

“What keeps you up at night?”

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New Jersey gubernatorial transition abounds with healthcare activity; new opportunities for healthcare market

By Karen Palestini

It has been a busy new year for the New Jersey healthcare industry. On January 19, 2010, Chris Christie was sworn in as New Jersey's 55th governor. During the three-day period leading up to Governor Christie's inauguration, outgoing Governor Jon Corzine signed a number of bills affecting healthcare providers, patients and insurers. Not more than a week later, Governor Christie released his transition teams' reports, signaling some important areas to watch for all healthcare providers, but especially for ambulatory care facilities, ambulatory surgery centers and out-of-network providers. A summary of market opportunities likely to arise from these activities appears at the end of this article.

BILLS SIGNED BY GOVERNOR CORZINE DURING THE THREE-DAY PERIOD PRIOR TO THE INAUGURATION OF GOVERNOR CHRISTIE

Insurers to remit payments directly to providers upon assignment of benefits (S114/A132; Signed, January 16, 2010) – Responding to complaints from the provider community that insurers were not honoring patient assignments of benefits to non-participating healthcare providers, S114/A132 requires carriers that offer managed care plans that provide both in-network and out-of-network benefits to honor patient assignments for medically necessary services by remitting payment for reimbursement *directly* to the healthcare provider. Payments made only to the patient under these circumstances will be considered unpaid and subject to the interest charge provisions of R.L.1999, c.154 if not received by the provider within the timeframes established by that act.

Transfer of emergency department patients needing behavioral health services to be prompt and efficient (A3582/S2444, A3583/S2445, A3584/S2446; Signed January, 16, 2010) – Taken together, these bills aim to promote timely and meaningful admission of general hospital emergency department patients to behavioral healthcare facilities, as well as to identify all available inpatient, outpatient and residential behavioral health services. Targeting patients who remain in hospital emergency departments for 24 hours or longer awaiting placement in an

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appropriate behavioral health setting, A3582 requires the Department of Health and Senior Services (“DHSS”) to develop procedures to enable hospitals to transfer these patients promptly by: designating DHSS staff to whom hospital emergency room personnel can refer such cases; providing clinical facilitators for such patients; and providing mechanisms for ongoing assessments of patient flow and access to care. Bill A3583 requires the Commissioner of Human Services, as well as the Commissioner of Children and Families, to establish standardized admission protocols and medical clearance criteria for admission to behavioral healthcare facilities, while A3584 requires these commissioners to identify available mental health services and perform needs assessments.

Ambulatory surgery centers required to file hospital-like billing forms and to report infection rates for public disclosure

(S2312/A356; Signed, January 17, 2010) – Driven by concerns that free-standing, non-hospital-affiliated ambulatory surgery centers (“ASCs”) compete with hospitals in the surgical services market without being subject to the same regulatory constraints, S2312 is designed to establish similar reporting and disclosure requirements for ASCs and hospitals competing in the same market for the same services. One of the ways this will be achieved is by requiring all ASCs to submit a common billing form developed by the Commissioner of DHSS, which will require disclosure by ASCs of the same information provided by hospitals, as applicable. In addition, ASCs will be required to report to DHS annually the number of patients served by the ASC (including numbers of medically indigent/Medicaid patients). ASCs will also be required to report to DHSS on a quarterly basis quality indicators of infection control and data on infection rates for major site categories that define facility-associated infection locations, multiple infections, and device-related and non-device-related infections. Much of the above information will be made available to the public on the DHSS website in a format to be determined by DHSS.

Healthcare professionals required to report abuse against

vulnerable adults (S1799/A853; Signed, January 17, 2010) – New Jersey healthcare professionals, paramedics, and emergency medical technicians (among others) will be required to report neglect or exploitation of vulnerable adults upon reasonable cause. Such persons, as well as others who may report such exploitation

or abuse on a voluntary basis, will be immune from civil and criminal liability arising from such a report, so long as it is made absent bad faith or malice. Vulnerable adults are those persons over the age of 18 who reside in a community setting, and, because of physical or mental illness, disability or deficiency, lack sufficient understanding or capacity to make, communicate or carry out decisions concerning their well-being.

Use of medical marijuana permitted (S119/A804; Signed January 18, 2010) – New Jersey will now join the thirteen other states that permit the use of marijuana for medical purposes. Those patients having a DHSS-issued registry identification card (as well as their primary caregivers, as applicable, and duly-authorized physicians and producers of marijuana for medical purposes) will be protected from arrest, prosecution, property forfeiture, and criminal and other penalties. A physician will provide written instructions for a registered qualified patient or his caregiver to present to an alternative treatment center concerning the total amount of useable marijuana that a patient may be dispensed, in weight, in a 30-day period, which amount will not exceed two ounces. Alternative treatment centers are established by the act to perform activities necessary to provide registered qualifying patients with useable marijuana and related paraphernalia. Such treatment centers are to be operated through the state pursuant to permits issued by DHSS. DHSS must issue at least two permits each in the northern, central and southern regions of the state. The first two centers issued a permit in each region must be nonprofit entities.

Chiropractors' scope of practice expanded (S565 /A2029; Signed January 18, 2010) – Consistent with a recent trend in New Jersey to expand the scope of various professional practice areas, this bill amends and supplements the existing statutes governing chiropractors. The bill replaces the former definition of chiropractic (e.g., "a system of adjusting the articulations of the spinal column by manipulation thereof") with the following:

A philosophy, science and healing art concerned with the restoration and preservation of health and wellness through the promotion of well-being, prevention of disease and promotion and support of the inherent or innate recuperative abilities of the body. The practice of chiropractic includes the reduction of chiropractic subluxation, and the examination, diagnosis, analysis, assessment, systems of adjustments, manipulation and

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treatment of the articulations and soft tissue of the body. It is within the lawful scope of the practice of chiropractic to diagnose, adjust, and treat the articulations of the spinal column and other joints, articulations, and soft tissue and to order and administer physical modalities and therapeutic, rehabilitative and strengthening exercises.

In addition, the bill provides that a chiropractor licensed by the State Board of Chiropractic Examiners (“Board”) may, upon a chiropractic examination appropriate to the presenting patient:

1. Use methods of treatment including chiropractic practice methods, physical medicine modalities, rehabilitation, splinting or bracing consistent with the practice of chiropractic, nutrition and first aid and may order such diagnostic or analytical tests, including diagnostic imaging, bioanalytical laboratory tests, and may perform such other diagnostic and analytical diagnostic tests including reagent strip tests, X-ray, computer-aided neuromuscular testing, and nerve conduction studies, and may interpret evoked potentials;
2. Sign or certify temporary or permanent impairments and other certifications consistent with a chiropractic practice such as pre-employment screenings. A chiropractic physician may use recognized references in making his determination; and
3. Provide dietary or nutritional counseling, such as the direction, administration, dispensing and sale of nutritional supplements, including, but not limited to, all food concentrates, food extracts, vitamins, minerals, herbs, enzymes, amino acids, homeopathic remedies and other dietary supplements, including, but not limited to, tissue or cell salts, glandular extracts, nutraceuticals, botanicals and other nutritional supplements; provided the chiropractor has successfully completed a course of study concerning human nutrition, consisting of not less than 45 hours from a college or university accredited by a regional or national accrediting agency recognized by the United States Department of Education and approved by the Board

The bill additionally requires that licensed chiropractors complete 30 credits of continuing chiropractic education during each biennial

registration period. Chiropractors will also be required to obtain and maintain medical malpractice liability insurance coverage, at appropriate amounts, as set forth in regulations by the Board.

REPORTS OF GOVERNOR CHRISTIE’S TRANSITION TEAM SUBCOMMITTEES ON HEALTH, BANKING AND INSURANCE

On January 22, 2010, Governor Christie released his transition team subcommittee reports to the public. The transition team committees play an important role in the transition of one administration to another. Among other things, the committees interview existing staff at the various state agencies, review past budget and expense information, evaluate industry climate, and provide recommendations as to the timing and substance of Executive Branch initiatives.

Sub-Committee on Health

Ambulatory Surgery Centers, Ambulatory Care Facilities and Out-of-Network Providers “Siphoning Patients Away from Hospitals”

The Health Subcommittee cited three major factors driving the fiscal crisis of the New Jersey hospital industry: (1) unlike other states, and in excess of federal regulations, New Jersey requires its hospitals to provide necessary medical care to all regardless of the ability to pay; (2) the low level of payment hospitals receive for care delivered to Medicaid and Charity Care eligible patients; and (3) the proliferation of ambulatory care and ambulatory surgery centers in competition with hospitals without any obligation to care for the uninsured or underinsured.

In addition to other recommendations, the Health Subcommittee recommended that the Christie Administration pursue measures that would “level the health care playing field,” such as: (1) placing the same regulatory requirements on ambulatory care facilities as are placed on hospitals competing in the same market for the same services (including but not limited to cost and quality data reporting requirements) – which has already begun with the passage of S2312, as described above; (2) requiring additional assessments on ambulatory care facilities to provide financial

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support to distressed, essential hospitals whose market share has been affected by the proliferation of ASCs; and (3) placing caps on out-of-network charges and prohibiting the waiver of co-pays and deductibles at ambulatory facilities, except in cases of hardship, and requiring public posting of prices charged to uninsured patients at these facilities.

Sub-Committee on Banking and Insurance

Payments to Out-of-Network Providers “Undermine the System”

The Banking and Insurance Subcommittee cited its own reasons for wanting to curb payments to out-of-network providers: (1) when out-of-network payments are not capped at in-network reimbursement rates, this leads to higher health care bills; (2) when out-of-network providers waive co-payments and deductibles, it further increases this upward trend; and (3) as more providers are encouraged to move out-of-network (by enactment of measures such as S114/A132, etc.), the strain on the health insurance market intensifies, especially since New Jersey has only five health insurance carriers and the state’s regulatory structure (particularly as it relates to pre-existing condition exclusions and guaranteed issue) make it unlikely that additional carriers will emerge.

Based on the above, the Banking and Insurance Subcommittee recommended that the Christie administration consider the following options: (1) imposing a fee schedule for out-of-network costs; (2) setting up a dispute resolution system outside of the current arbitration system to impose a greater degree of cost effectiveness; and/or (3) re-examining how carriers and providers negotiate contracts to find a method that will encourage greater in-network participation while providing adequate compensation for services.

February 8, 2010, Assembly Financial Institutions and Insurance Committee Hearing

As an interesting post-script to the recommendations of the Health and Banking and Insurance Subcommittees, on February 8, 2010, the Assembly Financial Institutions and Insurance Committee held a public hearing to receive testimony “concerning various issues related to

reimbursements by health insurance carriers to out-of-network health care providers.” Providers and insurers alike will want to stay tuned, as this issue continues to take shape on both the executive and legislative agendas.

OPPORTUNITIES IN THE NEW JERSEY HEALTHCARE MARKET

Given the most recent round of legislative and executive activity, we anticipate the following opportunities will be available in the New Jersey healthcare market:

- Willing buyers/partners for physician-owned ASCs, in light of increased reporting/regulatory requirements and out-of-network scrutiny;
- Need for applicants to operate alternative treatment facilities for the provision of useable marijuana and related paraphernalia to qualifying patients – initially, preferred applicants will be nonprofit organizations with mission statements that are consistent with the use of medical marijuana (i.e., palliative care; disease-specific care/support organizations);
- Need for providers of management services for physician-owned ASCs that need additional regulatory compliance assistance;
- Need for providers of management services, space and supplies for medical marijuana alternative treatment centers.

If you are interested in pursuing any of these opportunities, or have further questions about this article, please contact the author.

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