

SENATE, No. 3928

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED JUNE 15, 2021

Sponsored by:

Senator SHIRLEY K. TURNER

District 15 (Hunterdon and Mercer)

SYNOPSIS

Requires Medicaid coverage for self-administered hormonal contraceptives dispensed by pharmacist under standing order.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning Medicaid coverage for self-administered
2 hormonal contraceptives provided under a standing order and
3 amending P.L.1968, c.413.
4

5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:
7

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

10 6. a. Subject to the requirements of Title XIX of the federal
11 Social Security Act, the limitations imposed by this act and by the
12 rules and regulations promulgated pursuant thereto, the department
13 shall provide medical assistance to qualified applicants, including
14 authorized services within each of the 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) Early and periodic screening and diagnosis of individuals
20 who are eligible under the program and are under age 21, to
21 ascertain their physical or mental health status and the health care,
22 treatment, and other measures to correct or ameliorate defects and
23 chronic conditions discovered thereby, as may be provided in
24 regulations of the Secretary of the federal Department of Health and
25 Human Services and approved by the commissioner;
26 (5) Physician's services furnished in the office, the patient's
27 home, a hospital, a skilled nursing, or intermediate care facility or
28 elsewhere.

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

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

- 40 (1) Medical care not included in subsection a.(5) above, or any
41 other type of remedial care recognized under State law, furnished
42 by licensed practitioners within the scope of their practice, as
43 defined by State law;
44 (2) Home health care services;
45 (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 thus is new matter.

- 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 Obstetricians and Gynecologists; 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. For the purposes of this paragraph, "doula"
- 41 means a trained professional who provides continuous physical,
- 42 emotional, and informational support to a mother before, during,
- 43 and shortly after childbirth, to help her to achieve the healthiest,
- 44 most satisfying experience possible;
- 45 (19) Comprehensive pediatric care, which may include:
- 46 ambulatory, preventive, and primary care health services. The
- 47 preventive services shall include, at a minimum, the basic number

1 of preventive visits recommended by the American Academy of
2 Pediatrics;

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

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

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

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

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

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

42 (b) Expenses for medical nutrition therapy as an effective
43 component of the person's overall treatment plan upon a: diagnosis
44 of diabetes, gestational diabetes, or pre-diabetes; change in the
45 beneficiary's medical condition, treatment, or diagnosis; or
46 determination of a physician, advanced practice nurse, or physician
47 assistant that reeducation or refresher education is necessary.
48 Medical nutrition therapy shall be provided by an in-State provider

1 who is a dietitian registered by a nationally-recognized professional
2 association of dietitians, or a nutritionist holding a certified
3 nutritionist specialist (CNS) credential from the Board for
4 Certification of Nutrition Specialists, who is familiar with the
5 components of diabetes medical nutrition therapy;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 (c) Prior authorization requirements shall not be imposed on any
45 tobacco cessation services provided pursuant to this paragraph
46 except in the following circumstances where prior authorization
47 may be required: for a treatment that exceeds the duration
48 recommended by the most recently published United States Public

1 Health Service clinical practice guidelines on treating tobacco use
2 and dependence; or for services associated with more than two
3 attempts to quit within a 12-month period.

4 (26) Expenses incurred in the provision of self-administered
5 hormonal contraceptives as prescribed by a standing order and
6 dispensed by a pharmacist.

7 For the purposes of this paragraph:

8 “Self-administered hormonal contraceptive” means any oral,
9 transdermal, or vaginal contraceptive product, including, but not
10 limited to, birth control pills, vaginal rings, and diaphragms; and

11 “Standing order” means a prewritten medication order
12 authorizing pharmacists in this State to furnish self-administered
13 hormonal contraceptives to patients without an individual
14 prescription.

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

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

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

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

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

47 (1) Is an inmate of a public institution (except as a patient in a
48 medical institution); provided, however, that an individual who is

1 otherwise eligible may continue to receive services for the month in
2 which he becomes an inmate, should the commissioner determine to
3 expand the scope of Medicaid eligibility to include such an
4 individual, subject to the limitations imposed by federal law and
5 regulations, or

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

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

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

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

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

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

38 (1) Pregnant women shall be provided prenatal care and delivery
39 services and postpartum care, including the services cited in
40 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
41 (10), (12), (15), and (17) of this section, and nursing facility
42 services cited in subsection b.(13) of this section.

43 (2) Dependent children shall be provided with services cited in
44 subsections a.(3) and (5) of this section and subsections b.(1), (2),
45 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
46 nursing facility services cited in subsection b.(13) of this section.

47 (3) Individuals who are 65 years of age or older shall be
48 provided with services cited in subsections a.(3) and (5) of this

1 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
2 (7), (8), (10), (12), (15), and (17) of this section, and nursing
3 facility services cited in subsection b.(13) of this section.

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

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

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

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

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

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

45 j. In the case of a qualified individual pursuant to 42 U.S.C.
46 s.1396a(aa), the only medical assistance provided under this act
47 shall be payment for authorized services provided during the period

1 in which the individual requires treatment for breast or cervical
2 cancer, in accordance with criteria established by the commissioner.

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

9
10 2. The Commissioner of Human Services shall apply for such
11 State plan amendments or waivers as may be necessary to
12 implement the provisions of this act and to secure federal financial
13 participation for State Medicaid expenditures under the federal
14 Medicaid program.

15
16 3. The Commissioner of Human Services, pursuant to the
17 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
18 seq.), shall adopt rules and regulations necessary to implement the
19 provisions of this act.

20
21 4. This act shall take immediately.

22 23 24 STATEMENT

25
26 This bill requires the State's Medicaid program to cover
27 expenses incurred in the provision of self-administered hormonal
28 contraceptives as prescribed by a standing order and dispensed by a
29 pharmacist. Under the bill, "self-administered hormonal
30 contraceptive" means any oral, transdermal, or vaginal
31 contraceptive product, including, but not limited to, birth control
32 pills, vaginal rings, and diaphragms. "Standing order" means a
33 prewritten medication order authorizing pharmacists in this State to
34 furnish self-administered hormonal contraceptives to patients
35 without an individual prescription.

36 Currently, there is no standing order as defined under the bill in
37 place in New Jersey. However, legislation pending before the
38 Legislature permits pharmacists to furnish self-administered hormonal
39 contraceptives pursuant to a standing order, in accordance with
40 protocols established by Board of Pharmacy and Board of Medical
41 Examiners. That bill, in conjunction with this bill, would eliminate the
42 need for Medicaid beneficiaries to get a prescription from a doctor for
43 a self-administered hormonal contraceptive, as is the existing
44 requirement, before going to have it filled at a pharmacy; thereby
45 increasing access to these medications.