New Jersey State Legislative Update

"Opioid Addiction and Abuse Prevention"

Legislative Package Moves Forward

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May 12, 2015

The New Jersey Legislature is currently on a short recess for the Traditional Budget Work Period which will continue throughout April.

A good number of the bills in the original "Opioid Addiction and Abuse Prevention Package" have moved forward in the legislative process. However, as a whole, the original 21 bills have not been enacted as quickly as originally expected. Here's the latest status:

S-2366/A-3712 – Mandates that prescribers inform patients of opioid dangers
Status: Passed Senate 36-1. Awaiting a hearing in the Assembly Health Committee

S-2377/A-3713 – Requires schools to use evidence based substance abuse curriculum
Status: Passed Senate. Ready for Assembly Floor Vote,

S-1998/A-3062 - Mandates checking the New Jersey PMP before prescribing dangerous drugs
Status: Assembly and Senate passed but needs Senate Concurrence with Assembly Amendments

S-2369/A-2859 - Codifies the Project Medicine Drop Program in statute
Status: On Governor's Desk

S-2370/A-709 – Requires prescribers and pharmacies to tell patients how to dispose of medication
Status: Passed in both houses. Needs Assembly concurrence with Senate amendments.

S-2372/A-1436 –Authorizes the Attorney General to direct statewide anti-opioid abuse efforts
Status: On Governor's Desk

S-2373/A-3716 – Requires the state to publish annual report on substance abuse treatment provider performance
Status: Signed into law by the Governor

S-2377/A-3719 – Directs colleges to establish substance abuse recovery housing
Status: Passed Senate 37-0. Awaiting a hearing in the Assembly Higher Education Committee

S-2378/A-3720 – Extends the Overdose Prevention Act to healthcare professionals who provide naloxone
Status: Signed into Law by the Governor

S-2379/A-3721 – Requires the state to identify Medicaid eligible prisoner so as to ensure continuous coverage
Status: Passed the Senate 28-8. Awaiting hearing in the Assembly Appropriations Committee.

S-2380/A-3712 – Requires DHS and Corrections to plan to treat inmates' mental and substance abuse
Status: Signed into law by the Governor

S--2381/A-3723 - Allows those using medication to treat addiction to complete drug court
Status: Passed Senate 39-0. Ready for Assembly Floor Vote.

This leaves nine of the bills in the original package that have not advanced since their introductions in the fall. Once again, that is the current tally. We can expect more action to come now that the Legislature has reconvened.

Bills to Revise Provisions of the New Jersey PMP Nears Governor's Desk

It is important to take note of recent changes to S-1998/A-3062 because they will impact the way medicine is practiced going forward.

The key changes for physicians are as follows:

- A check of the PMP will be mandatory for all new patients prior to prescribing a **Schedule II** medication. If the patient stays on a **Schedule II** medication, quarterly checks of the PMP are required prior to renewing those prescriptions
- For all existing patients, who are maintained on a Schedule II medication, quarterly checks of the PMP are required prior to renewing those prescriptions.
- Because of the new requirement for mandatory checks, the sponsors of the bills allowed changes to the program which will lessen any additional administrative burden.

In particular, permitting the use of medical assistants to access the system as designated by the physician will greatly facilitate compliance with the new requirements.

Also, the following exemptions are of major importance:

b. The provisions of subsection a. of this section shall not apply to:

(1) a veterinarian;

(2) a practitioner or the practitioner's agent administering methadone, or another controlled dangerous substance designated by the director as appropriate for treatment of a patient with a substance abuse disorder, as interim treatment for a patient on a waiting list for admission to an authorized substance abuse treatment program;

(3) a practitioner administering a controlled dangerous substance directly to a patient;

(4) a practitioner prescribing a controlled dangerous substance to be dispensed by an institutional pharmacy, as defined in N.J.A.C.13:39-9.2;

(5) a practitioner prescribing a controlled dangerous substance in the emergency department of a general hospital, provided that the quantity prescribed does not exceed a five day supply of the substance;

(6) a practitioner prescribing a controlled dangerous substance to a patient under the care of a hospice;

(7) a situation in which it is not reasonably possible for the practitioner or pharmacist to access the Prescription Monitoring Program in a timely manner, no other individual authorized to access the Prescription Monitoring Program is reasonably available, and the quantity of controlled dangerous substance prescribed or dispensed does not exceed a five day supply of the substance;

(8) a practitioner or pharmacist acting in compliance with regulations promulgated by the director as to circumstances under which consultation of the Prescription Monitoring Program would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of the patient;

(9) a situation in which the Prescription Monitoring Program is not operational as determined by the division or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation;

(10) a practitioner or pharmacist who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner or pharmacist, or other exceptional circumstances demonstrated by the practitioner or pharmacist, pursuant to a process established in regulation, and in the discretion of the director; or

(11) a practitioner who is prescribing a controlled dangerous substance to a patient immediately after the patient has undergone an operation, procedure, or treatment for acute trauma, when less than a 30-day supply is prescribed.

Bill Permitting Physicians to Dispense Vitamins and Nutraceuticals in Office Advances in New Jersey General Assembly

On February 23, A-4413 sponsored by Assemblyman Thomas P. Giblin (D-34) passed the New Jersey General Assembly overwhelmingly by a vote of 76 -0.

In specific, the bill makes one small change to the current law concerning physician dispensing which would allow physicians and podiatric physicians so desiring to make these products available to their patients. It is the belief of our organization that under the appropriate circumstances this legislation has the potential to improve patient outcomes within the continuum of care in terms of convenience and efficacy of treatment.

The bill now awaits further action in the New Jersey Senate.

New Proposal on Telemedicine Contains Issues of Major Concern

S-2729 was recently introduced by Senator Vitale. This is a 52 page proposal designed to regulate telemedicine in the State of New Jersey. It seeks to substantially modify existing BME regulations, and needs to be carefully evaluated.

This bill would authorize health care practitioners in the State – including physicians, nurse practitioners, psychologists, psychiatrists, psychoanalysts, licensed clinical social workers, physician assistants, and any other health care professional acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes – to deliver health care services, and establish a practitioner/patient relationship, through the use of telemedicine. This authorization would extend to mental health screeners, who, as specified by the bill, would

be allowed to engage in mental health screening procedures through telemedicine without necessitating a waiver from existing rules.

"Telemedicine" is defined by the bill to mean the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between the health care practitioner who is located at one site, and a patient who is located at a different, remote site, either with or without the assistance of an intervening health care provider, and which typically involves the provision of health care services through the application of secure, two-way videoconferencing or store-and-forward technology that is designed to replicate the traditional in-person encounter and interaction between health care practitioner and patient by allowing for interactive, real-time visual and auditory communication, and the electronic transmission of images, diagnostics, and medical records. "Telemedicine" would not include the use of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

Pursuant to the bill's provisions, the delivery of health care services through the use of telemedicine would be subject to the same standards of care and rules of practice as are applicable to traditional in-person practice, and the use of telemedicine would not reduce or eliminate any existing duty or responsibility of the health care practitioner, or any assistant thereof, including any duty or responsibility related to recordkeeping or the maintenance of patient confidentiality. Any health care practitioner who engages in telemedicine without complying with the ordinary standards of care or rules of practice applicable to in-person practice would be subject to discipline by the respective licensing board, as provided by law.

The bill would authorize an out-of-State health care practitioner to engage in telemedicine with patients in this State, but only pursuant to a reciprocal medical practice (or other appropriate practice) license. Existing law at N.J.S.A.45:1-7.5 – which was enacted in 2013 and became effective on July 1, 2014 – already provides that a reciprocal license must be granted to any out-of-State health care practitioner, upon application therefor, if: (1) the other state has substantially equivalent requirements for licensure, registration, or certification; (2) the applicant has practiced in the profession within the five-year period preceding application; (3) the respective New Jersey State board receives documentation showing that the applicant's out-of-State license is in

good standing, and that the applicant has no conviction for a disqualifying offense; and (4) an agent in this State is designated for service of process if the non-resident applicant does not have an office in this State. Consistent with the provisions of N.J.S.A.45:1-7.5, this bill would amend the individual practice laws pertaining to the reciprocal licensure (or licensure by indorsement) of physicians, nurse practitioners, social workers, psychologists, psychoanalysts, and physician assistants – which, in most cases, currently provide only for discretionary reciprocal licensure – in order to clarify that a reciprocal license: (1) must be granted if the conditions established by N.J.S.A.45:1-7.5 are satisfied; and (2) may still be granted, in the discretion of the respective licensing board, in cases where those statutory conditions are not satisfied.

In addition to clarifying the existing State law that pertains to the reciprocal licensing of health care practitioners, the bill would also require the Board of Medical Examiners to evaluate the interstate Telemedicine Licensure Compact that is currently being promoted by the Federation of State Medical Boards, and which, if adopted, would establish a universally-accepted and more simplistic system of reciprocal licensing for physicians. Within 180 days after the bill's effective date, the board would be required to submit to the Governor and Legislature, a report of its findings on the matter, and recommendations for legislation or other State action necessary to implement the compact in this State.

In order to facilitate the use of telemedicine in this State, and except when contrary to federal or State law, the bill would prohibit the State Medicaid and NJ FamilyCare programs, as well as any private health benefits plan – including those provided by private carriers, and those contained in contracts purchased by the State Health Benefits Commission and the School Employees' Health Benefits Commission – from requiring in-person contact between a health care practitioner and a patient, or from establishing any siting or location restrictions on a health care practitioner or a patient, as a condition of reimbursement under the respective program or plan. The bill would further require such programs and plans to provide coverage and reimbursement for: (1) health care services that are delivered through telemedicine, to the same extent, and at the same reimbursement rate, that such services are covered and reimbursed when provided in-person (so long as the use of telemedicine is not medically contraindicated), and (2) any professional or facility fees that may be associated with the delivery of covered services through telemedicine,

so long as such fees would otherwise be eligible for coverage or reimbursement in the case of in-person service delivery.

Finally, the bill would specify that a health care practitioner may engage in consultations with out-of-State peer professionals, including, but not limited to, a sub-specialist, using electronic or other means, without obtaining a separate license or authorization therefor.

In addition to the substantive changes described above, the bill would incorporate a number of technical and stylistic changes to the existing laws that govern the practice of various types of health care practitioners, as is necessary to both accomplish the bill's purposes and enhance clarity and readability in these areas. In particular, the bill would:

(1) redefine various statutory terms and revise various statutory provisions that are used to delineate the scope of practice for various health care practitioners, in order to expressly include telemedicine as an acceptable means or method of practice and service delivery;

(2) update language contained in relevant sections of Title 45 of the Revised Statutes, in order to reflect the changes that have been made by the bill;

(3) ensure that the laws being amended by the bill contain modern language, avoid the use of archaic or redundant terminology, use language consistently from section to section, and conform to modern tenets of statutory drafting (including, for instance, the tenet that provides for the alphabetization of definitional terms);

(4) consolidate two existing sections of law (R.S.45:9-18 and R.S.45:9-18.1) that are used to help define both the "practice of medicine" and the unauthorized practice thereof, but which are presently allocated separately from other similar provisions of law, and incorporate these provisions into a more logical and cohesive statutory location – in particular, into the existing statutory definitions and sections of law that outline the parameters of acceptable medical practice;

(5) repeal the existing sections of law being consolidated; and

(6) eliminate certain provisions of law which are applicable to a class of people who are no longer practicing (specifically, persons who matriculated in college prior to 1935 and persons who were practicing medicine before July 4, 1890).

More hot topics for discussion:

- Scope of Practice
- Out of Network
- Mandatory CME

Please stay alert for further updates. We will let you know if membership grassroots action is needed on any of these bills. Thank you!