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SYNOPSIS

Requires DOH to establish three-year Obstetric Discrimination Prevention and Mitigation Pilot Program.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 6/20/2023)

AN ACT concerning the prevention of obstetric discrimination and supplementing Title 26 of the Revised Statutes.

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

1. The Legislature finds and declares that:

a. Every person should be entitled to dignity, safety, and respect during and after pregnancy and childbirth, and every patient should receive the best possible and most equitable health care regardless of age, race, ethnicity, religion, ancestry, disability, sex, gender identity, gender expression, sexual orientation, or socioeconomic status.

b. The United States has the highest maternal mortality rate in the developed world. According to a report from the National Center for Health Statistics, in 2021, 1,250 women died of maternal causes, a rate that was compounded by the coronavirus disease 2019 (COVID-19) pandemic.

c. The report also noted significant racial inequities in the nation's maternal death rate. From 2018 to 2021, the maternal death rate increased across all racial groups, with the largest rise disproportionately affecting Black mothers. For example, in 2021, the rate for Black women was 69.9 deaths per 100,000 live births, which is 2.6 times the rate for White women, at 26.6 per 100,000.

d. While the federal Centers for Disease Control and Prevention (CDC) finds that the majority of pregnancy-related deaths are preventable, maternal death rates have been either stable or rising across the United States. Factors including high rates of cesarean sections, inadequate prenatal care, high rates of pregnancy and childbirth among older women, lack of health insurance covering the period beyond six weeks postpartum, elevated rates of chronic illnesses prior to pregnancy, like obesity and diabetes, pregnancy-related hemorrhage disorders, and pregnancy-related hypertension disorders may be contributing to the high maternal morbidity and mortality rate in the United States.

e. These factors, however, do not fully explain the disparity seen in the maternal mortality and morbidity rates disproportionately impacting Black birthing communities.

f. In 2022, the CDC released findings from an analysis of 1,018 pregnancy-related deaths in the United States from 2017 to 2021. The analysis found that 84 percent of deaths across 36 states were preventable, 53 percent occurred between seven days and one year after childbirth, and although Black women make up approximately 13 percent of total population of women in the United States, nearly one in three persons who died identified as non-Hispanic black.

g. The CDC analysis demonstrated the ongoing failures of the country's health care systems to keep Black women safe throughout pregnancy, childbirth, and the first year postpartum. The analysis

further reinforced the fact that the primary drivers of preventable harm and death are variations in quality and patient safety in hospitals in the United States and the absence of meaningful accountability measures.

h. In spite of an emphasis on patient safety measures and continuous quality improvement strategies, there is a growing body of evidence that discrimination, specifically obstetric discrimination, is a key driver of variations in the quality of perinatal care patient safety in maternity care hospitals, resulting in unfair and preventable pregnancy-related deaths and disproportionate impacts on the lives, livelihoods, and reproductive, perinatal, and mental health of Black mothers

i. Perinatal quality improvement tools, used to evaluate quality of care and patient safety and improve preventable perinatal morbidity and mortality, tend to focus on clinical outcomes and the disparate rates of adverse pregnancy-related outcomes between Black mothers and non-Black birthing communities, namely, differences in outcomes whereby race, and not obstetric discrimination, is the risk factor.

j. Perinatal quality improvement tools that focus on clinical outcomes and measure the differences in adverse pregnancy-related outcomes between Black mothers and non-Black birthing communities in terms of race, not discrimination, create a false narrative of quality, value, and patient safety in hospitals.

k. These types outcome measurements also fail to capture hospital performance based on how well or how poorly hospitals see, hear, believe, support, and celebrate Black mothers during the provision of care during and after pregnancy and childbirth.

l. Perinatal quality improvement tools based on clinical outcome measurements do not address the systemic exclusion and erasure of Black patient experiences and community wisdom in shaping terminology, measurement selection, and monitoring strategies, silencing Black patient voices and undermines the agency and self-efficacy of Black mothers in telling their stories and having others see, hear, and believe them when making health care decisions during and after pregnancy and childbirth.

m. As a result, perinatal quality improvement tools do not recognize obstetric discrimination as an adverse event that violates the quality of care provided to, and safety of, Black mothers during childbirth hospitalizations.

n. Further, current perinatal quality improvement tools do not take into account how obstetric discrimination, perpetrated by health care professional and other hospital staff, creates and facilitates physical, emotional, and socio-cultural harm, violating the quality of care provided to, and safety of Black mothers.

o. Perinatal quality improvement tools and patient safety programs that do not address obstetric discrimination create mistruths that cause data specialists, quality control and patient

safety professionals, and insurance companies to conflate the absence of perinatal complications or pathology as evidence of perinatal quality, safety, and equity. For example, a hospital's high rate of Black vaginal births does not necessarily mean that the hospital's staff is routinely present, engaged, and responsive to needs of Black mothers during childbirth hospitalizations.

p. The authors of an article published in the British Medical Journal Quality and Safety Journal, entitled Emotional safety is patient safety, justify the need for a new patient safety paradigm to bridge the gap between "feeling safe" as defined by patient experiences and "being safe" as defined by traditional quality control and patient safety professionals, using obstetric discrimination as an exemplar.

q. Obstetric discrimination leads to adverse events that violate patient safety and the quality of care provided to a patient during a childbirth hospitalization. These adverse events during a childbirth hospitalization lead to anti-Black, racialized perinatal health inequities and maternal morbidity and mortality that disproportionately impact Black mothers.

r. Without addressing the presence, perpetuation, and impact of obstetric discrimination as an adverse event during childbirth hospitalizations for Black mothers, the use of current perinatal quality improvement tools create barriers to developing and implementing research-based action plans that can be adapted to measure, monitor, report, prevent, or mitigate language used and behaviors enshrined in existing hospital policies, procedures, and programs.

s. The use of a valid perinatal quality improvement tool that takes into account obstetric discrimination as a critical driver of health inequities can assist policy makers and health care professionals in making measurable and meaningful improvements in perinatal health care and reproductive and perinatal health care experiences and outcomes for Black mothers.

t. Therefore, it is necessary to promote and protect the health, dignity, safety, and welfare of all citizens of New Jersey by establishing a pilot program that allows maternity care hospitals and licensed birthing centers to utilize and assess a valid perinatal quality improvement measurement tool designed to: name and recognize obstetric discrimination as an adverse event that violates the quality of care provided to, and the safety of, Black mothers; provide an evidence-based evaluation of the presence and magnitude of obstetric discrimination; and highlight how obstetric discrimination informs hospital policies, procedures, and programs and impacts the birthing experiences of Black mothers.

2. As used in this act:

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Eligible patient" means a person identifying as Black or African American residing in the State of New Jersey, aged 18 years or older, who has experienced labor, birth, and immediate postpartum in a maternity care hospital or birthing center licensed in the State.

"Medical discrimination" means prejudice and discrimination when within the context of providing medical care, the treatment or diagnostic decisions made by a health care professional are influenced by the health care professional's response to, or interpretation of, a patient's race or ethnicity, resulting in missed, delayed, inappropriate, or harmful screening, diagnosis, prognosis, treatment, and clinical and social complications, that create new or exacerbate existing health inequities that unfairly, uniquely, and disproportionally impact Black people and persons of color.

"Obstetric discrimination" means an analytical framework that captures the harmful experiences and conditions of a Black woman, Black person, or person of color that occur while seeking health care services during the reproductive, antepartum, intrapartum, perinatal, or postpartum period, and result in the onset or increased frequency, intensity, duration, and exacerbation of gender-based and obstetric violence.

"Obstetric violence" means a form of gender-based violence, including, but not limited to, acts of control or dominance, perpetrated by hospital personnel or health care professionals against a woman or person seeking perinatal care during pregnancy, labor, and birth, which results in the woman or person's loss of autonomy, safety, and dignity when making decisions about reproductive and perinatal care.

"Pilot program" means the Obstetric Discrimination Prevention and Mitigation Pilot Program established pursuant to this act.

3. a. The Department of Health shall establish a three-year Obstetric Discrimination Prevention and Mitigation Pilot Program under which a select number of maternity care hospitals and licensed birthing centers, as determined by the commissioner, will utilize and evaluate the effectiveness of a perinatal quality improvement measurement tool in:

(1) recognizing and reporting obstetric discrimination as an adverse event that violates the quality of care provided to, and the safety of, Black mothers;

(2) providing an evidence-based evaluation of the presence and magnitude of obstetric discrimination and how obstetric discrimination impacts the birthing experiences of Black mothers during pregnancy, labor, birth, and post-partum; and

(3) improving the maternal health care provided to Black mothers during childbirth hospitalizations and reducing adverse pregnancy-related experiences outcomes associated with obstetric discrimination.

b. The department shall:

(1) develop a process for maternity care hospitals and licensed birthing centers that are interested in participating in the pilot program to apply or otherwise request to participate; and

(2) identify a perinatal quality improvement measurement tool to be utilized by maternity care hospitals and licensed birthing centers that are interested in participating in the pilot program pursuant to subsection d. of this section; and

(3) designate a person as a content expert who shall assist the commissioner in administering the pilot program in accordance with the provisions of subsection c. of this section who has the following qualifications and credentials:

(a) has completed a master's degree in public health; and

(b) is board certified in obstetrics and gynecology.

c. The commissioner, in consultation with the content expert, shall determine the total number of maternity care hospitals and licensed birthing centers to be included in the pilot program, except that, at a minimum, the commissioner shall select at least one hospital or birthing center from each of the northern, central, and southern regions of the State for inclusion.

d. The hospitals and birthing centers that are selected by the commissioner, in consultation with the content expert, to participate in the pilot program shall:

(1) require all hospital and birthing center clinicians and staff who provide maternity care services to complete a training program, as identified by the commissioner, on obstetric discrimination;

(2) require hospital and birthing center staff who will administer the pilot program to complete a training program, as selected by the commissioner, on advancing obstetric patient safety by addressing obstetric discrimination in hospitals and on the use of the perinatal quality improvement measurement tool identified by the department pursuant to subsection d. of this section;

(3) recruit, screen, verify, and enroll eligible patients, as defined in this act, to complete the perinatal quality improvement measurement tool by providing information on their labor, birth, and immediate postpartum experiences; and

(4) assess the effectiveness of the perinatal quality improvement measurement tool in meeting the stated goals of the pilot program as outlined in subsection a. of this section by collecting and analyzing the information provided by the eligible patients pursuant to paragraph (3) of this subsection during the pilot program period.

4. a. The pilot program established pursuant to this act shall be funded through the State Medicaid program using a value-based payment system. The value-based payment system shall provide payment to the maternity care hospitals and licensed birthing centers participating in the pilot program for the purposes of financing the total costs of providing maternity care to the eligible

patients under the program, including, but not limited to, the costs associated with hospital and birthing center staff completing the training program on obstetric discrimination and the use of the perinatal quality improvement measurement tool pursuant to paragraphs (1) and (2) of subsection d. of section 3 of this act and the costs associated with recruiting, screening, verifying, and enrolling eligible patients to complete the perinatal quality improvement metric tool pursuant to paragraph (3) of subsection d. of section 3 of this act.

b. The value-based payment rate shall be established by the Commissioner of Health, based on the following factors:

(1) the number of eligible patients, identified pursuant to paragraph (3) of subsection d. of section 3 of this act, who are expected to complete the perinatal quality improvement measurement tool and receive maternity care services;

(2) the average anticipated per-patient cost of maternity care service for eligible patients;

(3) the reduction in adverse pregnancy-related experiences and outcomes associated with obstetric discrimination during the pilot program period as measured by the perinatal quality improvement measurement tool completed by eligible patients pursuant to paragraph (3) of subsection d. of section 3 of this act; and

(4) any other factors that may affect the cost of care for eligible patients.

c. The value-based payment provided under this section shall be limited to the rate established by the commissioner under subsection b. of this section, and shall not be subject to increase, regardless of whether the actual costs of care received by patients in the pilot program exceed the payment rate provided hereunder. If the actual per-patient costs of care for patients engaged in the pilot program exceed the payment rate established by the commissioner under this section, the maternity care hospitals and licensed birthing centers participating in the pilot program shall ensure that all eligible patients continue to receive appropriate maternity care services without being subject to an increase in out-of-pocket costs. If the maternity care hospitals and licensed birthing centers participating in the pilot program are able to reduce adverse pregnancy-related experiences and outcomes associated with obstetric discrimination through the effective use of the perinatal quality improvement measurement tool, the maternity care hospitals and licensed birthing centers may retain, and shall not be required to repay, any payment funds that remain unexpended.

5. The Department of Health shall, no later than four years after the date the pilot program is established, prepare and submit to the Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1) to the Legislature, a report that shall include:

a. an analysis on the impact of the pilot program on reducing adverse pregnancy-related experiences and outcomes associated with obstetric discrimination using the information collected pursuant to paragraph (3) of subsection d. of section 3 of this act;

b. any recommendations for legislative or regulatory action to continue the pilot program on a permanent basis;

c. any recommendations for executive, legislative, and other actions that can be undertaken by the State to improve quality and patient safety when providing maternal health care to Black mothers during childbirth hospitalizations; and

d. any other information the department deems relevant in evaluating the effectiveness of the pilot program.

6. The Commissioner of Health shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and secure federal financial participation for State Medicaid expenditures under the federal Medicaid program.

7. The Department of Health shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), as may be necessary to implement the provisions of this act.

8. This act shall take effect 90 days after the date of enactment.

STATEMENT

This bill establishes the three-year Obstetric Discrimination Prevention and Mitigation Pilot Program in the Department of Health (DOH). Under the program, a number of maternity care hospitals and licensed birthing centers, as determined by the Commissioner of Health, will utilize and evaluate the effectiveness of a perinatal quality improvement measurement tool in: (1) recognizing and reporting obstetric discrimination as an adverse event; (2) providing an evidence-based evaluation of the presence and magnitude of obstetric discrimination and how obstetric discrimination impacts the birthing experiences of Black mothers; and (3) improving the maternal health care provided to Black mothers during childbirth hospitalizations and reducing adverse pregnancy-related experiences and outcomes associated with obstetric discrimination.

Under the bill, the DHS is to develop a process for maternity care hospitals and birthing centers to apply or otherwise request to participate in the program and identify a perinatal quality improvement measurement tool to be utilized by participating maternity care hospitals and birthing centers.

The commissioner, in consultation with a content expert hired by the DHS, is to determine the total number of maternity care hospitals and birthing centers to be included in the program but at least one hospital or birthing center from each of the northern, central, and southern regions of the State is to be selected for inclusion. The hospitals and birthing centers selected to participate in the program are to meet the requirements outlined in the bill.

The program is be funded through the State Medicaid program using a value-based payment methodology. Payment will be provided to the maternity care hospitals and birthing centers participating in the program for financing the total costs of providing maternity care to the eligible patients under the program.

The value-based payment rate is to established by the commissioner, based on factors outlined in the bill, and is to be limited to the rate established by the commissioner. If the maternity care hospitals and birthing centers participating in the program reduce adverse pregnancy-related experiences and outcomes associated with obstetric discrimination, the hospitals and birthing centers may retain any unexpended payment funds.

The bill requires the DOH, no later than four years after the date the program is established, to prepare and submit to the Governor and Legislature a report that includes: an analysis on the impact of the program on reducing adverse pregnancy-related experiences outcomes associated with obstetric discrimination; any recommendations for legislative or regulatory action to continue the program on a permanent basis and to improve quality of care and patient safety when providing maternal health care to Black mothers during childbirth hospitalizations; and any other information deemed relevant in evaluating the effectiveness of the program.

The commissioner will be required to apply for any State plan amendments or waivers as may be necessary to implement the bill’s provisions and secure federal financial participation for State Medicaid expenditures under the federal Medicaid program.