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Assemblyman Benson, Assemblywomen Mosquera, Jimenez,
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SYNOPSIS
Requires Medicaid coverage for diabetes self-management education,
training, services, and equipment for patients diagnosed with diabetes,
gestational diabetes, and pre-diabetes.

CURRENT VERSION OF TEXT
As amended by the Senate on June 22, 2017.

(Sponsorship Updated As Of: 6/23/2017)
AN ACT concerning Medicaid coverage for diabetes treatment and
amending P.L.1968, c.413.

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

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

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

(1) Inpatient hospital services;
(2) Outpatient hospital services;
(3) Other laboratory and X-ray services;
(4) (a) Skilled nursing or intermediate care facility services;
(b) Early and periodic screening and diagnosis of individuals
who are eligible under the program and are under age 21, to
ascertain their physical or mental defects and the health care,
treatment, and other measures to correct or ameliorate defects and
chronic conditions discovered thereby, as may be provided in
regulations of the Secretary of the federal Department of Health and
Human Services and approved by the commissioner;
(5) Physician's services furnished in the office, the patient's
home, a hospital, a skilled nursing, or intermediate care facility or
elsewhere.

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

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

(1) Medical care not included in subsection a.(5) above, or any
other type of remedial care recognized under State law, furnished
by licensed practitioners within the scope of their practice, as
defined by State law;
(2) Home health care services;
(3) Clinic services;

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
1Assembly AHE committee amendments adopted October 6, 2016.
2Senate floor amendments adopted June 22, 2017.
(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 drug abuse, when the treatment is prescribed by
a physician and provided in a licensed hospital or in a narcotic and
drug abuse treatment center approved by the Department of Health
pursuant to P.L.1970, c.334 (C.26:2G-21 et seq.) and whose staff
includes a medical director, and limited to those services eligible
for federal financial participation under Title XIX of the federal
Social Security Act;
(17) Any other medical care and any other type of remedial care
recognized under State law, specified by the Secretary of the federal
Department of Health and Human Services, and approved by the
commissioner;
(18) Comprehensive maternity care, which may include: the
basic number of prenatal and postpartum visits recommended by the
American College of Obstetrics and Gynecology; additional
prenatal and postpartum visits that are medically necessary;
necessary laboratory, nutritional assessment and counseling, health
education, personal counseling, managed care, outreach, and
follow-up services; treatment of conditions which may complicate
pregnancy; and physician or certified nurse-midwife delivery
services;
(19) Comprehensive pediatric care, which may include:
ambulatory, preventive, and primary care health services. The
preventive services shall include, at a minimum, the basic number
of preventive visits recommended by the American Academy of
Pediatrics;
(20) Services provided by a hospice which is participating in the
Medicare program established pursuant to Title XVIII of the Social
Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement,

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

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

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

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

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

(b) Expenses for medical nutrition therapy as an effective component of the person’s overall treatment plan upon a diagnosis of diabetes, gestational diabetes, or pre-diabetes; change in the beneficiary’s medical condition, treatment, or diagnosis; or determination of a physician, advanced practice nurse, or physician assistant that reeducation or refresher education is necessary. Medical nutrition therapy shall be provided by an in-State provider who is a dietitian registered by a nationally-recognized professional association of dietitians, or a nutritionist holding a certified nutritionist specialist (CNS) credential from the Board for...
Certification of Nutrition Specialists, who is\(^2\) familiar with the components of diabetes medical nutrition therapy;

(c) For a person diagnosed with pre-diabetes, items and services furnished under \(^1\) an in-State\(^2\) diabetes prevention program that meets the standards of the National Diabetes Prevention Program, as established by the \(^1\) federal\(^1\) Centers for Disease Control and Prevention; and

(d) Expenses for any \(^1\) medically appropriate and necessary\(^4\) supplies and equipment recommended or prescribed by a physician, advanced practice nurse, or physician assistant for the management and treatment of diabetes, gestational diabetes, or pre-diabetes, including, but not limited to: equipment and supplies for self-management of blood glucose; insulin pens; insulin pumps and related supplies; and other insulin delivery devices.

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

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

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

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

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

(1) Is an inmate of a public institution (except as a patient in a medical institution); provided, however, that an individual who is
otherwise eligible may continue to receive services for the month in
which he becomes an inmate, should the commissioner determine to
expand the scope of Medicaid eligibility to include such an
individual, subject to the limitations imposed by federal law and
regulations, or
(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
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
subsection a.(1), (3), and (5) of this section and subsection 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
subsection a.(3) and (5) of this section and subsection 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.
(3) Individuals who are 65 years of age or older shall be
provided with services cited in subsection a.(3) and (5) of this
section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

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

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

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

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

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

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

j. In the case of a qualified individual pursuant to 42 U.S.C. s.1396a(aa), the only medical assistance provided under this act shall be payment for authorized services provided during the period
in which the individual requires treatment for breast or cervical cancer, in accordance with criteria established by the commissioner. (cf: P.L.2012, c.17, s.359)

2. (New section) Within 180 days after the enactment of this act, the Commissioner of Human Services shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program.

3. (New section) The Commissioner of Human Services shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to effectuate the purposes of this act; except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner shall adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed six months and shall thereafter be amended, adopted, or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

4. This act shall take effect immediately except that the provisions of section 1 shall remain inoperable until the commissioner receives approval, from the United States Secretary of Health and Human Services, of the State plan amendments or waivers that are necessary to obtain federal financial participation for the State Medicaid expenditures that are to be made pursuant to that section.