

ASSEMBLY, No. 2281

STATE OF NEW JERSEY

222nd LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2026 SESSION

Sponsored by:

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District 11 (Monmouth)

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District 38 (Bergen)

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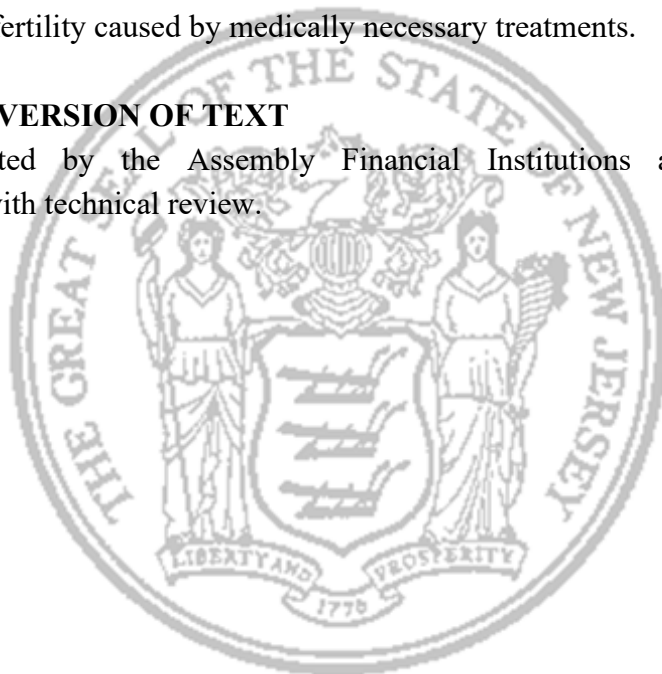
Assemblymen Verrelli, Stanley, Assemblywomen Reynolds-Jackson, Drulis, Kane, Haider, Peterpaul, McCoy, Bagolie, Speight, Murphy, Assemblyman Tully, Assemblywomen Sweeney, Rowan, Assemblymen Kearney and Schnall

SYNOPSIS

Requires Medicaid coverage for fertility preservation services in cases of iatrogenic infertility caused by medically necessary treatments.

CURRENT VERSION OF TEXT

As reported by the Assembly Financial Institutions and Insurance Committee with technical review.



(Sponsorship Updated As Of: 10/5/2026)

1 AN ACT concerning Medicaid coverage for fertility preservation
2 services and amending P.L.1968, c.413.

3

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

6

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

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

14 (1) Inpatient hospital services

15 (2) Outpatient hospital services;

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

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

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

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

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

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

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

42 (2) Home health care services;

43 (3) Clinic services;

44 (4) Dental services;

45 (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 thus is new matter.

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

1 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
2 services shall be provided subject to approval of the Secretary of the
3 federal Department of Health and Human Services for federal
4 reimbursement;

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

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

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

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

33 (ii) an entity meeting the National Standards for Diabetes Self-
34 Management Education and Support, as evidenced by a recognition by
35 the American Diabetes Association or accreditation by the American
36 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 of
39 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. Medical
43 nutrition therapy shall be provided by an in-State provider who is a
44 dietitian registered by a nationally-recognized professional association
45 of dietitians, or a nutritionist holding a certified nutritionist specialist
46 (CNS) credential from the Board for Certification of Nutrition
47 Specialists, who is familiar with the components of diabetes medical
48 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 the
3 standards of the National Diabetes Prevention Program, as established
4 by the federal Centers for Disease Control and Prevention; and

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

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

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

17 (i) is a site accredited by the Centering Healthcare Institute, or is a
18 site engaged in an active implementation contract with the Centering
19 Healthcare institute, that utilizes the Centering Pregnancy model; and

20 (ii) incorporates the applicable information outlined in any best
21 practices manual for prenatal and postpartum maternal care developed
22 by the Department of Health into the curriculum for each group
23 prenatal visit;

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

27 (c) no more than 10 group prenatal care visits occur per
28 pregnancy. As used in this paragraph, "group prenatal care services"
29 means a series of prenatal care visits provided in a group setting which
30 are based upon the Centering Pregnancy model developed by the
31 Centering Healthcare Institute and which include health assessments,
32 social and clinical support, and educational activities;

33 (24) Expenses incurred for the provision of pasteurized donated
34 human breast milk, which shall include human milk fortifiers if
35 indicated in a medical order provided by a licensed medical
36 practitioner, to an infant under the age of six months; provided that the
37 milk is obtained from a human milk bank that meets quality guidelines
38 established by the Department of Health and a licensed medical
39 practitioner has issued a medical order for the infant under at least one
40 of the following circumstances:

41 (a) the infant is medically or physically unable to receive maternal
42 breast milk or participate in breast feeding, or the infant's mother is
43 medically or physically unable to produce maternal breast milk in
44 sufficient quantities or participate in breast feeding despite optimal
45 lactation support; or

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

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

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

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

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

17 (a) Information regarding the availability of the tobacco cessation
18 services described in this paragraph shall be provided to all individuals
19 authorized to receive the tobacco cessation services pursuant to this
20 paragraph at the following times: no later than 90 days after the
21 effective date of P.L.2019, c.473: upon the establishment of an
22 individual's eligibility for medical assistance; and upon the
23 redetermination of an individual's eligibility for medical assistance;

24 (b) The following conditions shall not be imposed on any tobacco
25 cessation services provided pursuant to this paragraph: copayments or
26 any other forms of cost-sharing, including deductibles; counseling
27 requirements for medication; stepped care therapy or similar
28 restrictions requiring the use of one service prior to another; limits on
29 the duration of services; or annual or lifetime limits on the amount,
30 frequency, or cost of services, including, but not limited to, annual or
31 lifetime limits on the number of covered attempts to quit; and

32 (c) Prior authorization requirements shall not be imposed on any
33 tobacco cessation services provided pursuant to this paragraph except
34 in the following circumstances where prior authorization may be
35 required: for a treatment that exceeds the duration recommended by
36 the most recently published United States Public Health Service
37 clinical practice guidelines on treating tobacco use and dependence; or
38 for services associated with more than two attempts to quit within a
39 12-month period;

40 (26) Provided that there is federal financial participation available,
41 benefits for expenses incurred in conducting a colorectal cancer
42 screening in accordance with United States Preventive Services Task
43 Force recommendations. The method and frequency of screening to
44 be utilized shall be in accordance with the most recent published
45 recommendations of the United States Preventive Services Task Force
46 and as determined medically necessary by the covered person's
47 physician, in consultation with the covered person.

1 No deductible, coinsurance, copayment, or any other cost-sharing
2 requirement shall be imposed for a colonoscopy performed following a
3 positive result on a non-colonoscopy, colorectal cancer screening test
4 recommended by the United States Preventive Services Task Force;
5 **【and】**

6 (27) (a) Within 24 months of the effective date of P.L.2023, c.187
7 (C.30:4D-6u et al.), and conditional on the receipt of all necessary
8 federal approvals and the securing of federal financial participation
9 pursuant to section 2 of P.L.2023, c.187 (C.30:4D-6u), community-
10 based palliative care benefits which shall include, but not be limited to,
11 all of the following:

12 (i) specialized medical care and emotional and spiritual support
13 for beneficiaries with serious advanced illnesses;

14 (ii) relief of symptoms, pain, and stress of serious illness;

15 (iii) Improvement of quality of life for both the beneficiary and the
16 beneficiary's family; and

17 (iv) appropriate care for any age and for any stage of serious
18 illness, along with curative treatment.

19 (b) Benefits provided under this paragraph shall include, but shall
20 not be limited to, services provided by a hospice pursuant to paragraph
21 (20) of subsection b. of this section, provided that:

22 (i) hospice services may be provided at the same time that curative
23 treatment is available, to the extent that services are not duplicative;

24 (ii) hospice services may be provided to beneficiaries whose
25 conditions may result in death, regardless of the estimated length of
26 the beneficiary's remaining period of life; and

27 (iii) the Division of Medical Assistance and Health Services in the
28 Department of Human Services may include any other service deemed
29 appropriate under the benefits provided under this paragraph.

30 (c) Providers authorized to deliver benefits provided under this
31 paragraph shall include Medicaid-approved licensed hospice agencies,
32 Medicaid-approved home health agencies licensed to provide hospice
33 care, and other Medicaid-approved licensed health care providers.

34 (d) Nothing in this paragraph shall be construed to result in the
35 elimination or reduction of covered benefits or services under the
36 Medicaid program.

37 (e) This paragraph shall not affect a beneficiary's eligibility to
38 receive, concurrently with services provided for in this paragraph, any
39 services, including home health services, for which the beneficiary
40 would have been eligible in the absence of this paragraph, to the extent
41 that services are not duplicative; and

42 (28) (a) Coverage for standard fertility preservation services when
43 a medically necessary treatment may directly or indirectly cause
44 iatrogenic infertility. Benefits provided pursuant to this paragraph
45 shall be limited to one fertility preservation cycle. unless that
46 procedure is unsuccessful.

47 (b) Benefits provided pursuant to this paragraph shall not be
48 determined by an eligible beneficiary's expected length of life, present

1 or predicted disability, degree of medical dependency, perceived
2 quality of life, or other health conditions, or based on personal
3 characteristics, age, gender, gender identity, sexual orientation, or
4 marital status.

5 (c) For the purposes of this paragraph:

6 “Iatrogenic infertility” means an impairment of fertility caused by
7 surgery, radiation, chemotherapy, or other medical treatment affecting
8 reproductive organs or processes;

9 “May directly or indirectly cause” means a medical treatment with
10 a likely side effect of iatrogenic infertility as established by the
11 American Society for Reproductive Medicine, the American Society
12 of Clinical Oncology, or as defined by the New Jersey Department of
13 Health; and

14 “Standard fertility preservation services” means procedures
15 consistent with established medical practices and professional
16 guidelines published by the American Society for Reproductive
17 Medicine, the American Society of Clinical Oncology, or as defined
18 by the New Jersey Department of Health.

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

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

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

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

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

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

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

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

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

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

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

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

40 (1) Pregnant women shall be provided prenatal care and delivery
41 services and postpartum care, including the services cited in
42 subsections a.(1), (3), and (5) of this section and subsections b.(1)-
43 (10), (12), (15), and (17) of this section, and nursing facility services
44 cited in subsection b.(13) of this section.

45 (2) Dependent children shall be provided with services cited in
46 subsections a.(3) and (5) of this section and subsections b.(1), (2), (3),
47 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing
48 facility services cited in subsection b.(13) of this section.

1 (3) Individuals who are 65 years of age or older shall be provided
2 with services cited in subsections a.(3) and (5) of this section and
3 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
4 (12), (15), and (17) of this section, and nursing facility services cited
5 in subsection b.(13) of this section.

6 (4) Individuals who are blind or disabled shall be provided with
7 services cited in subsections a.(3) and (5) of this section and
8 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), 3
9 (12), (15), and (17) of this section, and nursing facility services cited
10 in subsection b.(13) of this section.

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

21 (b) Outpatient hospital services, subsection a.(2) of this section,
22 shall only be provided to eligible medically needy individuals if the
23 federal Department of Health and Human Services discontinues the
24 State's waiver to establish outpatient hospital reimbursement rates for
25 the Medicare and Medicaid programs under the authority of section
26 601(c)(3) of the Social Security Amendments of 1983, Pub.L.98-21
27 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital services may be
28 extended to all or to certain medically needy individuals if the federal
29 Department of Health and Human Services directs that these services
30 be included. However, the use of outpatient hospital services shall be
31 limited to clinic services and to emergency room services for injuries
32 and significant acute medical 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 h6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
37 only medical assistance provided under this act shall be the payment of
38 premiums for Medicare part A under 42 U.S.C. ss.1395i-2 and 1395r.

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

44 j. In the case of a qualified individual pursuant to 42 U.S.C.
45 s.1396a(aa), the only medical assistance provided under this act shall
46 be payment for authorized services provided during the period in
47 which the individual requires treatment for breast or cervical cancer, in
48 accordance with criteria established by the commissioner.

1 k. (1) In the case of a qualified individual pursuant to 42 U.S.C.
2 s.1396a(ii), the only medical assistance provided under this act shall be
3 payment for family planning services and supplies as described at 42
4 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and treatment
5 services that are provided pursuant to a family planning service in a
6 family planning setting.

7 (2) For the purposes of this subsection, and subject to federal
8 approval under Titles XIX and XXI of the Social Security Act,
9 coverage of family planning services and supplies for a qualified
10 individual shall include the provision of standard fertility preservation
11 services, as defined in paragraph (28) of subsection b. of this section,
12 when a medically necessary treatment may directly or indirectly cause
13 iatrogenic infertility, as defined under paragraph (28) of subsection b.
14 of this section. Benefits provided pursuant to this subsection shall be
15 limited to one fertility preservation cycle, unless that procedure is
16 unsuccessful.

17 (cf: P.L.2023, c.187, s.1)

18
19 2. (New section) The Commissioner of Human Services shall
20 apply for such State plan amendments or waivers as may be
21 necessary to implement the provisions of this act and to secure
22 federal financial participation for State Medicaid expenditures
23 under the federal Medicaid program.

24
25 3. (New section) The Commissioner of Human Services shall,
26 in accordance with the "Administrative Procedure Act," P.L.1968,
27 c.410 (C.52:14B-1 et seq.), adopt rules and regulations as necessary
28 to implement this act.

29
30 4. This act shall take effect immediately.