SENATE, No. 1407

STATE OF NEW JERSEY

221st LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2024 SESSION

Sponsored by:
Senator TROY SINGLETON
District 7 (Burlington)
Senator M. TERESA RUIZ
District 29 (Essex and Hudson)

Co-Sponsored by:
Senator McKnight

SYNOPSIS

Requires Medicaid coverage for community violence prevention services; Requires DOH to approve training and certification program for violence prevention professionals.

CURRENT VERSION OF TEXT

As reported by the Senate Health, Human Services and Senior Citizens Committee with technical review.

(Sponsorship Updated As Of: 3/14/2024)

1 **AN ACT** concerning violence prevention services and training,
2 amending Title 30 of the Revised Statutes, and supplementing
3 Title 26 of the Revised Statutes.
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
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.

(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 Obstetricians and Gynecologists; 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

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; and
4 (26) Community violence prevention services to an individual
5 who has: (a) received medical treatment for an injury sustained as a
6 result of an act of community violence, and (b) been referred by a
7 certified or licensed health care provider or social services provider
8 to receive community violence prevention services from a certified
9 violence prevention professional, after such provider determines
10 such beneficiary to be at elevated risk of a violent injury or
11 retaliation resulting from another act of community violence.
12 As used in this paragraph:
13 "Certified violence prevention professional" means an individual
14 who has completed an accredited training and certification program
15 regarding violence prevention services, approved by the Department
16 of Health in accordance with section 3 of P.L. , c. (C.)
17 (pending before the Legislature as this bill), and who has
18 maintained such certification;
19 "Community violence" means any intentional act of physical
20 force against one or more other persons by an individual or small
21 group of individuals committed in one or more public areas, where
22 no actor is a family member or intimate partner of any such victim;
23 and
24 "Community violence prevention services" means evidence-
25 based, trauma-informed, supportive and non-psychotherapeutic
26 services provided by a certified violence prevention professional,
27 within or outside of a clinical setting, for the purpose of promoting
28 improved health outcomes and positive behavioral change,
29 preventing injury recidivism, and reducing the likelihood that
30 individuals who are victims of community violence will commit or
31 promote violence themselves. "Community violence prevention
32 services" may include the provision of peer support and counseling,
33 mentorship, conflict mediation, crisis intervention, targeted case
34 management, referrals to certified or licensed health care
35 professionals or social services providers, patient education, or
36 screening services to victims of community violence.
37 c. Payments for the foregoing services, goods, and supplies
38 furnished pursuant to this act shall be made to the extent authorized
39 by this act, the rules and regulations promulgated pursuant thereto
40 and, where applicable, subject to the agreement of insurance
41 provided for under this act. The payments shall constitute payment
42 in full to the provider on behalf of the recipient. Every provider
43 making a claim for payment pursuant to this act shall certify in
44 writing on the claim submitted that no additional amount will be
45 charged to the recipient, the recipient's family, the recipient's
46 representative or others on the recipient's behalf for the services,
47 goods, and supplies furnished pursuant to this act.

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

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

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

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

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

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

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

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

(2) In addition, any provision in a contract of insurance, health benefits plan, or other health care coverage document, will, trust, agreement, court order, or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or

1 potential eligibility for or receipt of Medicaid benefits shall be null
2 and void, and no payments shall be made under this act as a result
3 of any such provision.
4 (3) Notwithstanding any provision of law to the contrary, the
5 provisions of paragraph (2) of this subsection shall not apply to a
6 trust agreement that is established pursuant to 42 U.S.C.
7 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
8 provided by government entities to a person who is disabled as
9 defined in section 1614(a)(3) of the federal Social Security Act
10 (42 U.S.C. s.1382c (a)(3)).
11 g. The following services shall be provided to eligible
12 medically needy individuals as follows:
13 (1) Pregnant women shall be provided prenatal care and delivery
14 services and postpartum care, including the services cited in
15 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
16 (10), (12), (15), and (17) of this section, and nursing facility
17 services cited in subsection b.(13) of this section.
18 (2) Dependent children shall be provided with services cited in
19 subsections a.(3) and (5) of this section and subsections b.(1), (2),
20 (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and
21 nursing facility services cited in subsection b.(13) of this section.
22 (3) Individuals who are 65 years of age or older shall be
23 provided with services cited in subsections a.(3) and (5) of this
24 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
25 (7), (8), (10), (12), (15), and (17) of this section, and nursing
26 facility services cited in subsection b.(13) of this section.
27 (4) Individuals who are blind or disabled shall be provided with
28 services cited in subsections a.(3) and (5) of this section and
29 subsections b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
30 (12), (15), and (17) of this section, and nursing facility services
31 cited in subsection b.(13) of this section.
32 (5) (a) Inpatient hospital services, subsection a.(1) of this
33 section, shall only be provided to eligible medically needy
34 individuals, other than pregnant women, if the federal Department
35 of Health and Human Services discontinues the State's waiver to
36 establish inpatient hospital reimbursement rates for the Medicare
37 and Medicaid programs under the authority of section 601(c)(3) of
38 the Social Security Act Amendments of 1983, Pub.L.98-21
39 (42 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
40 extended to other eligible medically needy individuals if the federal
41 Department of Health and Human Services directs that these
42 services be included.
43 (b) Outpatient hospital services, subsection a.(2) of this section,
44 shall only be provided to eligible medically needy individuals if the
45 federal Department of Health and Human Services discontinues the
46 State's waiver to establish outpatient hospital reimbursement rates
47 for the Medicare and Medicaid programs under the authority of
48 section 601(c)(3) of the Social Security Amendments of 1983,

1 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
2 services may be extended to all or to certain medically needy
3 individuals if the federal Department of Health and Human Services
4 directs that these services be included. However, the use of
5 outpatient hospital services shall be limited to clinic services and to
6 emergency room services for injuries and significant acute medical
7 conditions.
8 (c) The division shall monitor the use of inpatient and outpatient
9 hospital services by medically needy persons.
10 h. In the case of a qualified disabled and working individual
11 pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the
12 only medical assistance provided under this act shall be the
13 payment of premiums for Medicare part A under 42 U.S.C.
14 ss.1395i-2 and 1395r.
15 i. In the case of a specified low-income Medicare beneficiary
16 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical
17 assistance provided under this act shall be the payment of premiums
18 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
19 U.S.C. s.1396d(p)(3)(A)(ii).
20 j. In the case of a qualified individual pursuant to 42 U.S.C.
21 s.1396a(aa), the only medical assistance provided under this act
22 shall be payment for authorized services provided during the period
23 in which the individual requires treatment for breast or cervical
24 cancer, in accordance with criteria established by the commissioner.
25 k. In the case of a qualified individual pursuant to 42 U.S.C.
26 s.1396a(ii), the only medical assistance provided under this act shall
27 be payment for family planning services and supplies as described
28 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
29 treatment services that are provided pursuant to a family planning
30 service in a family planning setting.
31 (cf: P.L.2019, c.473, s.1)]
32
33 1. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read
34 as follows:
35 6. a. Subject to the requirements of Title XIX of the federal
36 Social Security Act, the limitations imposed by this act and by the
37 rules and regulations promulgated pursuant thereto, the department
38 shall provide medical assistance to qualified applicants, including
39 authorized services within each of the following classifications:
40 (1) Inpatient hospital services
41 (2) Outpatient hospital services;
42 (3) Other laboratory and X-ray services;
43 (4) (a) Skilled nursing or intermediate care facility services;
44 (b) Early and periodic screening and diagnosis of individuals
45 who are eligible under the program and are under age 21, to
46 ascertain their physical or mental health status and the health care,
47 treatment, and other measures to correct or ameliorate defects and
48 chronic conditions discovered thereby, as may be provided in

1 regulation of the Secretary of the federal Department of Health and
2 Human Services and approved by the commissioner;
3 (5) Physician's services furnished in the office, the patient's
4 home, a hospital, a skilled nursing, or intermediate care facility or
5 elsewhere.
6 As used in this subsection, "laboratory and X-ray services"
7 includes HIV drug resistance testing, including, but not limited to,
8 genotype assays that have been cleared or approved by the federal
9 Food and Drug Administration, laboratory developed genotype
10 assays, phenotype assays, and other assays using phenotype
11 prediction with genotype comparison, for persons diagnosed with
12 HIV infection or AIDS.
13 b. Subject to the limitations imposed by federal law, by this
14 act, and by the rules and regulations promulgated pursuant thereto,
15 the medical assistance program may be expanded to include
16 authorized services within each of the following classifications:
17 (1) Medical care not included in subsection a.(5) above, or any
18 other type of remedial care recognized under State law, furnished
19 by licensed practitioners within the scope of their practice, as
20 defined by State law;
21 (2) Home health care services;
22 (3) Clinic services;
23 (4) Dental services;
24 (5) Physical therapy and related services;
25 (6) Prescribed drugs, dentures, and prosthetic devices; and
26 eyeglasses prescribed by a physician skilled in diseases of the eye
27 or by an optometrist, whichever the individual may select;
28 (7) Optometric services;
29 (8) Podiatric services;
30 (9) Chiropractic services;
31 (10) Psychological services;
32 (11) Inpatient psychiatric hospital services for individuals under
33 21 years of age, or under age 22 if they are receiving such services
34 immediately before attaining age 21;
35 (12) Other diagnostic, screening, preventative, and rehabilitative
36 services, and other remedial care;
37 (13) Inpatient hospital services, nursing facility services, and
38 immediate care facility services for individuals 65 years of age or
39 over in an institution for mental diseases;
40 (14) Intermediate care facility services;
41 (15) Transportation services;
42 (16) Services in connection with the inpatient or outpatient
43 treatment or care of substance use disorder, when the treatment is
44 prescribed by a physician and provided in a licensed hospital or in a
45 narcotic and substance use disorder treatment center approved by
46 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
47 et. seq.) and whose staff includes a medical director, and limited

1 those services eligible for federal financial participation under Title
2 XIX of the federal Social Security Act;
3 (17) Any other medical care and any other type of remedial care
4 recognized under State law, specified by the Secretary of the federal
5 Department of Health and Human Services, and approved by the
6 commissioner;
7 (18) Comprehensive maternity care, which may include: the
8 basic number of prenatal and postpartum visits recommended by the
9 American College of Obstetrics and Gynecology; additional
10 prenatal and postpartum visits that are medically necessary;
11 necessary laboratory, nutritional assessment and counseling, health
12 education, personal counseling, managed care, outreach, and
13 follow-up services; treatment of conditions which may complicate
14 pregnancy doula care; and physician or certified nurse midwife
15 delivery services. For the purposes of this paragraph, "doula"
16 means a trained professional who provides continuous physical,
17 emotional, and informational support to a mother before, during,
18 and shortly after childbirth, to help her to achieve the healthiest,
19 most satisfying experience possible;
20 (19) Comprehensive pediatric care, which may include:
21 ambulatory, preventive, and primary care health services. The
22 preventive services shall include, at a minimum, the basic number
23 of preventive visits recommended by the American Academy of
24 Pediatrics;
25 (20) Services provided by a hospice which is participating in the
26 Medicare program established pursuant to Title XVIII of the Social
27 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
28 services shall be provided subject to approval of the Secretary of
29 the federal Department of Health and Human Services for federal
30 reimbursement;
31 (21) Mammograms, subject to approval of the Secretary of the
32 federal Department of Health and Human Services for federal
33 reimbursement, including one baseline mammogram for women
34 who are at least 35 but less than 40 years of age; one mammogram
35 examination every two years or more frequently, if recommended
36 by a physician, for women who are at least 40 but less than 50 years
37 of age; and one mammogram examination every year for women
38 age 50 and over;
39 (22) Upon referral by a physician, advanced practice nurse, or
40 physician assistant of a person who has been diagnosed with
41 diabetes, gestational diabetes, or pre-diabetes, in accordance with
42 standards adopted by the American Diabetes Association:
43 (a) Expenses for diabetes self-management education or training
44 to ensure that a person with diabetes, gestational diabetes, or pre-
45 diabetes can optimize metabolic control, prevent and manage
46 complications, and maximize quality of life. Diabetes self-
47 management education shall be provided by an in-State provider
48 who is:

1 (i) a licensed, registered, or certified health care professional
2 who is certified by the National Certification Board of Diabetes
3 Educators as a Certified Diabetes Educator, or certified by the
4 American Association of Diabetes Educators with a Board
5 Certified-Advanced Diabetes Management credential, including, but
6 not limited to: a physician, an advanced practice or registered nurse,
7 a physician assistant, a pharmacist, a chiropractor, a dietitian
8 registered by a nationally recognized professional association of
9 dietitians, or a nutritionist holding a certified nutritionist specialist
10 (CNS) credential from the Board for Certification of Nutrition
11 Specialists; or
12 (ii) an entity meeting the National Standards for Diabetes Self-
13 Management Education and Support, as evidenced by a recognition
14 by the American Diabetes Association or accreditation by the
15 American Association of Diabetes Educators;
16 (b) Expenses for medical nutrition therapy as an effective
17 component of the person's overall treatment plan upon a: diagnosis
18 of diabetes, gestational diabetes, or pre-diabetes; change in the
19 beneficiary's medical condition, treatment, or diagnosis; or
20 determination of a physician, advanced practice nurse, or physician
21 assistant that reeducation or refresher education is necessary.
22 Medical nutrition therapy shall be provided by an in-State provider
23 who is a dietitian registered by a nationally-recognized professional
24 association of dietitians, or a nutritionist holding a certified
25 nutritionist specialist (CNS) credential from the Board for
26 Certification of Nutrition Specialists, who is familiar with the
27 components of diabetes medical nutrition therapy;
28 (c) For a person diagnosed with pre-diabetes, items and services
29 furnished under an in-State diabetes prevention program that meets
30 the standards of the National Diabetes Prevention Program, as
31 established by the federal Centers for Disease Control and
32 Prevention; and
33 (d) Expenses for any medically appropriate and necessary
34 supplies and equipment recommended or prescribed by a physician,
35 advanced practice nurse, or physician assistant for the management
36 and treatment of diabetes, gestational diabetes, or pre-diabetes,
37 including, but not limited to: equipment and supplies for self-
38 management of blood glucose; insulin pens; insulin pumps and
39 related supplies; and other insulin delivery devices;
40 (23) Expenses incurred for the provision of group prenatal
41 services to a pregnant woman, provided that:
42 (a) the provider of such services, which shall include, but not be
43 limited to, a federally qualified health center or a community health
44 center operating in the State:
45 (i) is a site accredited by the Centering Healthcare Institute, or is
46 a site engaged in an active implementation contract with the
47 Centering Healthcare institute, that utilizes the Centering Pregnancy
48 model; and

1 (ii) incorporates the applicable information outlined in any best
2 practices manual for prenatal and postpartum maternal care
3 developed by the Department of Health into the curriculum for each
4 group prenatal visit;
5 (b) each group prenatal care visit is at least 1.5 hours in duration,
6 with a. minimum of two women and a maximum of 20 women in
7 participation; and
8 (c) no more than 10 group prenatal care visits occur per
9 pregnancy. As used in this paragraph, "group prenatal care
10 services" means a series of prenatal care visits provided in a group
11 setting which are based upon the Centering Pregnancy model
12 developed by the Centering Healthcare Institute and which include
13 health assessments, social and clinical support, and educational
14 activities;
15 (24) Expenses incurred for the provision of pasteurized donated
16 human breast milk, which shall include human milk fortifiers if
17 indicated in a medical order provided by a licensed medical
18 practitioner, to an infant under the age of six months; provided that
19 the milk is obtained from a human milk bank that meets quality
20 guidelines established by the Department of Health and a licensed
21 medical practitioner has issued a medical order for the infant under
22 at least one of the following circumstances:
23 (a) the infant is medically or physically unable to receive
24 maternal breast milk or participate in breast feeding, or the infant's
25 mother is medically or physically unable to produce maternal breast
26 milk in sufficient quantities or participate in breast feeding despite
27 optimal lactation support; or
28 (b) the infant meets any of the following conditions:
29 (i) a body weight below healthy levels, as determined by the
30 licensed medical practitioner issuing the medical order for the
31 infant;
32 (ii) the infant has a congenital or acquired condition that places
33 the infant at a high risk for development of necrotizing
34 enterocolitis; or
35 (iii) the infant has a congenital or acquired condition that may
36 benefit from the use of donor breast milk and human milk fortifiers,
37 as determined by the Department of Health;
38 (25) Comprehensive tobacco cessation benefits to an individual
39 who is 18 years of age or older, or who is pregnant. Coverage shall
40 include: brief and high intensity individual counseling, brief and
41 high intensity group counseling, and telemedicine as defined by
42 section 1 of P.L.2017, c.117 (C.45:1-61); all medications approved
43 for tobacco cessation by the U.S. Food and Drug Administration;
44 and other tobacco cessation counseling recommended by the
45 Treating Tobacco Use and Dependence Clinical Practice Guideline
46 issued by the U.S. Public Health Service. Notwithstanding the
47 provisions of any other law, rule, or regulation to the contrary, and
48 except as otherwise provided in this section:

1 (a) Information regarding the availability of the tobacco
2 cessation services described in this paragraph shall be provided to
3 all individuals authorized to receive the tobacco cessation services
4 pursuant to this paragraph at the following times: no later than 90
5 days after the effective date of P.L.2019, c.473: upon the
6 establishment of an individual's eligibility for medical assistance;
7 and upon the redetermination of an individual's eligibility for
8 medical assistance;
9 (b) The following conditions shall not be imposed on any
10 tobacco cessation services provided pursuant to this paragraph:
11 copayments or any other forms of cost-sharing, including
12 deductibles; counseling requirements for medication; stepped care
13 therapy or similar restrictions requiring the use of one service prior
14 to another; limits on the duration of services; or annual or lifetime
15 limits on the amount, frequency, or cost of services, including, but
16 not limited to, annual or lifetime limits on the number of covered
17 attempts to quit; and
18 (c) Prior authorization requirements shall not be imposed on any
19 tobacco cessation services provided pursuant to this paragraph
20 except in the following circumstances where prior authorization
21 may be required: for a treatment that exceeds the duration
22 recommended by the most recently published United States Public
23 Health Service clinical practice guidelines on treating tobacco use
24 and dependence; or for services associated with more than two
25 attempts to quit within a 12-month period;
26 (26) Provided that there is federal financial participation
27 available, benefits for expenses incurred in conducting a colorectal
28 cancer screening in accordance with United States Preventive
29 Services Task Force recommendations. The method and frequency
30 of screening to be utilized shall be in accordance with the most
31 recent published recommendations of the United States Preventive
32 Services Task Force and as determined medically necessary by the
33 covered person's physician, in consultation with the covered person.
34 No deductible, coinsurance, copayment, or any other cost-
35 sharing requirement shall be imposed for a colonoscopy performed
36 following a positive result on a non-colonoscopy, colorectal cancer
37 screening test recommended by the United States Preventive
38 Services Task Force; 【and】
39 (27) (a) Within 24 months of the effective date of P.L.2023,
40 c.187 (C.30:4D-6u et al.), and conditional on the receipt of all
41 necessary federal approvals and the securing of federal financial
42 participation pursuant to section 2 of P.L.2023, c.187 (C.30:4D-6u),
43 community-based palliative care benefits which shall include, but
44 not be limited to, all of the following:
45 (i) specialized medical care and emotional and spiritual support
46 for beneficiaries with serious advanced illnesses;
47 (ii) relief of symptoms, pain, and stress of serious illness;

(iii) improvement of quality of life for both the beneficiary and the beneficiary's family; and

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

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

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

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

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

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

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

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

(28) Community violence prevention services to an individual who has: (a) received medical treatment for an injury sustained as a result of an act of community violence, and (b) been referred by a certified or licensed health care provider or social services provider to receive community violence prevention services from a certified violence prevention professional, after such provider determines such beneficiary to be at elevated risk of a violent injury or retaliation resulting from another act of community violence.

As used in this paragraph:

"Certified violence prevention professional" means an individual who has completed an accredited training and certification program regarding violence prevention services, approved by the Department of Health in accordance with section 3 of P.L. , c. (C.) (pending before the Legislature as this bill), and who has maintained such certification;

"Community violence" means any intentional act of physical force against one or more other persons by an individual or small group of individuals committed in one or more public areas, where

no actor is a family member or intimate partner of any such victim; and

"Community violence prevention services" means evidence-based, trauma-informed, supportive and non-psychotherapeutic services provided by a certified violence prevention professional, within or outside of a clinical setting, for the purpose of promoting improved health outcomes and positive behavioral change, preventing injury recidivism, and reducing the likelihood that individuals who are victims of community violence will commit or promote violence themselves. "Community violence prevention services" may include the provision of peer support and counseling, mentorship, conflict mediation, crisis intervention, targeted case management, referrals to certified or licensed health care professionals or social services providers, patient education, or screening services to victims of community violence.

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 form 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 provided 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 33 perform the service or services required (including an organization which provides such services, or arranges for their availability on a prepayment basis), who undertakes to provide the individual such services.

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

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

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

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

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

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

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

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

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

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

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

1 (3) Individuals who are 65 years of age or older shall be
2 provided with services cited in subsections a.(3) and (5) of this
3 section and subsections b.(1)-(5), (6) excluding prescribed drugs,
4 (7), (8), (10), (12), (15), and (17) of this section, and nursing
5 facility services cited 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),
9 3 (12), (15), and (17) of this section, and nursing facility services
10 cited in subsection b.(13) of this section.
11 (5) (a) Inpatient hospital services, subsection a.(1) of this
12 section, shall only be provided to eligible medically needy
13 individuals, other than pregnant women, if the federal Department
14 of Health and Human Services discontinues the State's waiver to
15 establish inpatient hospital reimbursement rates for the Medicare
16 and Medicaid programs under the authority of section 601(c)(3) of
17 the Social Security Act Amendments of 1983, Pub.L.98-21 (42
18 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be
19 extended to other eligible medically needy individuals if the federal
20 Department of Health and Human Services directs that these
21 services be included.
22 (b) Outpatient hospital services, subsection a.(2) of this section,
23 shall only be provided to eligible medically needy individuals if the
24 federal Department of Health and Human Services discontinues the
25 State's waiver to establish outpatient hospital reimbursement rates
26 for the Medicare and Medicaid programs under the authority of
27 section 601(c)(3) of the Social Security Amendments of 1983,
28 Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital
29 services may be extended to all or to certain medically needy
30 individuals if the federal Department of Health and Human Services
31 directs that these services be included. However, the use of
32 outpatient hospital services shall be limited to clinic services and to
33 emergency room services for injuries and significant acute medical
34 conditions.
35 (c) The division shall monitor the use of inpatient and outpatient
36 hospital services by medically needy persons.
37 h. In the case of a qualified disabled and working individual
38 pursuant to section h6408 of Pub.L.101-239 (42 U.S.C. s.1396d),
39 the only medical assistance provided under this act shall be the
40 payment of premiums for Medicare part A under 42 U.S.C.
41 ss.1395i-2 and 1395r.
42 i. In the case of a specified low-income Medicare beneficiary
43 pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical
44 assistance provided under this act shall be the payment of premiums
45 for Medicare part B under 42 U.S.C. s.1395r as provided for in 42
46 U.S.C. s.1396d(p)(3)(A)(ii).
47 j. In the case of a qualified individual pursuant to 42 U.S.C.
48 s.1396a(aa), the only medical assistance provided under this act

1 shall be payment for authorized services provided during the period
2 in which the individual requires treatment for breast or cervical
3 cancer, in accordance with criteria established by the commissioner.
4 k. In the case of a qualified individual pursuant to 42 U.S.C.
5 s.1396a(ii), the only medical assistance provided under this act shall
6 be payment for family planning services and supplies as described
7 at 42 U.S.C. s.1396d(a)(4)(C), including medical diagnosis and
8 treatment services that are provided pursuant to a family planning
9 service in a family planning setting.
10 (cf: P.L.2023, c.187, s.1)
11
12 2. (New section) The Commissioner of Human Services shall
13 apply for such State plan amendments or waivers as may be
14 necessary to implement the provisions of this act and to secure
15 federal financial participation for State Medicaid expenditures
16 under the federal Medicaid program.
17
18 3. (New section) a. Within six months of the effective date of
19 P.L. , c. (C.) (pending before the Legislature as this bill),
20 the Department of Health shall approve at least one accredited
21 training and certification program for certified violence prevention
22 professionals. A program approved by the department pursuant to
23 this subsection shall include:
24 (1) At least 35 hours of initial training, collectively addressing
25 all of the following:
26 (a) the effects of trauma and violence and the basics of trauma-
27 informed care;
28 (b) community violence prevention strategies, including, but not
29 limited to, conflict mediation and retaliation prevention related to
30 community violence;
31 (c) case management and advocacy practices; and
32 (d) patient privacy and the federal "Health Insurance Portability
33 and Accountability Act of 1996," P.L. 104-191; and
34 (2) At least six hours of continuing education every two years.
35 b. Any entity that employs or contracts with a certified
36 violence prevention professional to provide community violence
37 prevention services shall:
38 (1) Maintain documentation that the certified violence
39 prevention professional has completed a training and certification
40 program that meets the requirements of subsection a. of this section;
41 and
42 (2) Ensure that the certified violence prevention professional is
43 providing community violence prevention services in compliance
44 with any applicable standards of care, rules, regulations, and
45 governing law of the State or federal government.
46 c. No person, unless certified as a violence prevention
47 professional pursuant to this section, may use the title "certified
48 violence prevention professional" or make use of any title, words,

letters, abbreviations, or insignia indicating or implying that the person is a certified violence prevention professional.

d. Nothing in this section shall be construed to alter the scope of practice for any health care professional.

e. As used in this section:

"Certified violence prevention professional" means an individual who has completed an accredited training and certification program regarding violence prevention services, approved by the Department of Health in accordance with this section, and who has maintained such certification.

"Community violence" means any intentional act of physical force against one or more other persons by an individual or small group of individuals committed in one or more public areas, where no actor is a family member or intimate partner of any such victim.

"Community violence prevention services" means evidence-based, trauma-informed, supportive and non-psychotherapeutic services provided by a certified violence prevention professional, within or outside of a clinical setting, for the purpose of promoting improved health outcomes and positive behavioral change, preventing injury recidivism, and reducing the likelihood that individuals who are victims of community violence will commit or promote violence themselves. "Community violence prevention services" may include the provision of peer support and counseling, mentorship, conflict mediation, crisis intervention, targeted case management, referrals to certified or licensed health care professionals or social services providers, patient education, or screening services to victims of community violence.

4. The Commissioners of Human Services and Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

5. This act shall take effect immediately.