30:4D-6

LEGISLATIVE HISTORY CHECKLIST
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NJSA: 30:4D-6 **(Medicaid---mammogram coverage)**

LAWS OF: 1991 **CHAPTER:** 371

Bill No: A802

Sponsor(s): Bush

Date Introduced: Pre-filed

Committee: **Assembly:** Health & Human Services

Senate: Institutions, Health & Welfare

Amended during passage: Yes Amendments during passage denoted by asterisks

Date of Passage: **Assembly:** June 20, 1990

Senate: December 16, 1991

Date of Approval: January 10, 1992

Following statements are attached if available:

Sponsor statement: Yes

Committee Statement: **Assembly:** Yes

Senate: Yes

Fiscal Note: No

Veto Message: No

Message on signing: No

Following were printed:

Reports: No

Hearings: No

See newspaper clippings---attached

KBG/dgw

[FIRST REPRINT]

ASSEMBLY, No. 802

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1990 SESSION

By Assemblywoman BUSH, Assemblyman McGREEVEY
and Assemblywoman Randall

AN ACT to provide Medicaid coverage for mammograms 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) Such 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 defects and such 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.

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;

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 Assembly AHH committee amendments adopted October 15, 1990.

(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, skilled 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 drug abuse, when the treatment is prescribed by a physician and provided in a licensed hospital or in a narcotic and drug abuse 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 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; and physician or certified nurse-midwife delivery services;

(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. § 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[1], 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[1].

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. Said 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, his family, his representative or others on his 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 him 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 he 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. Any provision in a contract of insurance, will, trust agreement or other instrument which reduces or excludes coverage or payment for goods and services to an individual because of that individual's 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.

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 section 6 of P.L.1968, c.413 (C.30:4D-6a.(1), (3) and (5)) and subsection b.(1)-(10), (12), (15) and (17) of section 6 of P.L.1968, c.413 (C.30:4D-6b.(1)-(10), (12), (15) and (17)).

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

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

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

(5) (a) Inpatient hospital services, subsection a.(1) of section 6 of P.L.1968, c.413 (C.30:4D-6a.(1)), 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. § 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 section 6 of P.L.1968, c.413 (C.30:4D-6a.(2)), 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. § 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.

(cf: P.L.1989, c.251, s.1)

2. This act shall take effect on the 90th day after enactment.

HEALTH

Requires Medicaid coverage for mammograms.

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. §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.

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

2. This act shall take effect on the 90th day after enactment.

STATEMENT

This bill requires the State Medicaid program to provide coverage to eligible beneficiaries for mammograms, subject to approval by the United States Secretary of Health and Human Services. The bill is designed to encourage women to take advantage of mammograms which are capable of detecting breast cancer in its early stages.

HEALTH

Requires Medicaid coverage for mammograms.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

[FIRST REPRINT]

ASSEMBLY, No. 802

STATE OF NEW JERSEY

DATED: JANUARY 24, 1991

The Assembly Insurance Committee reports favorably Assembly Bill No. 802 (1R).

This bill requires that the Medicaid benefit cover 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 or age; and one mammogram examination every year for women age 50 and over.

Under current law, P.L.1968, c.413 (C.30:4D-1 et seq.), mammograms are not specifically included as a Medicaid-covered service; however, the law authorizes coverage of "diagnostic, screening, preventive and rehabilitative services," and the Medicaid program does pay for mammograms for Medicaid recipients as "medically required."

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 802

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: OCTOBER 15, 1990

The Assembly Health and Human Services Committee favorably reports Assembly Bill No. 802 with committee amendments.

As amended by the committee, this bill amends the "New Jersey Medical Assistance and Health Services Act," P.L.1968, c.413 (C.30:4D-1 et seq.) to require that the Medicaid program provide coverage to eligible beneficiaries for mammograms, subject to approval by the United States Secretary of Health and Human Services.

The amended bill specifies that the Medicaid benefit for mammograms shall cover 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.

Mammograms are not specifically included as a Medicaid-covered service in P.L.1968, c.413; however, the law authorizes coverage of "diagnostic, screening, preventive, and rehabilitative services," and the Medicaid program does pay for mammograms for Medicaid recipients as medically required.

This bill is similar to Assembly Bill No. 2511 of 1988 (Bush). A fiscal note to that bill indicated that no additional State costs would be incurred as a result of its enactment because "mammograms are already provided to Medicaid recipients if required."

The committee amended the bill at the request of the sponsor to specify how frequently a woman may receive a mammogram, based upon the woman's age.

This bill was pre-filed for introduction in the 1990-91 session pending technical review. As reported, the bill includes the changes required by technical review which has been performed.

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO

[FIRST REPRINT]

ASSEMBLY, No. 802

STATE OF NEW JERSEY

DATED: DECEMBER 9, 1991

The Senate Institutions, Health and Welfare Committee favorably reports Assembly Bill No. 802 (1R).

This bill requires that the Medicaid program cover 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 or age; and one mammogram examination every year for women age 50 and over.

Under current law, P.L.1968, c.413 (C.30:4D-1 et seq.), mammograms are not specifically included as a Medicaid covered service; however, the law authorizes coverage of "diagnostic, screening, preventive and rehabilitative services," and the Medicaid program does pay for mammograms for Medicaid recipients as "medically required."

LEGISLATIVE FISCAL ESTIMATE TO

[FIRST REPRINT]

ASSEMBLY, No. 802

STATE OF NEW JERSEY

DATED: July 18, 1991

Assembly Bill No. 802 [1R] of 1990 requires the State's Medicaid program to provide the following service to women: 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 for women between the ages of 40 and 50, and one examination every year for women over the age of 50.

The Department of Human Services and the Office of Management and Budget have not provided any fiscal information on the current version of Assembly Bill No. 802, though on the previous version it was noted that mammograms were a covered service under the State's Medicaid program.

During federal FY 1990, an estimated 146,000 women over the age of 35 were enrolled in Medicaid: approximately 27,000 women between the ages of 35 and 40; approximately 28,000 between the ages of 40 and 50, and approximately 91,000 over the age of 50. Based on current Medicaid reimbursement of $36 for a bilateral mammogram (including $14.40 for professional services of a physician) it could cost the State $2.4 million annually to provide mammograms, assuming 50 percent federal reimbursement. The total cost of $4.8 million represents the following: (a) $1.0 million to provide a baseline mammogram to women between the ages of 35 and 40; (b) $.5 million to provide one mammogram examination every year to women between the ages of 40 and 50, and (c) $3.3 million to provide one mammogram examination every year to women over the age of 50.

The $2.4 million estimate represents new costs to the State as current State expenditures for mammography services are under $100,000. The $2.4 million estimate also assumes that all women eligible for the service will be able to obtain the service. As Medicaid reimbursement of $36 for a bilateral mammogram is significantly below what Blue Cross/Blue Shield reimburses ($129 and $56 for a bilateral mammogram and physician services, respectively) there is a possibility that the service may not be available to all eligible women. If Medicaid reimbursement must be increased above the current $36 for a bilateral mammogram, the cost of providing the service will increase beyond the estimated $2.4 million (State share). Though the provision of mammography services is intended to reduce Medicaid expenditures in the long term by the early detection and treatment of breast cancer, such "savings" cannot be determined.

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.