

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*)

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

3

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

6

7 ²1. (New section) The Legislature finds and declares that:

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

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

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

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

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

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

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

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

33

34 ²**[1.]** 2.² Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to
35 read as follows:

36 6. a. Subject to the requirements of Title XIX of the federal
37 Social Security Act, the limitations imposed by this act and by the
38 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:

¹Assembly AAP committee amendments adopted March 18, 2019.

²Senate floor amendments adopted May 30, 2019.

1 shall provide medical assistance to qualified applicants, including
2 authorized services within each of the following classifications:

- 3 (1) Inpatient hospital services;
- 4 (2) Outpatient hospital services;
- 5 (3) Other laboratory and X-ray services;
- 6 (4) (a) Skilled nursing or intermediate care facility services;
- 7 (b) Early and periodic screening and diagnosis of individuals who
8 are eligible under the program and are under age 21, to ascertain their
9 physical or mental health status and the health care, treatment, and
10 other measures to correct or ameliorate defects and chronic conditions
11 discovered thereby, as may be provided in regulations of the Secretary
12 of the federal Department of Health and Human Services and approved
13 by the commissioner;

14 (5) Physician's services furnished in the office, the patient's home,
15 a hospital, a skilled nursing, or intermediate care facility or elsewhere.

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

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

27 (1) Medical care not included in subsection a.(5) above, or any
28 other type of remedial care recognized under State law, furnished by
29 licensed practitioners within the scope of their practice, as defined by
30 State law;

- 31 (2) Home health care services;
- 32 (3) Clinic services;
- 33 (4) Dental services;
- 34 (5) Physical therapy and related services;
- 35 (6) Prescribed drugs, dentures, and prosthetic devices; and
36 eyeglasses prescribed by a physician skilled in diseases of the eye or
37 by an optometrist, whichever the individual may select;
- 38 (7) Optometric services;
- 39 (8) Podiatric services;
- 40 (9) Chiropractic services;
- 41 (10) Psychological services;
- 42 (11) Inpatient psychiatric hospital services for individuals under 21
43 years of age, or under age 22 if they are receiving such services
44 immediately before attaining age 21;
- 45 (12) Other diagnostic, screening, preventive, and rehabilitative
46 services, and other remedial care;

47 (13) Inpatient hospital services, nursing facility services, and
48 intermediate care facility services for individuals 65 years of age or
49 over in an institution for mental diseases;

- 1 (14) Intermediate care facility services;
- 2 (15) Transportation services;
- 3 (16) Services in connection with the inpatient or outpatient
4 treatment or care of substance use disorder, when the treatment is
5 prescribed by a physician and provided in a licensed hospital or in a
6 narcotic and substance use disorder treatment center approved by the
7 Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et
8 seq.) and whose staff includes a medical director, and limited to those
9 services eligible for federal financial participation under Title XIX of
10 the federal Social Security Act;
- 11 (17) Any other medical care and any other type of remedial care
12 recognized under State law, specified by the Secretary of the federal
13 Department of Health and Human Services, and approved by the
14 commissioner;
- 15 (18) Comprehensive maternity care, which may include: the basic
16 number of prenatal and postpartum visits recommended by the
17 American College of Obstetrics and Gynecology; additional prenatal
18 and postpartum visits that are medically necessary; necessary
19 laboratory, nutritional assessment and counseling, health education,
20 personal counseling, managed care, outreach, and follow-up services;
21 treatment of conditions which may complicate pregnancy; and
22 physician or certified nurse-midwife delivery services;
- 23 (19) Comprehensive pediatric care, which may include:
24 ambulatory, preventive, and primary care health services. The
25 preventive services shall include, at a minimum, the basic number of
26 preventive visits recommended by the American Academy of
27 Pediatrics;
- 28 (20) Services provided by a hospice which is participating in the
29 Medicare program established pursuant to Title XVIII of the Social
30 Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice
31 services shall be provided subject to approval of the Secretary of the
32 federal Department of Health and Human Services for federal
33 reimbursement;
- 34 (21) Mammograms, subject to approval of the Secretary of the
35 federal Department of Health and Human Services for federal
36 reimbursement, including one baseline mammogram for women who
37 are at least 35 but less than 40 years of age; one mammogram
38 examination every two years or more frequently, if recommended by a
39 physician, for women who are at least 40 but less than 50 years of age;
40 and one mammogram examination every year for women age 50 and
41 over;
- 42 (22) Upon referral by a physician, advanced practice nurse, or
43 physician assistant of a person who has been diagnosed with diabetes,
44 gestational diabetes, or pre-diabetes, in accordance with standards
45 adopted by the American Diabetes Association:
- 46 (a) Expenses for diabetes self-management education or training to
47 ensure that a person with diabetes, gestational diabetes, or pre-diabetes
48 can optimize metabolic control, prevent and manage complications,

1 and maximize quality of life. Diabetes self-management education
2 shall be provided by an in-State provider who is:

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

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

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

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

33 (d) Expenses for any medically appropriate and necessary supplies
34 and equipment recommended or prescribed by a physician, advanced
35 practice nurse, or physician assistant for the management and
36 treatment of diabetes, gestational diabetes, or pre-diabetes, including,
37 but not limited to: equipment and supplies for self-management of
38 blood glucose; insulin pens; insulin pumps and related supplies; and
39 other insulin delivery devices ¹【.】; and¹

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

43 (a) the provider of such services ²,which shall include, but not be
44 limited to, a federally qualified health center or a community health
45 center operating in the State² :

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

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

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

8 (c) no more than ~~10~~ 10¹ group prenatal care visits occur per
9 pregnancy.

10 As used in this paragraph, “group prenatal care services” means a
11 series of prenatal care visits provided in a group setting which are
12 based upon the CenteringPregnancy model developed by the Centering
13 Healthcare Institute and ¹which¹ include health assessments, social
14 and clinical support, and educational activities.

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

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

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

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

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

47 (1) Is an inmate of a public institution (except as a patient in a
48 medical institution); provided, however, that an individual who is
49 otherwise eligible may continue to receive services for the month in

1 which he becomes an inmate, should the commissioner determine to
2 expand the scope of Medicaid eligibility to include such an individual,
3 subject to the limitations imposed by federal law and regulations, or

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

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

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

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

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

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

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

39 (2) Dependent children shall be provided with services cited in
40 subsection a.(3) and (5) of this section and subsection b.(1), (2), (3),
41 (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing
42 facility services cited in subsection b.(13) of this section.

43 (3) Individuals who are 65 years of age or older shall be provided
44 with services cited in subsection a.(3) and (5) of this section and
45 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
46 (12), (15), and (17) of this section, and nursing facility services cited
47 in subsection b.(13) of this section.

48 (4) Individuals who are blind or disabled shall be provided with
49 services cited in subsection a.(3) and (5) of this section and subsection

1 b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and
2 (17) of this section, and nursing facility services cited in subsection
3 b.(13) of this section.

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

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

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

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

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

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

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

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

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)

A5021 QUIJANO

2

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

3

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

6

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

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

14 (1) Inpatient hospital services;

15 (2) Outpatient hospital services;

16 (3) Other laboratory and X-ray services;

17 (4) (a) Skilled nursing or intermediate care facility services;

18 (b) Early and periodic screening and diagnosis of individuals
19 who are eligible under the program and are under age 21, to
20 ascertain their physical or mental health status and the health care,
21 treatment, and other measures to correct or ameliorate defects and
22 chronic conditions discovered thereby, as may be provided in
23 regulations of the Secretary of the federal Department of Health and
24 Human Services and approved by the commissioner;

25 (5) Physician's services furnished in the office, the patient's
26 home, a hospital, a skilled nursing, or intermediate care facility or
27 elsewhere.

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

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

39 (1) Medical care not included in subsection a.(5) above, or any
40 other type of remedial care recognized under State law, furnished
41 by licensed practitioners within the scope of their practice, as
42 defined by State law;

43 (2) Home health care services;

44 (3) Clinic services;

45 (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 thus is new matter.

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3

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

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1 the federal Department of Health and Human Services for federal
2 reimbursement;

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

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

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

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

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

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

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

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

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

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

15 (a) the provider of such services:

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

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

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

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

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

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

43 No provider whose claim for payment pursuant to this act has
44 been denied because the services, goods, or supplies were
45 determined to be medically unnecessary shall seek reimbursement
46 from the recipient, his family, his representative or others on his
47 behalf for such services, goods, and supplies provided pursuant to
48 this act; provided, however, a provider may seek reimbursement

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

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

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

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

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

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

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

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

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

46 (3) Notwithstanding any provision of law to the contrary, the
47 provisions of paragraph (2) of this subsection shall not apply to a
48 trust agreement that is established pursuant to 42 U.S.C.

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1 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
2 provided by government entities to a person who is disabled as
3 defined in section 1614(a)(3) of the federal Social Security Act (42
4 U.S.C. s.1382c (a)(3)).

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

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

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

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

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

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

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

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

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

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

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

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

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

25

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

31

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

36

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

42

43

44

STATEMENT

45

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

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

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

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

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

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

34 (3) no more than ten group prenatal care visits occur per
35 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 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 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	<u>Annual</u>
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.

Section: Human Services

*Analyst: Sarah Schmidt
Senior Research Analyst*

*Approved: Frank W. Haines III
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

- 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	<u>Annual</u>
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.

Section: Human Services
Analyst: Sarah Schmidt
Senior Research Analyst
Approved: Frank W. Haines III
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.



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

3

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

6

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

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

14 (1) Inpatient hospital services;

15 (2) Outpatient hospital services;

16 (3) Other laboratory and X-ray services;

17 (4) (a) Skilled nursing or intermediate care facility services;

18 (b) Early and periodic screening and diagnosis of individuals
19 who are eligible under the program and are under age 21, to
20 ascertain their physical or mental health status and the health care,
21 treatment, and other measures to correct or ameliorate defects and
22 chronic conditions discovered thereby, as may be provided in
23 regulations of the Secretary of the federal Department of Health and
24 Human Services and approved by the commissioner;

25 (5) Physician's services furnished in the office, the patient's
26 home, a hospital, a skilled nursing, or intermediate care facility or
27 elsewhere.

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

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

39 (1) Medical care not included in subsection a.(5) above, or any
40 other type of remedial care recognized under State law, furnished
41 by licensed practitioners within the scope of their practice, as
42 defined by State law;

43 (2) Home health care services;

44 (3) Clinic services;

45 (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 thus is new matter.

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

1 the federal Department of Health and Human Services for federal
2 reimbursement;

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

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

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

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

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

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

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

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

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

16 (a) the provider of such services:

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

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

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

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

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

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

44 No provider whose claim for payment pursuant to this act has
45 been denied because the services, goods, or supplies were
46 determined to be medically unnecessary shall seek reimbursement
47 from the recipient, his family, his representative or others on his
48 behalf for such services, goods, and supplies provided pursuant to

1 this act; provided, however, a provider may seek reimbursement
2 from a recipient for services, goods, or supplies not authorized by
3 this act, if the recipient elected to receive the services, goods or
4 supplies with the knowledge that they were not authorized.

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

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

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

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

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

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

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

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

47 (3) Notwithstanding any provision of law to the contrary, the
48 provisions of paragraph (2) of this subsection shall not apply to a

1 trust agreement that is established pursuant to 42 U.S.C.
2 s.1396p(d)(4)(A) or (C) to supplement and augment assistance
3 provided by government entities to a person who is disabled as
4 defined in section 1614(a)(3) of the federal Social Security Act (42
5 U.S.C. s.1382c (a)(3)).

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

8 (1) Pregnant women shall be provided prenatal care and delivery
9 services and postpartum care, including the services cited in
10 subsection a.(1), (3), and (5) of this section and subsection b.(1)-
11 (10), (12), (15), and (17) of this section, and nursing facility
12 services cited in subsection b.(13) of this section.

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

17 (3) Individuals who are 65 years of age or older shall be
18 provided with services cited in subsection a.(3) and (5) of this
19 section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7),
20 (8), (10), (12), (15), and (17) of this section, and nursing facility
21 services cited in subsection b.(13) of this section.

22 (4) Individuals who are blind or disabled shall be provided with
23 services cited in subsection a.(3) and (5) of this section and
24 subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10),
25 (12), (15), and (17) of this section, and nursing facility services
26 cited in subsection b.(13) of this section.

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

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

1 emergency room services for injuries and significant acute medical
2 conditions.

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

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

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

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

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

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

27

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

33

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

38

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

44

45

STATEMENT

46

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

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

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

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

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

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

35 (3) no more than ten group prenatal care visits occur per
36 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 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

[Second Reprint]

SENATE, No. 3405

STATE OF NEW JERSEY 218th LEGISLATURE

DATED: JUNE 12, 2019

SUMMARY

- 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	<u>Annual</u>
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.

Section: Human Services

*Analyst: Sarah Schmidt
Senior Research Analyst*

*Approved: Frank W. Haines III
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 Huttie, 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 Huttie/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.