

ASSEMBLY, No. 2279

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED JANUARY 27, 2020

Sponsored by:

Assemblyman VINCENT MAZZEO

District 2 (Atlantic)

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District 37 (Bergen)

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District 14 (Mercer and Middlesex)

Co-Sponsored by:

Assemblywoman Chaparro

SYNOPSIS

Establishes pilot program for integrated system of treatment for opioid use disorders.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 11/8/2021)

1 AN ACT concerning treatment for opioid use disorders and
2 supplementing Title 26 of the Revised Statutes.

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. a. The Division of Mental Health and Addiction Services in
8 the Department of Human Services shall establish a pilot program
9 creating an integrated system of care for the treatment of opioid use
10 disorders. The integrated system of care shall comprise a
11 centralized opioid treatment program, which shall be primarily
12 responsible for the initial intake and stabilization of patients
13 participating in the integrated system of care, and a system of
14 office-based opioid treatment providers which shall be responsible
15 for the ongoing treatment of patients participating in the integrated
16 system of care upon referral by the centralized opioid treatment
17 program. The division shall designate an opioid treatment program
18 and an appropriate number of office-based opioid treatment
19 providers to participate in the pilot program, and shall determine the
20 location and the size of the geographic area to be served by the
21 integrated system of care. Patients shall be considered for
22 admission to the integrated system of care based on referrals from
23 primary health care professionals, behavioral and mental health care
24 professionals, hospitals, hospital emergency departments, urgent
25 care facilities, and other appropriate medical and behavioral and
26 mental health care entities.

27 b. The centralized opioid treatment program shall, at a
28 minimum:

29 (1) stabilize patients admitted to the integrated system of care,
30 including initiating appropriate treatment which may include, but
31 shall not be limited to, medication assisted treatment, inpatient
32 treatment, outpatient treatment, detoxification, counseling, and
33 therapy;

34 (2) develop an individualized long-term treatment plan for each
35 patient, which may include identifying and providing referrals to
36 social services necessary to facilitate the patient's ongoing
37 recovery, including, but not limited to, housing assistance,
38 employment assistance, transportation assistance, family and
39 recovery support services, peer support and recovery services, and
40 child care assistance;

41 (3) link patients with a medical home for ongoing primary
42 health care, behavioral and mental health care, and opioid use
43 disorder treatment;

44 (4) employ a board-certified addiction specialist, who shall
45 provide support and consultation services to office-based treatment
46 providers concerning patients admitted to the integrated system of
47 care;

1 (5) prioritize referrals made by office-based treatment providers
2 pursuant to subparagraph (d) of paragraph (3) of subsection c. of
3 this section; and

4 (6) meet any other requirements and provide any additional
5 services as shall be required by the division.

6 c. (1) Office-based treatment providers shall be responsible for
7 the ongoing treatment of patients upon referral by the centralized
8 opioid treatment center, including carrying out the patient's
9 individualized long-term treatment plan, making appropriate
10 modifications to the patient's treatment plan based on the patient's
11 current treatment needs, ensuring each patient receives a behavioral
12 and mental health assessment and counseling services, engaging in
13 ongoing communications with the centralized opioid treatment
14 program and the medication assisted treatment team concerning the
15 patient, and meeting any other requirements and providing any
16 additional services as shall be required by the division. If the
17 office-based treatment provider is unable to provide a service
18 directly to the patient, the provider shall provide referrals and other
19 assistance as may be necessary to ensure the patient receives the
20 service.

21 (2) Each office-based treatment provider shall comprise at least
22 one physician, physician assistant, or advanced practice nurse
23 authorized to prescribe, administer, and dispense narcotic drugs for
24 maintenance treatment or detoxification treatment pursuant to
25 subsection (g) of 21 U.S.C. s.823. Office-based treatment providers
26 shall be supported by a medication assisted treatment team that
27 meets the requirements of paragraph (3) of this subsection for each
28 100 patients served by the office-based treatment provider. A
29 medication assisted treatment team may provide support services to
30 more than one office-based treatment provider at one time, provided
31 that the total number of patients served by the medication assisted
32 treatment team at one time does not exceed 100 patients.

33 (3) A medication assisted treatment team providing support to
34 an office-based treatment provider shall:

35 (a) include at least one advanced practice nurse, who shall be
36 responsible for meeting with new patients, reviewing contracts and
37 consents, arranging for insurance authorizations, arranging for urine
38 drug screenings, authorizing buprenorphine refills to pharmacies,
39 and overseeing diversion control through random call backs and
40 reviewing the patient's prescription monitoring information;

41 (b) include at least one certified behavioral health professional
42 with at least a masters-level education, who shall be responsible for
43 coordinating counseling services, managing acute crises, providing
44 brief supportive counseling and check-ins, coordinating referrals
45 between the centralized opioid treatment program and the office-
46 based treatment provider, and assisting with social services
47 necessary to facilitate the patient's ongoing recovery, including, but
48 not limited to, housing assistance, employment assistance,

- 1 transportation assistance, family and recovery support services, peer
2 support and recovery services, and child care assistance;
- 3 (c) engage in regular, ongoing communications with the office-
4 based treatment provider to discuss cases, protocols, and
5 communications among staff; and
- 6 (d) take appropriate actions to respond to situations in which a
7 patient has a positive drug screen, which shall include evaluating
8 the patient's current treatment needs, providing additional clinical
9 support as needed, and, if necessary, referring the patient back to
10 the centralized opioid treatment provider for stabilization. Referrals
11 to the centralized opioid treatment provider shall be at the
12 discretion of the medication assisted treatment team in consultation
13 with the office-based treatment provider.
- 14 d. The division shall establish an educational program for
15 physicians, physician assistants, and advanced practice nurses
16 providing services through an office-based treatment provider and
17 for medication assisted treatment team staff concerning safe
18 prescribing, the use of evaluation tools, developing treatment plans,
19 responding to patient relapses, addressing patient noncompliance,
20 and diversion control. The educational program may include both
21 in-person and online training materials, and shall focus on
22 evidence-based best practices to facilitate communications among,
23 and the use of standardized practices, protocols, and procedures by,
24 the centralized opioid treatment provider, office-based treatment
25 providers, and medication assisted treatment teams.
- 26 e. The division shall develop a screening tool to be used to
27 assess patients upon intake into the integrated system of care to
28 evaluate the severity of the patient's opioid use disorder and
29 facilitate the process of linking patients with appropriate care and
30 treatment resources. The division may adapt the screening tool to
31 serve additional pilot program purposes, and may develop
32 additional screening and assessment tools as needed.
- 33 f. The division is authorized to solicit, receive, and accept
34 grants, funds, or anything of value from any public or private entity
35 and receive and accept contributions of money, property, labor, or
36 any other thing of value from any legitimate source for the purpose
37 of establishing an integrated system of care pursuant to this section.
38 The Commissioner of Human Services shall apply for such State
39 plan amendments or waivers as may be necessary to implement the
40 provisions of this section and to secure federal financial
41 participation for State expenditures under the federal Medicaid
42 program in connection with services provided through the
43 integrated system of care.
- 44 g. No later than two years after the effective date of this act,
45 and annually thereafter for the duration of the pilot program, the
46 division shall submit a report to the Legislature pursuant to section
47 2 of P.L.1991, c.164 (C.52:14-19.1) concerning the pilot program,
48 which shall include: the number of patients receiving treatment

1 through the integrated system of care; the number of primary health
2 care and behavioral and mental health care professionals providing
3 services to patients through the integrated system of care; the
4 number of incidents involving patient relapses, violations, and
5 noncompliance with program requirements and the actions taken in
6 response to those incidents; patient outcomes, including the number
7 of patients who complete an individualized treatment plan and the
8 number of patients who leave the integrated system of care without
9 completing an individualized treatment plan, as well as long-term
10 recovery statistics, to the extent available; any differences in the
11 wait times for pilot program patients to receive treatment and
12 services in connection with an opioid use disorder as compared with
13 non-pilot program patients; funding sources for the pilot program;
14 the overall costs and savings associated with the pilot program; and
15 the division's recommendations as to whether the pilot program
16 should be continued, expanded, modified, or terminated, including
17 any recommendations for legislation or other action.

18
19 2. The Assistant Commissioner for the Division of Mental
20 Health and Addiction Services in the Department of Human
21 Services shall, pursuant to the "Administrative Procedure Act,"
22 P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations as
23 may be necessary to implement the provisions of this act.

24
25 3. This act shall take effect immediately.

26 27 28 STATEMENT

29
30 This bill requires the Division of Mental Health and Addiction
31 Services (DMHAS) in the Department of Human Services to
32 establish a pilot program creating an integrated system of care for
33 the treatment of opioid use disorders. The integrated system of care
34 will comprise a centralized opioid treatment program, which will
35 provide initial intake and stabilization for patients entering the
36 integrated system of care, and a system of office-based opioid
37 treatment providers which will be responsible for the ongoing
38 treatment of patients following stabilization. The division will
39 designate providers to participate in the pilot program and will
40 determine the location and the size of the geographic area to be
41 served by the integrated system of care.

42 The centralized opioid treatment program will be required to:
43 initiate treatment for patients entering the integrated system of care,
44 including, but not limited to, medication assisted treatment (MAT),
45 inpatient treatment, outpatient treatment, detoxification, counseling,
46 and therapy; develop an individualized long-term treatment plan for
47 each patient; link patients with a medical home for ongoing health
48 care, behavioral and mental health care, and opioid use disorder

1 treatment; employ a board-certified addiction specialist, who will
2 provide support and consultation services to office-based treatment
3 providers; prioritize referrals made by office-based treatment
4 providers for patients experiencing a relapse; and meet any other
5 requirements and provide any additional services as are required by
6 the DMHAS.

7 Office-based treatment providers will be responsible for the
8 ongoing treatment of patients upon referral by the centralized
9 opioid treatment center, including carrying out the patient's
10 individualized long-term treatment plan, making appropriate
11 modifications to the patient's treatment plan based on the patient's
12 current treatment needs, ensuring each patient receives a behavioral
13 and mental health assessment and counseling services, engaging in
14 ongoing communications with the centralized opioid treatment
15 program and the MAT team concerning the patient, and meeting
16 any other requirements and providing any additional services as are
17 required by the DMHAS. If the office-based treatment provider is
18 unable to provide a service directly to the patient, the provider is to
19 provide referrals and other assistance as may be necessary to ensure
20 the patient receives the service.

21 Office-based treatment providers will comprise at least one
22 physician, physician assistant, or advanced practice nurse
23 authorized to prescribe, administer, and dispense narcotic drugs for
24 maintenance treatment or detoxification treatment pursuant to
25 federal law, and will be supported by one MAT team for each 100
26 patients served by the office-based treatment provider. A MAT
27 team may provide support to more than one office-based treatment
28 provider, provided that the total number of patients supported by
29 the MAT team at any one time does not exceed 100 patients.

30 Each MAT team is to include at least one advanced practice
31 nurse and at least one certified behavioral health professional with
32 at least a masters-level education. The nurse will be responsible for
33 meeting with new patients, reviewing contracts and consents,
34 arranging for insurance authorizations, arranging for urine drug
35 screenings, authorizing buprenorphine refills to pharmacies, and
36 overseeing diversion control through random call backs and
37 reviewing the patient's prescription monitoring information. The
38 behavioral health professional will be responsible for coordinating
39 counseling services, managing acute crises, providing brief
40 supportive counseling and check-ins, coordinating referrals between
41 the opioid treatment program and the office-based treatment
42 provider, and assisting the patient with obtaining social services
43 necessary to facilitate the patient's ongoing recovery, including
44 housing assistance, employment assistance, transportation
45 assistance, family and recovery support services, peer support and
46 recovery services, and child care assistance. MAT teams will be
47 required to engage in regular, ongoing communications with the

1 office-based treatment provider to discuss cases, protocols, and
2 communications among staff.

3 In the event that a patient receiving treatment through an office-
4 based treatment provider has a positive drug screen, the MAT team
5 is to evaluate the patient's needs, provide additional clinical
6 support, and refer the patient back to the centralized opioid
7 treatment provider for stabilization, if necessary. Referrals to the
8 centralized opioid treatment provider will be at the discretion of the
9 MAT team in consultation with the office-based treatment provider.

10 The DMHAS will be required to establish an educational
11 program for physicians, physician assistants, and advanced practice
12 nurses providing services through an office-based treatment
13 provider and for MAT team staff concerning safe prescribing, the
14 use of evaluation tools, developing treatment plans, responding to
15 patient relapse, addressing patient noncompliance, and diversion
16 control. The educational program may include both in-person and
17 online training materials, and will focus on evidence-based best
18 practices to facilitate communications among, and the use of
19 standardized practices, protocols, and procedures by, the centralized
20 opioid treatment provider, office-based treatment providers, and
21 MAT teams.

22 The DMHAS is additionally required to develop a screening tool
23 to be used to assess patients upon intake to evaluate the severity of
24 the patient's opioid use disorder and facilitate the process of linking
25 the patient with appropriate care and treatment resources; the
26 DMHAS may adapt the screening tool to serve additional pilot
27 program purposes and may develop additional screening and
28 assessment tools as needed.

29 The DMHAS will be authorized to solicit, receive, and accept
30 grants, funds, or anything of value from any public or private entity
31 and receive and accept contributions of money, property, labor, or
32 any other thing of value from any legitimate source for the purpose
33 of establishing the integrated system of care. The Commissioner of
34 Human Services will be required to apply for such State plan
35 amendments or waivers as may be necessary to secure federal
36 financial participation for State expenditures under the federal
37 Medicaid program in connection with services provided through the
38 integrated system of care.

39 No later than two years after the effective date of the bill, and
40 annually thereafter for the duration of the pilot program, the
41 division will be required to submit a report to the Legislature
42 concerning: the number of patients receiving treatment through the
43 program; the number of primary health care and mental health care
44 professionals providing services to patients through the program;
45 incidents involving patient relapses, violations, and noncompliance
46 and the responses to those incidents; patient outcomes; differences
47 in the wait times for pilot program patients commence treatment
48 and receive services in connection with an opioid use disorder as

1 compared with non-pilot program patients; the overall costs and
2 savings associated with the program; recommendations as to
3 whether the pilot program should be continued, expanded,
4 modified, or terminated; and recommendations for legislation or
5 other action.