ASSEMBLY, No. 1454

STATE OF NEW JERSEY

217th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2016 SESSION

Sponsored by:
Assemblywoman PAMELA R. LAMPITT
District 6 (Burlington and Camden)

SYNOPSIS

Provides for Medicaid coverage of comprehensive tobacco cessation services and prohibits certain restrictions on coverage.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning Medicaid coverage of tobacco cessation services and amending and supplementing 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 defects 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;

(5) Physical therapy and related 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.

(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 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. 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) Tobacco cessation services, including, but not limited to, individual counseling, group counseling, telephone counseling, nicotine patches, nicotine gum, nicotine lozenges, nicotine nasal sprays, nicotine inhalers, bupropion, varenicline, and any other tobacco cessation treatments approved by the federal Food and Drug Administration or recommended by the most recently published United States Public Health Service clinical practice guidelines on treating tobacco use and dependence. Tobacco cessation services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement. Notwithstanding the provisions of any other law, rule, or regulation to the contrary, and except as otherwise provided in this section:

(a) Coverage for all tobacco cessation services described in this paragraph shall be provided to: all individuals eligible to receive medical assistance pursuant to section 3 of P.L.1968, c.413 (C.30:4D-3); and all other individuals eligible to receive medical assistance pursuant to the State plan most recently approved under Title XIX of the federal Social Security Act (42 U.S.C. s.1396 et seq.), including, but not limited to, individuals eligible to receive medical assistance in accordance with section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act (42 U.S.C. s.1396a(a)(10)(A)(i)(VIII));

(b) 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 subparagraph (a) of this paragraph at the following times: no later than 30 days after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill); upon the establishment of an individual's eligibility for medical assistance; and upon the redetermination of an individual's eligibility for medical assistance;

(c) 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

(d) 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.

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)<u>, and (22)</u> 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 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3), (4), (5), (6), (7), (10), (12), (15), **[**and**]** (17)<u>, and (22)</u> 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 subsection a.(3) and (5) of this section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),

(8), (10), (12), (15), [and] (17), and (22) 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 subsection a.(3) and (5) of this section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), [and] (17), and (22) 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.
(cf: P.L.2012, c.17, s.359)

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; except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner shall adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and shall thereafter be amended, adopted, or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

4. This act shall take effect on the first day of the seventh month next following the date of enactment, but the commissioner may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

This bill requires the State Medicaid program to provide coverage of comprehensive tobacco cessation services. The required tobacco cessation services, include, but are not limited to, individual counseling, group counseling, telephone counseling, nicotine patches, nicotine gum, nicotine lozenges, nicotine nasal sprays, nicotine inhalers, bupropion, varenicline, and any other tobacco cessation treatments approved by the federal Food and Drug Administration (FDA) or recommended by the most recently published U.S. Public Health Service clinical practice guidelines on treating tobacco use and dependence.

The bill stipulates that the tobacco cessation services shall be covered by Medicaid subject to the approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement. The bill further stipulates that, except as otherwise provided by section 6 of P.L.1968, c.413, coverage for these tobacco cessation services shall be provided to: all individuals eligible for Medicaid pursuant to section 3 of P.L.1968, c.413; and all other individuals eligible for Medicaid pursuant to the most recent federally approved Medicaid State plan, including, but not

limited to, "newly eligible" adults meeting the eligibility criteria set forth in section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, pursuant to the federal "Patient Protection and Affordable Care Act," Pub.L.111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152 (ACA). The bill also amends current statutory provisions to include certain individuals who are eligible for Medicaid as "medically needy individuals," including certain pregnant women, dependent children, persons 65 years of age or older, and persons who are blind or disabled, among the individuals authorized to receive the Medicaid tobacco cessation services.

In addition, the bill prohibits the following conditions from being imposed on the Medicaid tobacco cessation services: 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. The bill also prohibits prior authorization requirements from being imposed on these services, except for: treatments that exceed the duration recommended by the U.S. Public Health Service clinical practice guidelines; or services associated with more than two attempts to quit within a 12-month period.

The bill requires that information regarding the availability of the Medicaid tobacco cessation services be provided to all individuals authorized to receive these services at the following times: no later than 30 days after the bill's effective date; upon the establishment of an individual's eligibility for Medicaid; and upon the redetermination of an individual's eligibility for Medicaid. Finally, the bill requires the Commissioner of Human Services to apply for any necessary Medicaid State plan amendments or waivers to provide coverage for the tobacco cessation services and to secure federal financial participation for associated State Medicaid expenditures under the federal Medicaid program.

Section 2502 of the federal "Patient Protection and Affordable Care Act" prevents states from excluding FDA-approved tobacco cessation medications from Medicaid coverage, effective January 1, 2014, and states are in the process of bringing their Medicaid programs into compliance with this ACA requirement. According to a March 2014 report by the American Lung Association and the federal Centers for Disease Control and Prevention (CDC), which was based on data collected prior to states' implementation of the new ACA requirement, New Jersey provided coverage to all Medicaid enrollees for nicotine gum, nicotine patches, and bupropion, but coverage for nicotine lozenges, nicotine nasal sprays, nicotine inhalers, and varenicline varied by Medicaid managed care plan and no Medicaid coverage was provided for

individual or group counseling. Further, the American Lung Association/CDC report found that some Medicaid managed care plans in New Jersey applied conditions to tobacco cessation coverage that represented potential "barriers" to services, such as copayments, prior authorization requirements, limits on the duration of services, and annual and lifetime limits on the amounts of services authorized.

This bill intends to provide New Jersey's Medicaid enrollees with coverage for all of the aforementioned tobacco cessation services and to minimize potential barriers for enrollees attempting to access these services. Expanding, and improving access to, tobacco cessation services has the potential to improve health outcomes among Medicaid enrollees while reducing Medicaid expenditures on hospitalizations and other services. For example, recent studies sponsored by the CDC have found that comprehensive Medicaid tobacco cessation services in Massachusetts were associated with substantial decreases in smoking prevalence and decreases in hospital admissions for cardiovascular conditions. Moreover, researchers from The George Washington University School of Public Health and Health Services found, over the first 2.5 years of Massachusetts' comprehensive Medicaid tobacco cessation coverage, that every $1.00 expended on tobacco cessation services was associated with $3.12 in Medicaid savings, on average. This bill would allow New Jersey to realize a similar return on investment while improving health outcomes among the State's most vulnerable residents.