

SENATE, No. 4017

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED JUNE 28, 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 read
9 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 who
20 are eligible under the program and are under age 21, to ascertain their
21 physical or mental health status and the health care, treatment, and
22 other measures to correct or ameliorate defects and chronic
23 conditions discovered thereby, as may be provided in regulations of
24 the Secretary of the federal Department of Health and Human
25 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 act,
37 and by the rules and regulations promulgated pursuant thereto, the
38 medical assistance program may be expanded to include authorized
39 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 by
42 licensed practitioners within the scope of their practice, as defined by
43 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 or
- 5 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 the
- 24 Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et
- 25 seq.) and whose staff includes a medical director, and limited to those
- 26 services eligible for federal financial participation under Title XIX
- 27 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 basic
- 33 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 follow-
- 38 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" means
- 41 a trained professional who provides continuous physical, emotional,
- 42 and informational support to a mother before, during, and shortly
- 43 after childbirth, to help her to achieve the healthiest, most satisfying
- 44 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 of

1 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 the
7 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 who
12 are at least 35 but less than 40 years of age; one mammogram
13 examination every two years or more frequently, if recommended by
14 a physician, for women who are at least 40 but less than 50 years of
15 age; and one mammogram examination every year for women age 50
16 and over;

17 (22) Upon referral by a physician, advanced practice nurse, or
18 physician assistant of a person who has been diagnosed with diabetes,
19 gestational diabetes, or pre-diabetes, in accordance with standards
20 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 who
26 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 Certified-
31 Advanced Diabetes Management credential, including, but not
32 limited to: a physician, an advanced practice or registered nurse, a
33 physician assistant, a pharmacist, a chiropractor, a dietitian registered
34 by a nationally recognized professional association of dietitians, or a
35 nutritionist holding a certified nutritionist specialist (CNS) credential
36 from the Board for Certification of Nutrition Specialists; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 (c) Prior authorization requirements shall not be imposed on any
43 tobacco cessation services provided pursuant to this paragraph except
44 in the following circumstances where prior authorization may be
45 required: for a treatment that exceeds the duration recommended by
46 the most recently published United States Public Health Service
47 clinical practice guidelines on treating tobacco use and dependence;

1 or for services associated with more than two attempts to quit within
2 a 12-month period.

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

6 For the purposes of this paragraph:

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

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

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 been
25 denied because the services, goods, or supplies were determined to
26 be medically unnecessary shall seek reimbursement from the
27 recipient, his family, his representative or others on his behalf for
28 such services, goods, and supplies provided pursuant to this act;
29 provided, however, a provider may seek reimbursement from a
30 recipient for services, goods, or supplies not authorized by this act, if
31 the recipient elected to receive the services, goods or supplies with
32 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 by
41 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 of
26 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 medically
35 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)-(10),
39 (12), (15), and (17) of this section, and nursing facility services cited
40 in subsection b.(13) of this section.

41 (2) Dependent children shall be provided with services cited in
42 subsections a.(3) and (5) of this section and subsections b.(1), (2),
43 (3), (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 provided
46 with services cited in subsections a.(3) and (5) of this section and
47 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),

1 (12), (15), and (17) of this section, and nursing facility services cited
2 in subsection b.(13) of this section.

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

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

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

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

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

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

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

47 k. In the case of a qualified individual pursuant to 42 U.S.C.
48 s.1396a(ii), the only medical assistance provided under this act shall

1 be payment for family planning services and supplies as described at
2 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
3 treatment services that are provided pursuant to a family planning
4 service in a family planning setting.

5
6 2. The Commissioner of Human Services shall apply for such
7 State plan amendments or waivers as may be necessary to implement
8 the provisions of this act and to secure federal financial participation
9 for State Medicaid expenditures under the federal Medicaid program.

10
11 3. The Commissioner of Human Services, pursuant to the
12 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
13 seq.), shall adopt rules and regulations necessary to implement the
14 provisions of this act.

15
16 4. This act shall take immediately.

17
18
19 STATEMENT

20
21 This bill requires the State's Medicaid program to cover expenses
22 incurred in the provision of self-administered hormonal
23 contraceptives as prescribed by a standing order and dispensed by a
24 pharmacist. Under the bill, "self-administered hormonal
25 contraceptive" means any oral, transdermal, or vaginal contraceptive
26 product, including, but not limited to, birth control pills, vaginal
27 rings, and diaphragms. "Standing order" means a prewritten
28 medication order authorizing pharmacists in this State to furnish self-
29 administered hormonal contraceptives to patients without an
30 individual prescription.

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