]⟦Community–based⟧ Within 24 months of the effective date of P.L. , c. (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. (C.) (pending before the Legislature as this bill), community-based[3] palliative care benefits which shall include, but not be limited to, all of the following:

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

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

[2]⟦(3)⟧ (iii)[2] improvement of quality of life for both the beneficiary and the beneficiary’s family; and

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

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

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

[2][(2)] (ii)[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

[2][(3)] (iii)[2] 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 [2][the] this[2] paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. This act shall take effect immediately.

Provides for coverage of community-based palliative care 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)

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

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

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

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

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

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

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

(5) Physical therapy and related services;

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

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

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

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

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

(14) Intermediate care facility services;

(15) Transportation services;

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

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

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

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

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

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

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

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

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

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

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

Certification of Nutrition Specialists, who is familiar with the components of diabetes medical nutrition therapy;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) (a) Community–based palliative care benefits which shall 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.

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

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

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

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

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

No provider whose claim for payment pursuant to this act has been denied because the services, goods, or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods, and supplies provided pursuant to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. This act shall take effect immediately.

STATEMENT

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

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

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

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.

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

Specifically, 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 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.

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

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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.

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

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

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

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

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

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

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

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

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

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

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

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

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

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

(5) Physical therapy and related services;

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

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

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

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

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

(14) Intermediate care facility services;

(15) Transportation services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) (a) Community–based palliative care benefits which shall 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. This act shall take effect immediately.

STATEMENT

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

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

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.

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

Specifically, 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 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.

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

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Legislative Budget and Finance Office
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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."

Respectfully,

[seal]

/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