# 30:4D-6
# LEGISLATIVE HISTORY CHECKLIST

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**LAWS OF**: 2019 **CHAPTER:** 237

**NJSA:** 30:4D-6 (Requires Medicaid coverage for group prenatal care services under certain circumstances.)

**BILL NO**: A5021 (Substituted for S3405)

**SPONSOR(S)** Annette Quijano and others

**DATE INTRODUCED:** 2/7/2019

**COMMITTEE:** **ASSEMBLY:** Appropriations

**SENATE:** Health, Human Services & Senior Citizens

**AMENDED DURING PASSAGE:** Yes

**DATE OF PASSAGE:** **ASSEMBLY:** 6/20/2019

**SENATE:** 6/10/2019

**DATE OF APPROVAL:** 8/9/2019

**FOLLOWING ARE ATTACHED IF AVAILABLE:**

**FINAL TEXT OF BILL** (Second Reprint enacted) Yes

**A5021**

**SPONSOR'S STATEMENT:** (Begins on page of 8 introduced bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: Yes

**SENATE:** No

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

**FLOOR AMENDMENT STATEMENT:** Yes 5/30/2019

**LEGISLATIVE FISCAL ESTIMATE:** Yes 3/26/2019
6/12/2019

**S3405**

**SPONSOR'S STATEMENT:** (Begins on page 8 of introduced bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: No

**SENATE:** Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

**FLOOR AMENDMENT STATEMENT:** Yes 5/30/2019

**LEGISLATIVE FISCAL ESTIMATE:** Yes 6/12/2019

**VETO MESSAGE:** No

**GOVERNOR'S PRESS RELEASE ON SIGNING:** Yes

**FOLLOWING WERE PRINTED:**

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**REPORTS:** No

**HEARINGS:** No

**NEWSPAPER ARTICLES:** No

RWH/CL

P.L. 2019, CHAPTER 237, ***approved August 9, 2019***
Assembly, No. 5021 ***(Second Reprint)***

**AN ACT** concerning Medicaid coverage for group prenatal care services and amending P.L.1968, c.413.

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

[2]1. (New section) The Legislature finds and declares that:

a. CenteringPregnancy is an evidence-based model of group prenatal care that has been shown to improve birth outcomes for both mothers and babies;

b. Research indicates that the benefits of CenteringPregnancy include: increased birth weights; increased rates of breastfeeding; reduced risk of pre-term pregnancies; and reduced risk of gestational diabetes;

c. For example, CenteringPregnancy reduces the odds of premature birth, the single largest contributor to infant mortality, between 33 percent and 47 percent across studies;

d. CenteringPregnancy appears to provide even greater benefits to certain high-risk populations and can be effective at reducing health disparities related to race, ethnicity, and socio-economic status;

e. By reducing the rate of negative birth outcomes, CenteringPregnancy prevents high-cost medical interventions and reduces overall costs of care;

f. In South Carolina, the Birth Outcomes Initiative continues to show significant cost savings within the Medicaid program with CenteringPregnancy becoming a covered benefit as of July 2017;

g. Other states including New York, Georgia, and Montana have implemented or are in the process of implementing enhanced payment programs for CenteringPregnancy with their Medicaid programs; and

h. Expanding patient access to CenteringPregnancy within New Jersey's Medicaid Program will simultaneously improve population health outcomes and reduce overall costs of healthcare delivery. [2]

[2]**[**1.**]** 2.[2] 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

**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:**
**[1]Assembly AAP committee amendments adopted March 18, 2019.**
**[2]Senate floor amendments adopted May 30, 2019.**

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 health status 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;

(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 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:

(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, 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

(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 familiar with the components of diabetes medical nutrition therapy;

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

(d) Expenses for any medically appropriate and necessary 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 [1][.] ; and[1]

(23) Expenses incurred for the provision of group prenatal care services to a pregnant woman [1][between the ages of 12 and 55 years of age][1] , provided that:

(a) the provider of such services [2],which shall include, but not be limited to, a federally qualified health center or a community health center operating in the State[2] :

(i) is a site accredited by the Centering Healthcare Institute [2], or is a site engaged in an active implementation contract with the Centering Healthcare Institute,[2] that utilizes the CenteringPregnancy model; and

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

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

(c) no more than [1]**[**ten**]** 10[1] group prenatal care visits occur per pregnancy.

As used in this paragraph, "group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the Centering Healthcare Institute and [1]which[1] include health assessments, social and clinical support, and educational activities.

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.

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

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

²[2.] 3.² 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.

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

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

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Requires Medicaid coverage for group prenatal care services under certain circumstances.

# ASSEMBLY, No. 5021

# STATE OF NEW JERSEY

## 218th LEGISLATURE

INTRODUCED FEBRUARY 7, 2019

**Sponsored by:**
**Assemblywoman ANNETTE QUIJANO**
**District 20 (Union)**

**Co-Sponsored by:**
**Assemblywoman Tucker**

**SYNOPSIS**

Requires Medicaid coverage for group prenatal care services under certain circumstances.

**CURRENT VERSION OF TEXT**

As introduced.

**(Sponsorship Updated As Of: 3/19/2019)**

**AN ACT** concerning Medicaid coverage for group prenatal care services 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 health status 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;

(4) Dental 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 <u>thus</u> is new matter.**

(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 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:

(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, 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

(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 familiar with the components of diabetes medical nutrition therapy;

(c) For a person diagnosed with pre-diabetes, items and services

furnished under an in-State diabetes prevention program that meets the standards of the National Diabetes Prevention Program, as established by the federal Centers for Disease Control and Prevention; and

(d) Expenses for any medically appropriate and necessary 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.

(23) Expenses incurred for the provision of group prenatal care services to a pregnant woman between the ages of 12 and 55 years of age, provided that:

(a) the provider of such services:

(i) is a site accredited by the Centering Healthcare Institute that utilizes the CenteringPregnancy model; and

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

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

(c) no more than ten group prenatal care visits occur per pregnancy.

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

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.

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

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

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

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

STATEMENT

The bill provides for an expansion of the State Medicaid program to include coverage of group prenatal care services under certain circumstances. As used in the bill, “group prenatal care services”

means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the Centering Healthcare Institute and include health assessments, social and clinical support, and educational activities. The CenteringPregnancy model is a health care redesign that changes the traditional model of the patient and health care provider in an exam room to a group setting which allows for care based on clinical and peer support. The Centering Healthcare Institute is a nonprofit organization established in 2001 that aims to improve healthcare through the training and support of group care providers.

Research indicates group prenatal care services provide benefits for mothers, babies, and providers, largely because access to care is increased. For example, data suggests that women who participate in group prenatal care visits have decreased rates of preterm and low weight babies, increased breastfeeding rates, and better pregnancy spacing. Furthermore, group prenatal care visits have been shown to nearly eliminate racial disparities in preterm birth. By preventing preterm birth, group prenatal care services also provide cost savings to the healthcare system, as preterm births can be more than ten times more expensive than that of a full-term delivery.

Specifically, this bill provides that coverage under the Medicaid program includes expenses incurred for the provision of group prenatal care services to a pregnant woman between the ages of 12 and 55 years of age, provided that:

(1) the provider of services: (a) is a site accredited by the Centering Healthcare Institute that utilizes the CenteringPregnancy model; and (b) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

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

(3) no more than ten group prenatal care visits occur per pregnancy.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

# ASSEMBLY, No. 5021

with committee amendments

# STATE OF NEW JERSEY

DATED: MARCH 18, 2019

The Assembly Appropriations Committee reports favorably Assembly Bill No. 5021, with committee amendments.

As amended by the committee, this bill provides for an expansion of the State Medicaid program to include coverage of group prenatal care services under certain circumstances. As used in the bill, " group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the Centering Healthcare Institute and which include health assessments, social and clinical support, and educational activities.

Specifically, the amended bill provides that coverage under the Medicaid program includes expenses incurred for the provision of group prenatal care services to a pregnant woman, provided that:

(1) the provider of services is a site accredited by the Centering Healthcare Institute that utilizes the CenteringPregnancy model and the provider incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

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

(3) no more than 10 group prenatal care visits occur per pregnancy.

COMMITTEE AMENDMENTS:

The committee amendments remove language that would have established an age range for pregnant women to receive coverage under the bill and make various technical corrections.

FISCAL IMPACT:

The Office of Legislative Services (OLS) estimates that this bill may provide an indeterminate decrease in expenditures to the State due to the provision of group prenatal care services to pregnant women who receive health care services under the State's Medicaid program. Any savings realized by the State under the bill will be

matched by a decrease in federal Medicaid funds. While the bill does not specify a reimbursement rate for group prenatal services, this estimate assumes that the rate will be less than the rate for one-on-one prenatal services provided under the Medicaid program, that eligible women will utilize group prenatal services as a replacement for one-on-one prenatal services, and that the number of group prenatal visits per eligible Medicaid enrollee will be comparable to the number of one-on-one prenatal services per eligible enrollee. Furthermore, research suggests that the provision of group prenatal services is associated with improved maternal outcomes. Therefore, the OLS concludes that there may be additional log-term cost savings due to the decrease in medical costs associated with the care of mothers and infants.

The OLS cannot predict the magnitude of the potential State savings that may result from this bill, but notes that the uptake of this benefit will be limited, at least initially, by the availability of accredited Center Healthcare Institute (CHI) sites to provide the services. According to the CHI website, there are currently 12 CenteringPregnancy sites in the State; however only three have successfully gone through CHI's Accreditation process, which is a requirement for the provision of group prenatal services under the bill.

STATEMENT TO

[First Reprint]

# ASSEMBLY, No. 5021

with Senate Floor Amendments
(Proposed by Senator VITALE)

ADOPTED: MAY 30, 2019

These Senate amendments explicitly state that providers included under the bill's provisions are to include, but are not to be limited to, federally qualified health centers and community health centers operating in the State. The amendments also allow services provided by a site not accredited by the Centering Healthcare Institute, but engaged in an active implementation contract with the Centering Healthcare Institute, that utilize the CenteringPregnancy model, to qualify for Medicaid coverage. Finally, the Senate amendments add a Legislative findings and declarations section to the bill.

# LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

# ASSEMBLY, No. 5021

# STATE OF NEW JERSEY
# 218th LEGISLATURE

DATED: MARCH 26, 2019

## SUMMARY

**Synopsis:** Requires Medicaid coverage for group prenatal care services under certain circumstances.

**Type of Impact:** Decrease of State expenditures and revenue; General Fund.

**Agencies Affected:** Department of Human Services.

**Office of Legislative Services Estimate**

| Fiscal Impact | Annual |
|---|---|
| **State Expenditure Decrease** | Indeterminate |
| **State Revenue Decrease** | Indeterminate |

- The Office of Legislative Services (OLS) estimates that this bill may result in an indeterminate decrease in expenditures to the State due to the provision of group prenatal care services to pregnant women who receive health care services under the State's Medicaid program. Any savings realized by the State under the bill will be matched by a decrease in federal Medicaid funds.

- While the bill does not specify a reimbursement rate for group prenatal services, this estimate assumes that the rate will be less than the rate for one-on-one prenatal services provided under the Medicaid program, that eligible women will utilize group prenatal services as a replacement for one-on-one prenatal services, and that the number of group prenatal visits per eligible Medicaid enrollee will be comparable to the number of one-on-one prenatal services per eligible enrollee.

- Furthermore, research suggests that the provision of group prenatal services is associated with improved maternal outcomes. Therefore, the OLS concludes that there may be additional long-term cost savings due to the decrease in medical costs associated with the care of mothers and infants.

- The OLS cannot predict the magnitude of the potential State savings that may result from this bill, but notes that the uptake of this benefit will be limited, at least initially, by the

availability of accredited Centering Healthcare Institute (CHI) sites to provide the services. According to the CHI website, there are currently 12 CenteringPregnancy sites in the State; however only three have successfully gone through CHI's Accreditation process, which is a requirement for the provision of group prenatal services under the bill.

## BILL DESCRIPTION

The bill provides for an expansion of the State Medicaid program to include coverage of group prenatal care services under certain circumstances. As used in the bill, "group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the Centering Healthcare Institute and which include health assessments, social and clinical support, and educational activities.

Specifically, this bill provides that coverage under the Medicaid program includes expenses incurred for the provision of group prenatal care services to a pregnant woman, provided that:

(1) the provider of services: (a) is a site accredited by the Centering Healthcare Institute that utilizes the CenteringPregnancy model; and (b) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

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

(3) no more than 10 group prenatal care visits occur per pregnancy.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

None received.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS estimates that this bill may result in an indeterminate decrease in expenditures to the State due to the provision of group prenatal care services to pregnant women who receive health care services under the State's Medicaid program. Any savings realized by the State under the bill will be matched by a decrease in federal Medicaid funds.

While the bill does not specify a reimbursement rate for group prenatal services, this estimate assumes that the rate will be less than the rate for one-on-one prenatal services provided under the Medicaid program, that eligible women will utilize group prenatal services as a replacement for one-on-one prenatal services, and that the number of group prenatal visits per eligible Medicaid enrollee will be comparable to the number of one-on-one prenatal services per eligible enrollee.

One factor of the bill's impact on State expenditures is the number of individuals who will be provided group prenatal care services under the bill. According to the New Jersey Health Assessment Data website, 31,151 of the 101,154 births in New Jersey in CY 2017 were financed by Medicaid, in CY 2016, there were 31,877 Medicaid births and in CY 2015 there were 30,986. The OLS, however, cannot predict how this population may change from year to year, or, more significantly, what portion of this population may choose to utilize group prenatal care services, rather than one-on-one prenatal visits.

Furthermore, research suggests that the provision of group prenatal services is associated with improved maternal outcomes. Therefore, the OLS concludes that there may be additional long-term cost savings due to the decrease in medical costs associated with the care of mothers and infants. For reference, a study performed in collaboration between the South Carolina Department of Health and Human Services, which provides a Medicaid group prenatal visit benefit, and the University of South Carolina estimated that CenteringPregnancy participation reduced the risk of premature birth and of a neonatal intensive care unit stay, as well as the incidence of delivering an infant with low birth weight. The study concluded that, after considering the state investment of $1.7 million to provide group prenatal services to Medicaid beneficiaries, there was an estimated return on investment of nearly $2.3 million.[1]

The OLS cannot predict the magnitude of the potential State savings that may result from this bill, but notes that the uptake of this benefit will be limited, at least initially, by the availability of accredited Center Healthcare Institute (CHI) sites to provide the services. According to the CHI website, there are currently 12 CenteringPregnancy sites in the State; however only three have successfully gone through CHI's Accreditation process, which is a requirement for the provision of group prenatal services under the bill.

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| *Section:* | *Human Services* |
| *Analyst:* | *Sarah Schmidt*<br>*Senior Research Analyst* |
| *Approved:* | *Frank W. Haines III*<br>*Legislative Budget and Finance Officer* |

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

[1] https://link.springer.com/article/10.1007%2Fs10995-016-1935-y

# LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

# ASSEMBLY, No. 5021

# STATE OF NEW JERSEY
# 218th LEGISLATURE

DATED: JUNE 12, 2019

## SUMMARY

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|---|---|
| **Synopsis:** | Requires Medicaid coverage for group prenatal care services under certain circumstances. |
| **Type of Impact:** | Indeterminate impact on State expenditures and revenue; General Fund. |
| **Agencies Affected:** | Department of Human Services. |

**Office of Legislative Services Estimate**

| Fiscal Impact | Annual |
|---|---|
| **State Expenditure Impact** | Indeterminate |
| **State Revenue Impact** | Indeterminate |

- The Office of Legislative Services (OLS) estimates that this bill will have an indeterminate impact on State expenditures due to the provision of group prenatal care services to pregnant women who receive health care services under the State's Medicaid program. To the extent that State Medicaid expenditures are matched by federal Medicaid funds, State revenues will also be affected under this bill.

- The fiscal impact of the bill is uncertain because the OLS is unable to determine if: the reimbursement rate for group prenatal care services will be more or less than this the reimbursement rate for one-on-one prenatal services provided under the Medicaid program; eligible women will utilize group prenatal care services as a replacement for one-on-one prenatal services; and the number of group prenatal care visits per eligible Medicaid enrollee will be comparable to the number of one-on-one prenatal visits per eligible enrollee. Furthermore, the number of pregnant Medicaid eligible women who will choose to receive prenatal care via group visits is unpredictable.

- Research suggests that the provision of group prenatal care services is associated with improved maternal outcomes. Therefore, there may be certain long-term cost savings due to the decrease in medical costs associated with the care of mothers and infants under the bill.

- The OLS notes that the uptake of this benefit will be limited by the availability of accredited Centering Healthcare Institute (CHI) sites, as well as sites engaged in an active implementation contract with the CHI, to provide the services. According to the CHI website, there are currently 12 CenteringPregnancy sites in the State; however only three have successfully gone through CHI's accreditation process.

## BILL DESCRIPTION

The bill provides for an expansion of the State Medicaid program to include coverage of group prenatal care services under certain circumstances. As used in the bill, "group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the CHI and which include health assessments, social and clinical support, and educational activities. Specifically, this bill provides that coverage under the Medicaid program includes expenses incurred for the provision of group prenatal care services to a pregnant woman, provided that:

(1) the provider of services: (a) is a site accredited by the CHI, or is engaged in an active implementation contract with the CHI, that utilizes the CenteringPregnancy model; and (b) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

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

(3) no more than 10 group prenatal care visits occur per pregnancy.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

None received.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS estimates that this bill will have an indeterminate impact on State expenditures due to the provision of group prenatal care services to pregnant women who receive health care services under the State's Medicaid program. To the extent that State Medicaid expenditures are matched by federal Medicaid funds, State revenues will also be affected under this bill. The fiscal impact of the bill is uncertain because the OLS is unable to determine if: the reimbursement rate for group prenatal care services will be more or less than this the reimbursement rate for one-on-one prenatal services provided under the Medicaid program; eligible women will utilize group prenatal care services as a replacement for one-on-one prenatal services; and the number of group prenatal care visits per eligible Medicaid enrollee will be comparable to the number of one-on-one prenatal visits per eligible enrollee. Furthermore, the number of pregnant Medicaid eligible women who will choose to receive prenatal care via group visits is unpredictable.

Currently, group prenatal care services are a covered benefit under the Medicaid program in South Carolina. Under the reimbursement system established in South Carolina, Medicaid

managed care organizations receive a $200 incentive payment, of which $150 must be passed onto the group prenatal care provider, for each of the Medicaid beneficiaries who attended five or more group prenatal visits. While this bill does not specify a reimbursement rate for group prenatal care services, if a similar enhanced reimbursement rate is implemented in New Jersey, the bill may increase State Medicaid expenditures.

Another factor of the bill's impact on State expenditures is the number of individuals who will be provided group prenatal care services. According to the New Jersey Health Assessment Data website, 31,151 of the 101,154 births in New Jersey in CY 2017 were financed by Medicaid, in CY 2016, there were 31,877 Medicaid births and in CY 2015 there were 30,986. The OLS, however, cannot predict how this population may change from year to year, or, more significantly, what portion of this population may choose to utilize group prenatal care services, rather than one-on-one prenatal services.

Furthermore, research suggests that the provision of group prenatal care services is associated with improved maternal outcomes. Therefore, the OLS concludes that there may be long-term cost savings due to the decrease in medical costs associated with the care of mothers and infants under the bill. For reference, a study performed in collaboration between the South Carolina Department of Health and Human Services, which as noted above provides a Medicaid group prenatal care visit benefit, and the University of South Carolina estimated that CenteringPregnancy participation reduced the risk of premature birth and of a neonatal intensive care unit stay, as well as the incidence of delivering an infant with low birth weight. The study concluded that, after considering the state investment of $1.7 million to provide group prenatal services to Medicaid beneficiaries, there was an estimated return on investment of nearly $2.3 million.[1]

The OLS notes that the uptake of this benefit will be limited by the availability of accredited CHI sites, as well as sites engaged in an active implementation contract with the CHI, to provide the services. According to the CHI website, there are currently 12 CenteringPregnancy sites in the State; however only three have successfully gone through CHI's accreditation process.

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| *Section:* | *Human Services* |
| *Analyst:* | *Sarah Schmidt*<br>*Senior Research Analyst* |
| *Approved:* | *Frank W. Haines III*<br>*Legislative Budget and Finance Officer* |

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

[1] https://link.springer.com/article/10.1007%2Fs10995-016-1935-y

# SENATE, No. 3405

# STATE OF NEW JERSEY

## 218th LEGISLATURE

INTRODUCED JANUARY 28, 2019

**Sponsored by:**
**Senator JOSEPH F. VITALE**
**District 19 (Middlesex)**
**Senator THOMAS H. KEAN, JR.**
**District 21 (Morris, Somerset and Union)**

**Co-Sponsored by:**
**Senator Rice**

**SYNOPSIS**

Requires Medicaid coverage for group prenatal care services under certain circumstances.

**CURRENT VERSION OF TEXT**

As introduced.

**AN ACT** concerning Medicaid coverage for group prenatal care services 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 health status 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;

(4) Dental 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 <u>thus</u> is new matter.**

(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 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:

(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, 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

(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 familiar with the components of diabetes medical nutrition therapy;

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

(d) Expenses for any medically appropriate and necessary 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.

(23)Expenses incurred for the provision of group prenatal care services to a pregnant woman between the ages of 12 and 55 years of age, provided that:

(a) the provider of such services:

(i) is a site accredited by the Centering Healthcare Institute that utilizes the CenteringPregnancy model; and

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

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

(c) no more than ten group prenatal care visits occur per pregnancy.

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

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.

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

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

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

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

STATEMENT

The bill provides for an expansion of the State Medicaid program to include coverage of group prenatal care services under certain

circumstances. As used in the bill, "group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the Centering Healthcare Institute and include health assessments, social and clinical support, and educational activities. The CenteringPregnancy model is a health care redesign that changes the traditional model of the patient and health care provider in an exam room to a group setting which allows for care based on clinical and peer support. The Centering Healthcare Institute is a nonprofit organization established in 2001 that aims to improve healthcare through the training and support of group care providers.

Research indicates group prenatal care services provide benefits for mothers, babies, and providers, largely because access to care is increased. For example, data suggests that women who participate in group prenatal care visits have decreased rates of preterm and low weight babies, increased breastfeeding rates, and better pregnancy spacing. Furthermore, group prenatal care visits have been shown to nearly eliminate racial disparities in preterm birth. By preventing preterm birth, group prenatal care services also provide cost savings to the healthcare system, as preterm births can be more than ten times more expensive than that of a full-term delivery.

Specifically, this bill provides that coverage under the Medicaid program includes expenses incurred for the provision of group prenatal care services to a pregnant woman between the ages of 12 and 55 years of age, provided that:

(1) the provider of services: (a) is a site accredited by the Centering Healthcare Institute that utilizes the CenteringPregnancy model; and (b) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

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

(3) no more than ten group prenatal care visits occur per pregnancy.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

# SENATE, No. 3405

with committee amendments

# STATE OF NEW JERSEY

DATED: MARCH 4, 2019

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 3405.

As amended by the committee, this bill provides for an expansion of the State Medicaid program to include coverage of group prenatal care services under certain circumstances. As used in the bill, "group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the Centering Healthcare Institute and which include health assessments, social and clinical support, and educational activities.

Specifically, the amended bill provides that coverage under the Medicaid program includes expenses incurred for the provision of group prenatal care services to a pregnant woman, provided that:

(1) the provider of services is a site accredited by the Centering Healthcare Institute that utilizes the CenteringPregnancy model and the provider incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

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

(3) no more than 10 group prenatal care visits occur per pregnancy.

COMMITTEE AMENDMENTS:

The committee amendments remove language that would have established an age range for pregnant women to receive coverage under the bill and make various technical corrections.

STATEMENT TO

[First Reprint]

# SENATE, No. 3405

with Senate Floor Amendmentss
(Proposed by Senator VITALE)

ADOPTED: MAY 30, 2019

These Senate amendments explicitly state that providers included under the bill's provisions are to include, but are not to be limited to, federally qualified health centers and community health centers operating in the State. The amendments also allow services provided by a site not accredited by the Centering Healthcare Institute, but engaged in an active implementation contract with the Centering Healthcare Institute, that utilize the CenteringPregnancy model, to qualify for Medicaid coverage. Finally, the Senate amendments add a Legislative findings and declarations section to the bill.

# LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

# SENATE, No. 3405

# STATE OF NEW JERSEY
# 218th LEGISLATURE

DATED: JUNE 12, 2019

## SUMMARY

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| **Synopsis:** | Requires Medicaid coverage for group prenatal care services under certain circumstances. |
| **Type of Impact:** | Indeterminate impact on State expenditures and revenue; General Fund. |
| **Agencies Affected:** | Department of Human Services. |

**Office of Legislative Services Estimate**

| Fiscal Impact | Annual |
|---|---|
| **State Expenditure Impact** | Indeterminate |
| **State Revenue Impact** | Indeterminate |

- The Office of Legislative Services (OLS) estimates that this bill will have an indeterminate impact on State expenditures due to the provision of group prenatal care services to pregnant women who receive health care services under the State's Medicaid program. To the extent that State Medicaid expenditures are matched by federal Medicaid funds, State revenues will also be affected under this bill.

- The fiscal impact of the bill is uncertain because the OLS is unable to determine if: the reimbursement rate for group prenatal care services will be more or less than this the reimbursement rate for one-on-one prenatal services provided under the Medicaid program; eligible women will utilize group prenatal care services as a replacement for one-on-one prenatal services; and the number of group prenatal care visits per eligible Medicaid enrollee will be comparable to the number of one-on-one prenatal visits per eligible enrollee. Furthermore, the number of pregnant Medicaid eligible women who will choose to receive prenatal care via group visits is unpredictable.

- Research suggests that the provision of group prenatal care services is associated with improved maternal outcomes. Therefore, there may be certain long-term cost savings due to the decrease in medical costs associated with the care of mothers and infants under the bill.

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- The OLS notes that the uptake of this benefit will be limited by the availability of accredited Centering Healthcare Institute (CHI) sites, as well as sites engaged in an active implementation contract with the CHI, to provide the services. According to the CHI website, there are currently 12 CenteringPregnancy sites in the State; however only three have successfully gone through CHI's accreditation process.

## BILL DESCRIPTION

The bill provides for an expansion of the State Medicaid program to include coverage of group prenatal care services under certain circumstances. As used in the bill, "group prenatal care services" means a series of prenatal care visits provided in a group setting which are based upon the CenteringPregnancy model developed by the CHI and which include health assessments, social and clinical support, and educational activities. Specifically, this bill provides that coverage under the Medicaid program includes expenses incurred for the provision of group prenatal care services to a pregnant woman, provided that:

(1) the provider of services: (a) is a site accredited by the CHI, or is engaged in an active implementation contract with the CHI, that utilizes the CenteringPregnancy model; and (b) incorporates the applicable information outlined in any best practices manual for prenatal and postpartum maternal care developed by the Department of Health into the curriculum for each group prenatal visit;

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

(3) no more than 10 group prenatal care visits occur per pregnancy.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

None received.

### *OFFICE OF LEGISLATIVE SERVICES*

The OLS estimates that this bill will have an indeterminate impact on State expenditures due to the provision of group prenatal care services to pregnant women who receive health care services under the State's Medicaid program. To the extent that State Medicaid expenditures are matched by federal Medicaid funds, State revenues will also be affected under this bill. The fiscal impact of the bill is uncertain because the OLS is unable to determine if: the reimbursement rate for group prenatal care services will be more or less than this the reimbursement rate for one-on-one prenatal services provided under the Medicaid program; eligible women will utilize group prenatal care services as a replacement for one-on-one prenatal services; and the number of group prenatal care visits per eligible Medicaid enrollee will be comparable to the number of one-on-one prenatal visits per eligible enrollee. Furthermore, the number of pregnant Medicaid eligible women who will choose to receive prenatal care via group visits is unpredictable.

Currently, group prenatal care services are a covered benefit under the Medicaid program in South Carolina. Under the reimbursement system established in South Carolina, Medicaid managed care organizations receive a $200 incentive payment, of which $150 must be passed onto the group prenatal care provider, for each of the Medicaid beneficiaries who attended five or more group prenatal visits. While this bill does not specify a reimbursement rate for group prenatal care services, if a similar enhanced reimbursement rate is implemented in New Jersey, the bill may increase State Medicaid expenditures.

Another factor of the bill's impact on State expenditures is the number of individuals who will be provided group prenatal care services. According to the New Jersey Health Assessment Data website, 31,151 of the 101,154 births in New Jersey in CY 2017 were financed by Medicaid, in CY 2016, there were 31,877 Medicaid births and in CY 2015 there were 30,986. The OLS, however, cannot predict how this population may change from year to year, or, more significantly, what portion of this population may choose to utilize group prenatal care services, rather than one-on-one prenatal services.

Furthermore, research suggests that the provision of group prenatal care services is associated with improved maternal outcomes. Therefore, the OLS concludes that there may be long-term cost savings due to the decrease in medical costs associated with the care of mothers and infants under the bill. For reference, a study performed in collaboration between the South Carolina Department of Health and Human Services, which as noted above provides a Medicaid group prenatal care visit benefit, and the University of South Carolina estimated that CenteringPregnancy participation reduced the risk of premature birth and of a neonatal intensive care unit stay, as well as the incidence of delivering an infant with low birth weight. The study concluded that, after considering the state investment of $1.7 million to provide group prenatal services to Medicaid beneficiaries, there was an estimated return on investment of nearly $2.3 million.[1]

The OLS notes that the uptake of this benefit will be limited by the availability of accredited CHI sites, as well as sites engaged in an active implementation contract with the CHI, to provide the services. According to the CHI website, there are currently 12 CenteringPregnancy sites in the State; however only three have successfully gone through CHI's accreditation process.

| | |
|---|---|
| *Section:* | *Human Services* |
| *Analyst:* | *Sarah Schmidt*<br>*Senior Research Analyst* |
| *Approved:* | *Frank W. Haines III*<br>*Legislative Budget and Finance Officer* |

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

[1] https://link.springer.com/article/10.1007%2Fs10995-016-1935-y

# Governor Murphy Takes Action on Legislation

08/9/2019

**TRENTON** - Today, Governor Phil Murphy signed the following bills into law:

**A312 (Pinkin, Conaway, Giblin, Holley, Danielsen, Mukherji, Wimberly/Vitale, Rice) -** Requires certain health care facilities to provide information concerning palliative care and hospice care services.

**A841 (Land, Calabrese/Andrzejczak)** - Provides for establishment of county college certificate programs to meet needs of certain regional employers.

**A1700 (Dancer, Vainieri Huttle, Calabrese/Cruz-Perez, Cunningham) -** Expands eligibility criteria for designating certain areas as being in need of redevelopment.

**A2004 (Karabinchak, Mazzeo, Pinkin, Coughlin/Diegnan) -** Requires municipality to pay certain nonresidential property tax appeal refunds in equal installments over period of three years.

**A3937 (DeAngelo, Reynolds-Jackson, Verrelli/Turner) -** Allows local government water system employees to reside in all municipalities served by water system.

**A4115 (Benson, DeAngelo, Holley/Greenstein)** - Clarifies that certain students are eligible for NJ STARS and NJ STARS II scholarship upon initial enrollment at institution of higher education on part-time basis.

**A4223 (Johnson, Rooney/Weinberg, Lagana)** - Requires State Treasurer to pay county prosecutor's expenses for overseeing certain law enforcement agencies.

**A4938 (Tucker, Pinkin, Vainieri Huttle/Ruiz, Greenstein) -** Requires DOH to establish "My Life, My Plan" program to support women of childbearing age in developing reproductive life plan.

**A5021 (Quijano, Bramnick, Reynolds-Jackson, Pinkin, Downey/Vitale, Kean)** - Requires Medicaid coverage for group prenatal care services under certain circumstances.

**A5322 (Burzichelli, Milam, Houghtaling, Taliaferro/Sweeney, Oroho, Beach, Andrzejczak)** - Establishes program for cultivation, handling, processing, transport, and sale of hemp; repeals New Jersey Industrial Hemp Pilot Program.

**A5392 (Quijano, Murphy/Vitale, Scutari)** - Establishes new liability standards in sexual abuse lawsuits filed against public entities and public employees.

**A5595 (Milam, Houghtaling, Dancer, Wirths/Oroho, Pennacchio) -** Expands eligibility for EDA small business loan program to specifically include certain farming operations and qualified dairy farmers.

**S601 (Smith, Greenstein/Pinkin, McKeon) -** Establishes "New Jersey Solar Panel Recycling Commission."

**S781 (Sarlo, O'Scanlon/Giblin, DiMaso, Handlin) -** Revises penalties for certain violations of law by public movers and warehousemen.

**S984 (Vitale, Singleton/Conaway, Mukherji, Murphy)** - Establishes certain requirements, including allowable fees, for provision of medical records to patients, legally authorized representatives, and authorized third parties.

**S1109 (Ruiz/Munoz, Quijano)** – Renames "Physician Orders for Life-Sustaining Treatment Act" as "Practitioner Orders for Life-Sustaining Treatment Act"; permits physician assistants to sign and modify POLST forms; requires continuing education concerning end-of-life care.

**S1739 (Oroho, Andrzejczak/Land, Space, Milam)** - Renames county corrections officers as county correctional police officers.

**S2807 (Cryan, Cruz-Perez/Pinkin, Moriarty, Zwicker)** - Concerns service of food or refreshments on mortuary premises.

**S2858 (Gopal, Diegnan/Houghtaling, Downey, Johnson)** - Prohibits issuance of certain badges to NJT board members, PANYNJ commissioners, and local and State elected officials.

**S3212 (Ruiz, Rice/Pintor Marin, Holley)** - Permits municipalities to establish temporary supplemental zoning boards of adjustment to address application backlogs.

**S3334 (Diegnan, Vitale/Conaway, Pinkin)** - Exempts certain surgical technologists from general educational and training requirements.