[First Reprint]

SENATE, No. 1784

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 5, 2018

Sponsored by:
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Assemblywoman SHAVONDA E. SUMTER
District 35 (Bergen and Passaic)

Co-Sponsored by:
Senator Ruiz, Assemblywomen Vainieri Huttle, Mosquera, Chaparro, Timberlake, Murphy, Lampitt, Reynolds-Jackson, Assemblyman Armato, Assemblywomen Speight, McKnight, Tucker, Downey and Jasey

SYNOPSIS

Provides Medicaid coverage for doula care.

CURRENT VERSION OF TEXT

As reported by the Assembly Appropriations Committee on March 18, 2019, with amendments.

(Sponsorship Updated As Of: 3/26/2019)

AN ACT concerning Medicaid coverage for doula care 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:

(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;

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 AAP committee amendments adopted March 18, 2019.

1 (4) Dental services;
2 (5) Physical therapy and related services;
3 (6) Prescribed drugs, dentures, and prosthetic devices; and
4 eyeglasses prescribed by a physician skilled in diseases of the eye
5 or by an optometrist, whichever the individual may select;
6 (7) Optometric services;
7 (8) Podiatric services;
8 (9) Chiropractic services;
9 (10) Psychological services;
10 (11) Inpatient psychiatric hospital services for individuals under
11 21 years of age, or under age 22 if they are receiving such services
12 immediately before attaining age 21;
13 (12) Other diagnostic, screening, preventive, and rehabilitative
14 services, and other remedial care;
15 (13) Inpatient hospital services, nursing facility services, and
16 intermediate care facility services for individuals 65 years of age or
17 over in an institution for mental diseases;
18 (14) Intermediate care facility services;
19 (15) Transportation services;
20 (16) Services in connection with the inpatient or outpatient
21 treatment or care of substance use disorder, when the treatment is
22 prescribed by a physician and provided in a licensed hospital or in a
23 narcotic and substance use disorder treatment center approved by
24 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
25 et seq.) and whose staff includes a medical director, and limited to
26 those services eligible for federal financial participation under Title
27 XIX of the federal Social Security Act;
28 (17) Any other medical care and any other type of remedial care
29 recognized under State law, specified by the Secretary of the federal
30 Department of Health and Human Services, and approved by the
31 commissioner;
32 (18) Comprehensive maternity care, which may include: the
33 basic number of prenatal and postpartum visits recommended by the
34 American College of Obstetrics and Gynecology; additional
35 prenatal and postpartum visits that are medically necessary;
36 necessary laboratory, nutritional assessment and counseling, health
37 education, personal counseling, managed care, outreach, and
38 follow-up services; treatment of conditions which may complicate
39 pregnancy; doula care; and physician or certified nurse-midwife
40 delivery services;
41 (19) Comprehensive pediatric care, which may include:
42 ambulatory, preventive, and primary care health services. The
43 preventive services shall include, at a minimum, the basic number
44 of preventive visits recommended by the American Academy of
45 Pediatrics;
46 (20) Services provided by a hospice which is participating in the
47 Medicare program established pursuant to Title XVIII of the Social
48 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice

1 services shall be provided subject to approval of the Secretary of
2 the federal Department of Health and Human Services for federal
3 reimbursement;
4 (21) Mammograms, subject to approval of the Secretary of the
5 federal Department of Health and Human Services for federal
6 reimbursement, including one baseline mammogram for women
7 who are at least 35 but less than 40 years of age; one mammogram
8 examination every two years or more frequently, if recommended
9 by a physician, for women who are at least 40 but less than 50 years
10 of age; and one mammogram examination every year for women
11 age 50 and over;
12 (22) Upon referral by a physician, advanced practice nurse, or
13 physician assistant of a person who has been diagnosed with
14 diabetes, gestational diabetes, or pre-diabetes, in accordance with
15 standards adopted by the American Diabetes Association:
16 (a) Expenses for diabetes self-management education or training
17 to ensure that a person with diabetes, gestational diabetes, or pre-
18 diabetes can optimize metabolic control, prevent and manage
19 complications, and maximize quality of life. Diabetes self-
20 management education shall be provided by an in-State provider
21 who is:
22 (i) a licensed, registered, or certified health care professional
23 who is certified by the National Certification Board of Diabetes
24 Educators as a Certified Diabetes Educator, or certified by the
25 American Association of Diabetes Educators with a Board
26 Certified-Advanced Diabetes Management credential, including, but
27 not limited to: a physician, an advanced practice or registered nurse,
28 a physician assistant, a pharmacist, a chiropractor, a dietitian
29 registered by a nationally recognized professional association of
30 dietitians, or a nutritionist holding a certified nutritionist specialist
31 (CNS) credential from the Board for Certification of Nutrition
32 Specialists ; or
33 (ii) an entity meeting the National Standards for Diabetes Self-
34 Management Education and Support, as evidenced by a recognition
35 by the American Diabetes Association or accreditation by the
36 American Association of Diabetes Educators;
37 (b) Expenses for medical nutrition therapy as an effective
38 component of the person's overall treatment plan upon a: diagnosis
39 of diabetes, gestational diabetes, or pre-diabetes; change in the
40 beneficiary's medical condition, treatment, or diagnosis; or
41 determination of a physician, advanced practice nurse, or physician
42 assistant that reeducation or refresher education is necessary.
43 Medical nutrition therapy shall be provided by an in-State provider
44 who is a dietitian registered by a nationally-recognized professional
45 association of dietitians, or a nutritionist holding a certified
46 nutritionist specialist (CNS) credential from the Board for
47 Certification of Nutrition Specialists, who is familiar with the
48 components of diabetes medical nutrition therapy;

1 (c) For a person diagnosed with pre-diabetes, items and services
2 furnished under an in-State diabetes prevention program that meets
3 the standards of the National Diabetes Prevention Program, as
4 established by the federal Centers for Disease Control and
5 Prevention; and
6 (d) Expenses for any medically appropriate and necessary
7 supplies and equipment recommended or prescribed by a physician,
8 advanced practice nurse, or physician assistant for the management
9 and treatment of diabetes, gestational diabetes, or pre-diabetes,
10 including, but not limited to: equipment and supplies for self-
11 management of blood glucose; insulin pens; insulin pumps and
12 related supplies; and other insulin delivery devices.
13 c. Payments for the foregoing services, goods, and supplies
14 furnished pursuant to this act shall be made to the extent authorized
15 by this act, the rules and regulations promulgated pursuant thereto
16 and, where applicable, subject to the agreement of insurance
17 provided for under this act. The payments shall constitute payment
18 in full to the provider on behalf of the recipient. Every provider
19 making a claim for payment pursuant to this act shall certify in
20 writing on the claim submitted that no additional amount will be
21 charged to the recipient, the recipient's family, the recipient's
22 representative or others on the recipient's behalf for the services,
23 goods, and supplies furnished pursuant to this act.
24 No provider whose claim for payment pursuant to this act has
25 been denied because the services, goods, or supplies were
26 determined to be medically unnecessary shall seek reimbursement
27 from the recipient, his family, his representative or others on his
28 behalf for such services, goods, and supplies provided pursuant to
29 this act; provided, however, a provider may seek reimbursement
30 from a recipient for services, goods, or supplies not authorized by
31 this act, if the recipient elected to receive the services, goods or
32 supplies with the knowledge that they were not authorized.
33 d. Any individual eligible for medical assistance (including
34 drugs) may obtain such assistance from any person qualified to
35 perform the service or services required (including an organization
36 which provides such services, or arranges for their availability on a
37 prepayment basis), who undertakes to provide the individual such
38 services.
39 No copayment or other form of cost-sharing shall be imposed on
40 any individual eligible for medical assistance, except as mandated
41 by federal law as a condition of federal financial participation.
42 e. Anything in this act to the contrary notwithstanding, no
43 payments for medical assistance shall be made under this act with
44 respect to care or services for any individual who:
45 (1) Is an inmate of a public institution (except as a patient in a
46 medical institution); provided, however, that an individual who is
47 otherwise eligible may continue to receive services for the month in
48 which he becomes an inmate, should the commissioner determine to

1 expand the scope of Medicaid eligibility to include such an
2 individual, subject to the limitations imposed by federal law and
3 regulations, or
4 (2) Has not attained 65 years of age and who is a patient in an
5 institution for mental diseases, or
6 (3) Is over 21 years of age and who is receiving inpatient
7 psychiatric hospital services in a psychiatric facility; provided,
8 however, that an individual who was receiving such services
9 immediately prior to attaining age 21 may continue to receive such
10 services until the individual reaches age 22. Nothing in this
11 subsection shall prohibit the commissioner from extending medical
12 assistance to all eligible persons receiving inpatient psychiatric
13 services; provided that there is federal financial participation
14 available.
15 f. (1) A third party as defined in section 3 of P.L.1968, c.413
16 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
17 this or another state when determining the person's eligibility for
18 enrollment or the provision of benefits by that third party.
19 (2) In addition, any provision in a contract of insurance, health
20 benefits plan, or other health care coverage document, will, trust,
21 agreement, court order, or other instrument which reduces or
22 excludes coverage or payment for health care-related goods and
23 services to or for an individual because of that individual's actual or
24 potential eligibility for or receipt of Medicaid benefits shall be null
25 and void, and no payments shall be made under this act as a result
26 of any such provision.
27 (3) Notwithstanding any provision of law to the contrary, the
28 provisions of paragraph (2) of this subsection shall not apply to a
29 trust agreement that is established pursuant to 42 U.S.C.
30 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
31 provided by government entities to a person who is disabled as
32 defined in section 1614(a)(3) of the federal Social Security Act (42
33 U.S.C. s.1382c (a)(3)).
34 g. The following services shall be provided to eligible
35 medically needy individuals as follows:
36 (1) Pregnant women shall be provided prenatal care and delivery
37 services and postpartum care, including the services cited in
38 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
39 (10), (12), (15), and (17) of this section, and nursing facility
40 services cited in subsection b.(13) of this section.
41 (2) Dependent children shall be provided with services cited in
42 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
43 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
44 nursing facility services cited in subsection b.(13) of this section.
45 (3) Individuals who are 65 years of age or older shall be
46 provided with services cited in subsection a.(3) and (5) of this
47 section and subsection 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 subsection a.(3) and (5) of this section and subsection 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.
(cf: P.L.2017, c.161, 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 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;

(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 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;

1 (21) Mammograms, subject to approval of the Secretary of the
2 federal Department of Health and Human Services for federal
3 reimbursement, including one baseline mammogram for women
4 who are at least 35 but less than 40 years of age; one mammogram
5 examination every two years or more frequently, if recommended
6 by a physician, for women who are at least 40 but less than 50 years
7 of age; and one mammogram examination every year for women
8 age 50 and over;
9 (22) Upon referral by a physician, advanced practice nurse, or
10 physician assistant of a person who has been diagnosed with
11 diabetes, gestational diabetes, or pre-diabetes, in accordance with
12 standards adopted by the American Diabetes Association:
13 (a) Expenses for diabetes self-management education or training
14 to ensure that a person with diabetes, gestational diabetes, or pre-
15 diabetes can optimize metabolic control, prevent and manage
16 complications, and maximize quality of life. Diabetes self-
17 management education shall be provided by an in-State provider
18 who is:
19 (i) a licensed, registered, or certified health care professional
20 who is certified by the National Certification Board of Diabetes
21 Educators as a Certified Diabetes Educator, or certified by the
22 American Association of Diabetes Educators with a Board
23 Certified-Advanced Diabetes Management credential, including, but
24 not limited to: a physician, an advanced practice or registered nurse,
25 a physician assistant, a pharmacist, a chiropractor, a dietitian
26 registered by a nationally recognized professional association of
27 dietitians, or a nutritionist holding a certified nutritionist specialist
28 (CNS) credential from the Board for Certification of Nutrition
29 Specialists; or
30 (ii) an entity meeting the National Standards for Diabetes Self-
31 Management Education and Support, as evidenced by a recognition
32 by the American Diabetes Association or accreditation by the
33 American Association of Diabetes Educators;
34 (b) Expenses for medical nutrition therapy as an effective
35 component of the person's overall treatment plan upon a: diagnosis
36 of diabetes, gestational diabetes, or pre-diabetes; change in the
37 beneficiary's medical condition, treatment, or diagnosis; or
38 determination of a physician, advanced practice nurse, or physician
39 assistant that reeducation or refresher education is necessary.
40 Medical nutrition therapy shall be provided by an in-State provider
41 who is a dietitian registered by a nationally-recognized professional
42 association of dietitians, or a nutritionist holding a certified
43 nutritionist specialist (CNS) credential from the Board for
44 Certification of Nutrition Specialists, who is familiar with the
45 components of diabetes medical nutrition therapy;
46 (c) For a person diagnosed with pre-diabetes, items and services
47 furnished under an in-State diabetes prevention program that meets
48 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.

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

1 (2) Has not attained 65 years of age and who is a patient in an
2 institution for mental diseases, or
3 (3) Is over 21 years of age and who is receiving inpatient
4 psychiatric hospital services in a psychiatric facility; provided,
5 however, that an individual who was receiving such services
6 immediately prior to attaining age 21 may continue to receive such
7 services until the individual reaches age 22. Nothing in this
8 subsection shall prohibit the commissioner from extending medical
9 assistance to all eligible persons receiving inpatient psychiatric
10 services; provided that there is federal financial participation
11 available.
12 f. (1) A third party as defined in section 3 of P.L.1968, c.413
13 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in
14 this or another state when determining the person's eligibility for
15 enrollment or the provision of benefits by that third party.
16 (2) In addition, any provision in a contract of insurance, health
17 benefits plan, or other health care coverage document, will, trust,
18 agreement, court order, or other instrument which reduces or
19 excludes coverage or payment for health care-related goods and
20 services to or for an individual because of that individual's actual or
21 potential eligibility for or receipt of Medicaid benefits shall be null
22 and void, and no payments shall be made under this act as a result
23 of any such provision.
24 (3) Notwithstanding any provision of law to the contrary, the
25 provisions of paragraph (2) of this subsection shall not apply to a
26 trust agreement that is established pursuant to 42 U.S.C.
27 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
28 provided by government entities to a person who is disabled as
29 defined in section 1614(a)(3) of the federal Social Security Act (42
30 U.S.C. s.1382c (a)(3)).
31 g. The following services shall be provided to eligible
32 medically needy individuals as follows:
33 (1) Pregnant women shall be provided prenatal care and delivery
34 services and postpartum care, including the services cited in
35 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
36 (10), (12), (15), and (17) of this section, and nursing facility
37 services cited in subsection b.(13) of this section.
38 (2) Dependent children shall be provided with services cited in
39 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
40 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
41 nursing facility services cited in subsection b.(13) of this section.
42 (3) Individuals who are 65 years of age or older shall be
43 provided with services cited in subsection a.(3) and (5) of this
44 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
45 (8), (10), (12), (15), and (17) of this section, and nursing facility
46 services cited in subsection b.(13) of this section.
47 (4) Individuals who are blind or disabled shall be provided with
48 services cited in subsection a.(3) and (5) of this section and

1 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
2 (12), (15), and (17) of this section, and nursing facility services
3 cited in subsection b.(13) of this section.
4 (5) (a) Inpatient hospital services, subsection a.(1) of this
5 section, shall only be provided to eligible medically needy
6 individuals, other than pregnant women, if the federal Department
7 of Health and Human Services discontinues the State's waiver to
8 establish inpatient hospital reimbursement rates for the Medicare
9 and Medicaid programs under the authority of section 601(c)(3) of
10 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
11 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
12 extended to other eligible medically needy individuals if the federal
13 Department of Health and Human Services directs that these
14 services be included.
15 (b) Outpatient hospital services, subsection a.(2) of this section,
16 shall only be provided to eligible medically needy individuals if the
17 federal Department of Health and Human Services discontinues the
18 State's waiver to establish outpatient hospital reimbursement rates
19 for the Medicare and Medicaid programs under the authority of
20 section 601(c)(3) of the Social Security Amendments of 1983,
21 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
22 services may be extended to all or to certain medically needy
23 individuals if the federal Department of Health and Human Services
24 directs that these services be included. However, the use of
25 outpatient hospital services shall be limited to clinic services and to
26 emergency room services for injuries and significant acute medical
27 conditions.
28 (c) The division shall monitor the use of inpatient and outpatient
29 hospital services by medically needy persons.
30 h. In the case of a qualified disabled and working individual
31 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
32 only medical assistance provided under this act shall be the
33 payment of premiums for Medicare part A under 42 U.S.C.
34 ss.1395i-2 and 1395r.
35 i. In the case of a specified low-income Medicare beneficiary
36 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical
37 assistance provided under this act shall be the payment of premiums
38 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
39 U.S.C. s.1396d(p)(3)(A)(ii).
40 j. In the case of a qualified individual pursuant to 42 U.S.C.
41 s.1396a(aa), the only medical assistance provided under this act
42 shall be payment for authorized services provided during the period
43 in which the individual requires treatment for breast or cervical
44 cancer, in accordance with criteria established by the commissioner.
45 k. In the case of a qualified individual pursuant to 42 U.S.C.
46 s.1396a(ii), the only medical assistance provided under this act shall
47 be payment for family planning services and supplies as described
48 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and

1 treatment services that are provided pursuant to a family planning
2 service in a family planning setting.[1]
3 (cf: P.L.2018, c.1, s.2)
4
5 2. The Commissioner of Human Services shall apply for such
6 State plan amendments or waivers as may be necessary to
7 implement the provisions of this act and to secure federal financial
8 participation for State Medicaid expenditures under the federal
9 Medicaid program [1]and shall receive approval for such State plan
10 amendments or waivers prior to the implementation of this act[1].
11
12 3. The Commissioner of Human Services, pursuant to the
13 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
14 seq.), shall adopt rules and regulations necessary to implement the
15 provisions of this act.
16
17 4. This act shall take effect on the first day of the [1]⟦fourth⟧
18 seventh[1] month next following the date of enactment, but the
19 Commissioner of Human Services may take such anticipatory
20 administrative action in advance thereof, including, but not limited
21 to, the submission of a State plan amendment to the federal Centers
22 for Medicare & Medicaid Services, as may be necessary for the
23 implementation of this act.