

ASSEMBLY, No. 856

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

Assemblyman NICHOLAS CHIARAVALLOTI

District 31 (Hudson)

SYNOPSIS

Expands Medicaid coverage regarding assistive devices for hearing impaired under certain circumstances.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



A856 CHIARAVALLOTI

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1 AN ACT concerning Medicaid coverage of hearing aids and other
2 assistive devices for the hearing impaired and amending
3 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
20 who are eligible under the program and are under age 21, to
21 ascertain their physical or mental health status and the health care,
22 treatment, and other measures to correct or ameliorate defects and
23 chronic conditions discovered thereby, as may be provided in
24 regulations of the Secretary of the federal Department of Health and
25 Human Services and approved by the commissioner;
- 26 (5) Physician's services furnished in the office, the patient's
27 home, a hospital, a skilled nursing, or intermediate care facility or
28 elsewhere.

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

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

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

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

Matter underlined thus is new matter.

- 1 (4) Dental services;
- 2 (5) Physical therapy and related services;
- 3 (6) Prescribed drugs, dentures, and prosthetic devices; and
- 4 eyeglasses prescribed by a physician skilled in diseases of the eye
- 5 or by an optometrist, whichever the individual may select;
- 6 (7) Optometric services;
- 7 (8) Podiatric services;
- 8 (9) Chiropractic services;
- 9 (10) Psychological services;
- 10 (11) Inpatient psychiatric hospital services for individuals under
- 11 21 years of age, or under age 22 if they are receiving such services
- 12 immediately before attaining age 21;
- 13 (12) Other diagnostic, screening, preventive, and rehabilitative
- 14 services, and other remedial care;
- 15 (13) Inpatient hospital services, nursing facility services, and
- 16 intermediate care facility services for individuals 65 years of age or
- 17 over in an institution for mental diseases;
- 18 (14) Intermediate care facility services;
- 19 (15) Transportation services;
- 20 (16) Services in connection with the inpatient or outpatient
- 21 treatment or care of substance use disorder, when the treatment is
- 22 prescribed by a physician and provided in a licensed hospital or in a
- 23 narcotic and substance use disorder treatment center approved by
- 24 the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21
- 25 et seq.) and whose staff includes a medical director, and limited to
- 26 those services eligible for federal financial participation under Title
- 27 XIX of the federal Social Security Act;
- 28 (17) Any other medical care and any other type of remedial care
- 29 recognized under State law, specified by the Secretary of the federal
- 30 Department of Health and Human Services, and approved by the
- 31 commissioner;
- 32 (18) Comprehensive maternity care, which may include: the
- 33 basic number of prenatal and postpartum visits recommended by the
- 34 American College of Obstetrics and Gynecology; additional
- 35 prenatal and postpartum visits that are medically necessary;
- 36 necessary laboratory, nutritional assessment and counseling, health
- 37 education, personal counseling, managed care, outreach, and
- 38 follow-up services; treatment of conditions which may complicate
- 39 pregnancy; and physician or certified nurse-midwife delivery
- 40 services;
- 41 (19) Comprehensive pediatric care, which may include:
- 42 ambulatory, preventive, and primary care health services. The
- 43 preventive services shall include, at a minimum, the basic number
- 44 of preventive visits recommended by the American Academy of
- 45 Pediatrics;
- 46 (20) Services provided by a hospice which is participating in the
- 47 Medicare program established pursuant to Title XVIII of the Social
- 48 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice

1 services shall be provided subject to approval of the Secretary of
2 the federal Department of Health and Human Services for federal
3 reimbursement;

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

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

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

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

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

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

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

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

13 (23) Expenses for unilateral or bilateral hearing aids, cochlear
14 implants, or auditory osseointegrated devices, as well as any related
15 accessories or services, provided that the devices, accessories, and
16 services are deemed to be medically necessary and are prescribed or
17 recommended by a licensed physician or audiologist.

18 As used in this paragraph:

19 “Auditory osseointegrated device” means a device implanted in
20 the skull that replaces the function of the middle ear and provides
21 mechanical energy to the cochlea via a mechanical transducer.

22 “Bilateral” means relating to or involving both ears.

23 “Cochlear implant” means a device that is implanted under the
24 skin that picks up sounds and converts them to impulses transmitted
25 to electrodes placed in the cochlea.

26 “Hearing aid” means an ear-level or body-worn electroacoustic
27 device for amplifying sound whose basic components are a
28 microphone, amplifier, and receiver.

29 “Unilateral” means relating to or involving one ear.

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

41 No provider whose claim for payment pursuant to this act has
42 been denied because the services, goods, or supplies were
43 determined to be medically unnecessary shall seek reimbursement
44 from the recipient, his family, his representative or others on his
45 behalf for such services, goods, and supplies provided pursuant to
46 this act; provided, however, a provider may seek reimbursement
47 from a recipient for services, goods, or supplies not authorized by

1 this act, if the recipient elected to receive the services, goods or
2 supplies with the knowledge that they were not authorized.

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

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

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

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

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

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

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

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

45 (3) Notwithstanding any provision of law to the contrary, the
46 provisions of paragraph (2) of this subsection shall not apply to a
47 trust agreement that is established pursuant to 42 U.S.C.
48 s.1396p(d)(4)(A) or (C) to supplement and augment assistance

1 provided by government entities to a person who is disabled as
2 defined in section 1614(a)(3) of the federal Social Security Act (42
3 U.S.C. s.1382c (a)(3)).

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

6 (1) Pregnant women shall be provided prenatal care and delivery
7 services and postpartum care, including the services cited in
8 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
9 (10), (12), (15), and (17) of this section, and nursing facility
10 services cited in subsection b.(13) of this section.

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

15 (3) Individuals who are 65 years of age or older shall be
16 provided with services cited in subsection a.(3) and (5) of this
17 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
18 (8), (10), (12), (15), and (17) of this section, and nursing facility
19 services cited in subsection b.(13) of this section.

20 (4) Individuals who are blind or disabled shall be provided with
21 services cited in subsection a.(3) and (5) of this section and
22 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
23 (12), (15), and (17) of this section, and nursing facility services
24 cited in subsection b.(13) of this section.

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

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

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

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

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

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

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

24 (cf: P.L.2018, c.1, s.2)

25

26 2. The Commissioner of Human Services shall apply for such
27 State plan amendments or waivers as may be necessary to
28 implement the provisions of this act and to secure federal financial
29 participation for State Medicaid expenditures under the federal
30 Medicaid program.

31

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

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37 4. This act shall take effect on the first day of the fourth month
38 next following the date of enactment, but the Commissioner of
39 Human Services may take such anticipatory administrative action in
40 advance thereof as may be necessary for the implementation of this
41 act.

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STATEMENT

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46 This bill requires Medicaid coverage for hearing aids and other
47 assistive devices for hearing impaired under certain circumstances.

1 Specifically, the bill provides that coverage under the Medicaid
2 Program includes expenses for unilateral or bilateral hearing aids,
3 cochlear implants, or auditory osseointegrated devices, as well as
4 any related accessories or services, provided that the devices,
5 accessories, and services are deemed to be medically necessary and
6 are prescribed or recommended by a licensed physician or
7 audiologist.

8 Under the bill, a “hearing aid” means an ear-level or body-worn
9 electroacoustic device for amplifying sound whose basic
10 components are a microphone, amplifier, and receiver; a “cochlear
11 implant” means a device that is implanted under the skin that picks
12 up sounds and converts them to impulses transmitted to electrodes
13 placed in the cochlea; and an “auditory osseointegrated device”
14 means a device implanted in the skull that replaces the function of
15 the middle ear and provides mechanical energy to the cochlea via a
16 mechanical transducer. Furthermore, “bilateral” means relating to
17 or involving both ears, while “unilateral” means relating to or
18 involving one ear.

19 Currently, the State’s Medicaid Plan provides that hearing aids
20 are a covered benefit for eligible participants of the Medicaid
21 Program if the hearing aid is determined to be medically necessary.
22 This bill codifies this existing provision, and expands upon the
23 benefit to include cochlear implants and auditory osseointegrated
24 devices, as well as any related accessories or services.