

30:4D-6

LEGISLATIVE HISTORY CHECKLIST

NJSA: 30:4D-6

(Hospice services-
-require Medicaid
coverage)

LAWS OF: 1989

CHAPTER: 251

Bill No: S2907

Sponsor(s): Bassano and Codey

Date Introduced: September 26, 1988

Committee: Assembly: Appropriations

Senate: Institutions, Health & Welfare; Revenue, Finance & Appropriations

Amended during passage: Yes Amendments during passage denoted by asterisks.

Date of Passage: Assembly: December 18, 1989

Senate: January 30, 1989

Date of Approval: January 3, 1989

Following statements are attached if available:

Sponsor statement: Yes

Committee Statement: Assembly: Yes

Senate: Yes 9-29-88 & 11-21-88

Fiscal Note: No

Veto Message: No

Message on signing: No

Following were printed:

Reports: No

Hearings: No

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SENATE, No. 2907

STATE OF NEW JERSEY

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INTRODUCED SEPTEMBER 26, 1988

By Senators BASSANO and CODEY

1 AN ACT providing for Medicaid coverage of hospice services
2 ²[and], ²amending P.L.1968, c.413 ²and making an
3 appropriation therefor².
4

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

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

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

15 (1) Inpatient hospital services;

16 (2) Outpatient hospital services;

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

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

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

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

30 b. Subject to the limitations imposed by federal law, by this
31 act, and by the rules and regulations promulgated pursuant
32 thereto, the medical assistance program may be expanded to

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SIH committee amendments adopted September 29, 1988.

² Assembly AAP committee amendments adopted December 11, 1989.

1 include authorized services within each of the following
2 classifications:

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

7 (2) Home health care services;

8 (3) Clinic services;

9 (4) Dental services;

10 (5) Physical therapy and related services;

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

14 (7) Optometric services;

15 (8) Podiatric services;

16 (9) Chiropractic services;

17 (10) Psychological services;

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

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

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

26 (14) Intermediate care facility services;

27 (15) Transportation services;

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

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

1 (18) Comprehensive maternity care, which may include: the
2 basic number of prenatal and postpartum visits recommended by
3 the American College of Obstetrics and Gynecology; additional
4 prenatal and postpartum visits that are medically necessary;
5 necessary laboratory, nutritional assessment and counseling,
6 health education, personal counseling, managed care, outreach
7 and follow-up services; treatment of conditions which may
8 complicate pregnancy; and physician or certified nurse-midwife
9 delivery services;

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

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

21 c. Payments for the foregoing services, goods and supplies
22 furnished pursuant to this act shall be made to the extent
23 authorized by this act, the rules and regulations promulgated
24 pursuant thereto and, where applicable, subject to the agreement
25 of insurance provided for under this act. Said payments shall
26 constitute payment in full to the provider on behalf of the
27 recipient. Every provider making a claim for payment pursuant
28 to this act shall certify in writing on the claim submitted that no
29 additional amount will be charged to the recipient, his family, his
30 representative or others on his behalf for the services, goods and
31 supplies furnished pursuant to this act.

32 No provider whose claim for payment pursuant to this act has
33 been denied because the services, goods or supplies were
34 determined to be medically unnecessary shall seek reimbursement
35 from the recipient, his family, his representative or others on his
36 behalf for such services, goods and supplies provided pursuant to
37 this act; provided, however, a provider may seek reimbursement
38 from a recipient for services, goods or supplies not authorized by
39 this act, if the recipient elected to receive the services, goods or

1 supplies with the knowledge that they were not authorized.

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

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

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

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

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

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

33 f. Any provision in a contract of insurance, will, trust
34 agreement or other instrument which reduces or excludes
35 coverage or payment for goods and services to an individual
36 because of that individual's eligibility for or receipt of Medicaid
37 benefits shall be null and void, and no payments shall be made
38 under this act as a result of any such provision.

39 g. The following services shall be provided to eligible

1 medically needy individuals as follows:

2 (1) Pregnant women shall be provided prenatal care and
3 delivery services and postpartum care, including the services
4 cited in subsection a.(1), (3) and (5) of section 6 of P.L.1968,
5 c.413 (C.30:4D-6a.(1), (3) and (5)) and subsection b.(1)-(10), (12),
6 (15) and (17) of section 6 of P.L.1968, c.413 (C.30:4D-6b.(1)-(10),
7 (12), (15) and (17)).

8 (2) Dependent children shall be provided with services cited in
9 subsection a.(3) and (5) of section 6 of P.L.1968, c.413
10 (C.30:4D-6a.(3) and (5)) and subsection b.(1), (2), (3), (4), (5), (6),
11 (7), (10), (12), (15) and (17) of section 6 of P.L.1968, c.413
12 (C.30:4D-6b.(1), (2), (3), (4), (5), (6), (7), (10), (12), (15) and (17)).

13 (3) Individuals who are 65 years of age or older shall be
14 provided with services cited in subsection a.(3) and (5) of section
15 6 of P.L.1968, c.413 (C.30:4D-6a.(3) and (5)) and subsection
16 b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15)
17 and (17) of section 6 of P.L.1968, c.413 (C.30:4D-6b.(1)-(5), (6)
18 excluding prescribed drugs, (7), (8), (10), (12), (15) and (17)).

19 (4) Individuals who are blind or disabled shall be provided with
20 services cited in subsection a.(3) and (5) of section 6 of P.L.1968,
21 c.413 (C.30:4D-6a.(3) and (5)) and subsection b.(1)-(5), (6)
22 excluding prescribed drugs, (7), (8), (10), (12), (15) and (17) of
23 section 6 of P.L.1968, c.413 (C.30:4D-6b.(1)-(5), (6) excluding
24 prescribed drugs, (7), (8), (10), (12), (15) and (17)).

25 (5)(a) Inpatient hospital services, subsection a.(1) of section 6
26 of P.L.1968, c.413 (C.30:4D-6a.(1)), shall only be provided to
27 eligible medically needy individuals, other than pregnant women,
28 if the federal Department of Health and Human Services
29 discontinues the State's waiver to establish inpatient hospital
30 reimbursement rates for the Medicare and Medicaid programs
31 under the authority of section 601(c)(3) of the Social Security Act
32 Amendments of 1983, Pub.L.98-21 (42 U.S.C. § 1395ww(c)(5)).
33 Inpatient hospital services may be extended to other eligible
34 medically needy individuals if the federal Department of Health
35 and Human Services directs that these services be included.

36 (b) Outpatient hospital services, subsection a.(2) of section 6
37 of P.L.1968, c.413 (C.30:4D-6a.(2)), shall only be provided to
38 eligible medically needy individuals if the federal Department of
39 Health and Human Services discontinues the State's waiver to

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

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

13 (cf: P.L.1987, c.115, s.3)

14 ²2. (New section) The Department of Human Services shall
15 report to the Legislature within one year after the effective date
16 of this act regarding the expenses incurred in the provision of
17 hospice services.²

18 ²3. There is appropriated to the Department of Human
19 Services from the amount remaining unexpended in the General
20 Fund line-item appropriation to Department of Human Services
21 for State Aid, Division of Medical Assistance and Health
22 Services, Payments for medical assistance recipients (State
23 share) - inpatient hospital account, so much as is necessary to
24 effectuate the purposes of this act. The department shall apply
25 to the Director of the Division of Budget and Accounting for
26 permission to transfer such funds pursuant to the general
27 provisions of the annual appropriations act concerning transfers
28 of funds.²

29 ²[2.] ⁴2 This act shall take effect ¹[immediately] one year
30 after the date of enactment¹.

31

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HEALTH

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Public Assistance

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35 Requires Medicaid program to cover hospice services and makes
36 and appropriation.

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

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

(cf: P.L.1987, c.115, s.3)

11 2. This act shall take effect immediately.

13

STATEMENT

15

16 This bill requires the Medicaid program to provide coverage for
17 services provided by a hospice which is participating in the
18 Medicare program. The bill stipulates that hospice services shall
19 be covered by Medicaid subject to the approval of the federal
20 Secretary of Health and Human Services for federal
21 reimbursement.

22 Hospices provide palliative and supportive care for terminally
23 ill patients and their families, making the entire family the unit
24 of care and centering the caring process in the home. Hospice
25 care includes social, physical, emotional, psychological and
26 spiritual support for the patient and the patient's family,
27 including the management of pain and other symptoms that will
28 enable the patient to live as fully as possible, and bereavement
29 care for the survivor.

30 The federal government has made hospice care available under
31 the Medicare program since 1983. Patients who are eligible for
32 Medicare hospital insurance can have their hospice care,
33 including home care, covered by Medicare if the patient's doctor
34 and the hospice medical director certify that the patient has a
35 life expectancy of six months or less, and if the patient uses a
36 Medicare-certified hospice provider. Medicare currently covers
37 up to 210 days and pays up to \$68 a day for hospice care, although
38 the limit on days of coverage will be eliminated under the
39 "Medicare Catastrophic Coverage Act of 1988," Pub.L. 100-360,

1 if the beneficiary is recertified at the end of the 210-day period
as terminally ill by the attending physician or hospice medical
3 director.

5

HEALTH
Public Assistance

7

9 Requires Medicaid program to cover hospice services.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

[FIRST REPRINT]

SENATE, No. 2907

with Assembly committee amendments

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STATE OF NEW JERSEY

DATED: DECEMBER 11, 1989

The Assembly Appropriations Committee reports favorably Senate Bill No. 2907 (1R) with committee amendments.

Senate Bill No. 2907 (1R), as amended, requires the Medicaid program to provide coverage for services provided by a hospice which is participating in the Medicare program. The bill stipulates that hospice services shall be covered by Medicaid subject to the approval of the federal Secretary of Health and Human Services for federal reimbursement. The bill, as amended, provides that the State share of hospice program costs shall be funded by transfers of appropriations made to the medical assistance inpatient hospital program.

Hospices provide palliative and supportive care for terminally ill patients and their families, making the entire family the unit of care and centering the caring process in the home. Hospice care includes social, physical, emotional, psychological and spiritual support for the patient and the patient's family, including the management of pain and other symptoms that will enable the patient to live as fully as possible, and bereavement care for the survivor.

The federal government has made hospice care available under the Medicare program since 1983. Patients who are eligible for Medicare hospital insurance can have their hospice care, including home care, covered by Medicare if the patient's doctor and the hospice medical director certify that the patient has a life expectancy of six months or less, and if the patient uses a Medicare-certified hospice provider.

The bill requires the Commissioner of Human Services to report to the Legislature within one year of the effective date of this bill regarding the expenses incurred.

This bill, as amended, is identical to Assembly Bill No. 3933 (1R), as amended.

FISCAL IMPACT

This bill, as amended, provides that the hospice program shall be funded by transfers of funds appropriated to the medical assistance inpatient hospital account. Hospice program costs will offset costs that would otherwise occur in the inpatient program.

COMMITTEE AMENDMENTS

The committee amendments insert a provision that the hospice program shall be funded by transfers of funds appropriated to the medical assistance inpatient hospital account. The amendments also require the Commissioner of Human Services to report to the Legislature within one year of the effective date of this bill regarding the expenses incurred.

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO

SENATE, No. 2907

with Senate committee amendments

STATE OF NEW JERSEY

DATED: SEPTEMBER 29, 1988

The Senate Institutions, Health and Welfare Committee favorably reports Senate Bill No. 2907 with committee amendments.

As amended by committee, this bill requires the Medicaid program to provide coverage for services provided by a hospice which is participating in the Medicare program. The bill stipulates that hospice services shall be covered by Medicaid subject to the approval of the federal Secretary of Health and Human Services for federal reimbursement.

Hospices provide palliative and supportive care for terminally ill patients and their families, making the entire family the unit of care and centering the caring process in the home. Hospice care includes social, physical, emotional, psychological and spiritual support for the patient and the patient's family, including the management of pain and other symptoms that will enable the patient to live as fully as possible, and bereavement care for the survivor.

The federal government has made hospice care available under the Medicare program since 1983. Patients who are eligible for Medicare hospital insurance can have their hospice care, including home care, covered by Medicare if the patient's doctor and the hospice medical director certify that the patient has a life expectancy of six months or less, and if the patient uses a Medicare-certified hospice provider. Medicare currently covers up to 210 days and pays up to \$68 a day for hospice care, although the limit on days of coverage will be eliminated under the "Medicare Catastrophic Coverage Act of 1988," Pub.L. 100-360, if the beneficiary is recertified at the end of the 210-day period as terminally ill by the attending physician or hospice medical director.

The committee amended the bill to extend the bill's effective date to one year from the date of enactment in order to provide the department with sufficient time to secure federal approval for the coverage of hospice services.

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SENATE REVENUE, FINANCE AND
APPROPRIATIONS COMMITTEE

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STATEMENT TO

[FIRST REPRINT]

SENATE, No. 2907

STATE OF NEW JERSEY

DATED: NOVEMBER 21, 1988

The Senate Revenue, Finance and Appropriations Committee reported Senate Bill No. 2907 [1R] favorably.

Senate Bill No. 2907 [1R] requires the Medicaid program to provide coverage for services provided by a hospice which is participating in the Medicare program. The bill stipulates that hospice services shall be covered by Medicaid subject to the approval of the federal Secretary of Health and Human Services for federal reimbursement.

The federal government has made hospice care available under the Medicare program since 1983. Patients who are eligible for Medicare hospital insurance can have their hospice care, including home care, covered by Medicare if the patient's doctor and the hospice medical director certify that the patient has a life expectancy of six months or less, and if the patient uses a Medicare-certified hospice provider. Medicare currently covers up to 210 days and pays up to \$68 a day for hospice care, although the limit on days of coverage will be eliminated under the "Medicare Catastrophic Coverage Act of 1988," Pub. L. 100-360, if the beneficiary is recertified at the end of the 210-day period as terminally ill by the attending physician or hospice medical director.

FISCAL IMPACT

The bill contains no appropriation. The Department of Human Services estimates that the State share of the cost of providing the hospice service will be approximately \$250,000 in the first year of operation and \$358,000 in the second year. An article in the Health Care Financing Review (Summer 1988) stated that the estimated costs of the federal Medicare hospice program equalled the estimated savings from the program.

FISCAL NOTE TO

[FIRST REPRINT]

SENATE, No. 2907

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STATE OF NEW JERSEY

DATED: June 21, 1989

Senate Bill No. 2907(1R) of 1988 requires the Medicaid program to cover hospice services. The bill allows the Department of Human Services to transfer such funds from the payments for medical assistance recipients (State share) - inpatient hospital account as are necessary to implement the program.

The Department of Human Services and the Office of Management and Budget have estimated the cost of providing hospice services as part of the Medicaid program at \$245,160 and \$346,065, respectively, in the first two years of the program.

The Office of Legislative Services, while not disputing the cost estimates, notes the provision of hospice services should be expenditure neutral, that is, the cost of providing the hospice service may be offset by reductions in other Medicaid costs, particularly hospitals. This conclusion is based on preliminary data regarding hospice services provided by the Medicare program ("Medicare Hospice Benefit: Early Program Experience," Health Care Financing Review, Summer 1988). The fact that the bill allows Medicaid to use existing appropriations to fund the cost of hospice services supports the belief that provision of hospice services will result in reductions in Medicaid costs for inpatient hospital services.

This fiscal note has been prepared pursuant to P.L.1980, c.67.