AMERICAN ACADEMY OF
FAMILY PHYSICIANS

Suggested State Legislation 2007
Volume 1

AAFP Commission on
Governmental Advocacy

American Academy of Family Physicians
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Introduction

The AAFP Commission on Governmental Advocacy (CGA) is pleased to bring you the first edition of CGA Suggested State Legislation for 2008.

The issue of model legislation for constituent chapters is not new. For the past two years, there has been a resolution on model legislation put forward through the Congress of Delegates. The issue also has been brought up at regional chapter meetings and directly by chapter executives. To address this need, the CGA Subcommittee on State Government Advocacy aims to identify recent and innovative legislation introduced and/or enacted by a state on issues of relevance to family medicine. For ease of reference, Suggested State Legislation will be categorized as follows:

- *Insurance*
- *Medical Liability*
- *Medical Home*
- *Non-Physician Scope of Practice*
- *Practice Impact/Enhancement*
- *Public Health*
- *Workforce*

The legislation in this document has been reviewed by members of the subcommittee using the following criteria:

1. Does the legislation address an issue of significance facing family medicine?
2. Does the issue have national or regional significance?
3. Is a fresh and/or innovative approach used to address the issue?
4. Does the legislation represent a practical approach to the issue?
5. Does the legislation represent a comprehensive approach to the issue or is it tied to a narrow approach that may have limited relevance for constituent chapters?

Constituent chapters are encouraged to submit – at any time – legislation which is likely to be of interest and relevance to other states. To facilitate the selection and review process, it will be helpful for chapters to document their activity and direct involvement in moving the legislation. This includes talking points, briefing notes, and other relevant educational pieces used to support the legislation. Legislation and accompanying materials should be submitted electronically directly to state government relations staff, Diana Ewert (dewert@aafp.org) or Greg Martin (gmartin@aafp.org).

Chapters should keep in mind that the AAFP is not in the position of advocating the enactment of items presented in this or future SSL volumes. The legislation contained in this publication is offered as an aid to chapters interested in drafting legislation in a specific area and can be looked upon as a guide to areas of broad current interest to family medicine.

The legislation presented is the enacted or last version available. Legislation may be amended and differ from the original filing. AAFP staff maintains an archive of electronic copies of legislation and, where available, any fiscal impact analysis conducted by the state.

We hope this document proves to be a useful tool in your ongoing advocacy efforts.

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List of Bills*

I. Insurance
Colorado Senate Bill 79
North Carolina House Bill 1590
Texas House Bill 839

II. Medical Home
Colorado Senate Bill 130

III. Medical Liability
No submissions

IV. Practice Impact/Enhancement
No submissions

V. Scope of Practice
Florida House Bill 587
New Mexico House Joint Memorial 71

VI. Public Health
Georgia Senate Bill 90 (2005)
Maryland House Bill 140

VII. Workforce
Hawaii Senate Bill 976

*Unless otherwise noted, all legislation was filed in the 2007 session.

I. Insurance

Colorado Senate Bill 79 - An Act concerning agreements with health care providers for health care services.

MGMA recently found that an average 10-physician practice spends as much as $247,500 per year on unnecessarily complex, wasteful, duplicative administrative tasks that add no value to a practice or its patients. The same study also found that such a practice spends as much as $33,800 per year negotiating insurance contracts with an average of 15 health plans.

This legislation requires payers to:

- Disclose payment terms in plain language, the duration of the contract, the identity of the person responsible for processing the physicians' claims, and the mechanism to resolve disputes;
- Define the manner of payment, such as fee-for-service, capitation or risk-sharing;
- Describe the method used to calculate fees, such as relative value unit (RVU), percentage of Medicare payment or percentage of billed charges;
- Provide the fee schedule for codes reasonably expected to be billed by physicians under the contract and, on request, for other codes that may be used by physicians;
- Give physicians advance notice of contract changes; and
- Drop demands that physicians accept "all product" clauses which would force them to accept insurance products such as workman's compensation business added to the contract without their knowledge after execution.

The legislation was amended during the legislative process. The language in this publication is the final enacted version, however, staff has file copies of the legislation as originally filed and amended prior to enactment. Additionally, there were two fiscal notes attached to the legislation indicating there would be no implementation costs incurred by the state. This data proved to be a counter argument as insurers claimed the state would see increased regulatory costs to implement and monitor the act.

North Carolina House Bill 1590 – An Act to require insurers that provide health benefit plans to provide health care provides with a fiscal impact report when the insurer makes a substantial policy change.

This legislation, drafted by the North Carolina AFP, would require insurers to conduct a fiscal impact analysis for any substantial change in policy and provide this report to the health care providers with whom the insurer contracts. NC-AFP developed this legislation as a direct result of an insurer's pre-authorization requirements for digital imaging services. The insurer claimed it would only take two to three minutes to get authorization for services. A survey conducted by the NC-AFP indicated that the average on-line time spent was fifteen minutes and average on-phone time spent was twenty-three minutes.

The legislation was written to require that when a policy change like this was being planned, then a fiscal impact study would have to be conducted to determine how this may affect health care providers. It also would make the insurer at least consider how any savings would be shared with those who helped bring about the savings (i.e., the health care provider). While the measure has not progressed beyond the introduction stage, introduction alone has opened a dialog between providers and insurers to discuss these areas of concern. Talking points on the legislation are available.

Texas House Bill 839 – Physician discount

This legislation addresses the physician billing phenomena known as the "silent PPO." The number of intermediary entities involved in the health care claims payment process is increasing dramatically. Rental network preferred provider organizations exist to market a physician's contractually discounted rates primarily to third-party payers, such as insurance brokers, third-party administrators, local or regional preferred provider organizations, or self-insured employers. A rental network preferred provider organization may also rent its networks and associated discounts to entities such as network brokers, re-pricers, or aggregators, whose sole purpose is finding and applying the lowest discounted rates, often without physician authorization. Many of these entities provide no value and exist for the sole purpose of trafficking in physician discounts.

This legislation implements regulation of this secondary market offering physicians remedy without retaliation while creating transparency in the secondary market for physicians and their patients.

II. Medical Home

Colorado Senate Bill 130 – An act concerning medical homes for children.

This legislation defines the term "medical home" that is consistent with the Joint Principles of a Patient-Centered Medical home. The legislation specifically refers to a "primary care practice" that provides continuous, accessible, and comprehensive medical and non-medical services to a child and his or her family. The Colorado AFP was instrumental in including the PC-MH reference in the legislation.

Additionally, the legislation instructs the state department of health care policy and financing to develop systems and standards to not only maximize the number of children who are enrolled in the medical assistance program or the children's basic health plan who have a medical home, but requires the department to report this progress annually.

The legislation was approved for inclusion by the Council of State Governments in the 2008 Suggested State Legislation. The AAFP representative to the Health Policy Task Force was able to speak to the specific nature of the PC-MH and encourage inclusion.

V. Scope of Practice

Florida House Bill 587 – An act relating to health care practitioners; providing legislative findings and intent relating to grounds for discipline, penalties, and enforcement applicable to health care practitioners; providing that a practitioner's failure to identify the type of license under which he or she is practicing constitutes grounds for disciplinary action; providing exceptions; authorizing certain entities to determine compliance with a disclosure requirement; providing penalties; specifying that a reference to the section constitutes a general reference under the doctrine of incorporation by reference; providing an effective date.

The state found a compelling interest in patients being informed of the credentials of the health care practitioners who treat them and in the public being protected from misleading health care advertising. The areas of licensure for the practice of health care can be extremely confusing for patients and that health care practitioners can easily mislead patients into believing that the practitioner is better qualified than other health care practitioners simply by creating a sham practice designation. The legislation addresses what the state believed the most direct and effective manner in which to protect patients from identifiable harm is to ensure that patients and the public that the training of the health care practitioner be disclosed.

New Mexico House Joint Memorial 71
Oregon Senate Bill 717

State legislators are becoming increasingly annoyed by scope of practice battles among health care providers. The New Mexico legislation calls for the legislature to establish a "fair and unbiased" method in which such issues can me discussed prior to the filing of legislation, thus saving legislative time and resources. The Oregon legislation defines the composition, authority and powers of the committee.

NM HJM 71 – A joint memorial requesting the Interim Legislative Health and Human Services Committee to establish an unbiased and fair process to review scopes of practice of the health care professions.

OR SB 717 - The legislation further directs the Department of Human Services to contract with a nonprofit institute to appoint and convene scope of practice review committees to review proposed changes by health professional regulatory boards, health care professionals or organizations representing health care professionals that request review if a change may fall under scope of what constitutes the practice of a health care profession. The legislation also:

- Requires committees to report results of proposal reviews to the board;
- Requires the board to forward committee reports to legislature;
- Specifies membership composition of committees and duties; and
- Outlines responsibilities of the department, institute and committees.

VI. Public Health

Georgia Senate Bill 90 – Georgia Smoke Free Air Act of 2005

Submitted for inclusion by the Georgia AFP, this smoke-free public places legislation passed in May 2005. All public places are included except:

- bars and restaurants that do not serve children
- workplaces with a separate ventilation system for smokers
- hotel rooms for smokers

Maryland House Bill 140 – Establishes the statewide advisory commission on immunizations.

Submitted by the Maryland AFP, MD HB 140 establishes a statewide advisory committee to respond to inequity in vaccine distribution, thimerosal in vaccine, and vaccine mandates. The advisory committee will make recommendations to the legislature regarding vaccine. Additionally, one committee task is the development of a universal vaccine purchasing program to increase access.

VII. Workforce

Hawaii Senate Bill 976 - Relating to rural primary healthcare and workforce development in the short-term.

This legislation attempts to address workforce issues related to primary care. The bill addresses the urgent need for primary care physicians in medically underserved areas and populations and in health professional shortage areas. The legislation also recognizes that residency training in rural areas increases placement and retention of physicians in rural practices. While there are 3,500 licensed physicians in the state with 42 percent representing primary care, most of the physicians are clustered in a specific area.

The legislation calls for increased funding of family medicine residency slots in recognition of the limited GME funds received and the growing need for family physicians in rural and underserved areas.

Attachments

2007 CO S 79
AUTHOR: Johnson
VERSION: Enacted
VERSION DATE: 03/30/2007

AN ACT

SENATE BILL 07-079 CONCERNING CONTRACTUAL AGREEMENTS WITH HEALTH CARE PROVIDERS FOR HEALTH CARE SERVICES.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Title 25, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 37

Contracts with Health Care Providers

25-37-101. Health care contracts - required provisions - definitions. (1) EFFECTIVE JANUARY 1, 2008, A PERSON OR ENTITY THAT CONTRACTS WITH A HEALTH CARE PROVIDER SHALL COMPLY WITH THIS ARTICLE AND SHALL INCLUDE THE PROVISIONS REQUIRED BY THIS ARTICLE IN THE CONTRACT. A CONTRACT IN EXISTENCE PRIOR TO JANUARY 1, 2008, THAT IS RENEWED OR RENEWS BY ITS TERMS SHALL COMPLY WITH THIS ARTICLE NO LATER THAN DECEMBER 31, 2008.

(2) AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CATEGORY OF COVERAGE" MEANS ONE OF THE FOLLOWING TYPES OF COVERAGE OFFERED BY A PERSON OR ENTITY:

(I) HEALTH MAINTENANCE ORGANIZATION PLANS;

(II) ANY OTHER COMMERCIAL PLAN OR CONTRACT THAT IS NOT A HEALTH MAINTENANCE ORGANIZATION PLAN;

(III) MEDICARE;

(IV) MEDICAID; OR

(V) WORKERS' COMPENSATION.

(b) "EDIT" MEANS A PRACTICE OR PROCEDURE PURSUANT TO WHICH ONE OR MORE ADJUSTMENTS ARE MADE REGARDING PROCEDURE CODES, INCLUDING THE AMERICAN MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY CODE, ALSO KNOWN AS A "CPT CODE", AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES HEALTH CARE COMMON PROCEDURE CODING SYSTEM, ALSO KNOWN AS "HCPCS", THAT RESULTS IN:

(I) PAYMENT FOR SOME, BUT NOT ALL, OF THE CODES;

(II) PAYMENT FOR A DIFFERENT CODE;

(III) A REDUCED PAYMENT AS A RESULT OF SERVICES PROVIDED TO A PATIENT THAT ARE CLAIMED UNDER MORE THAN ONE CODE ON THE SAME SERVICE DATE;

(IV) A REDUCED PAYMENT RELATED TO A MODIFIER USED WITH A PROCEDURE CODE; OR

(V) A REDUCED PAYMENT BASED ON MULTIPLE UNITS OF THE SAME CODE BILLED FOR A SINGLE DATE OF SERVICE.

(c) "HEALTH CARE CONTRACT" OR "CONTRACT" MEANS A CONTRACT ENTERED INTO OR RENEWED BETWEEN A PERSON OR ENTITY AND A HEALTH CARE PROVIDER FOR THE DELIVERY OF HEALTH CARE SERVICES TO OTHERS.

(d) "HEALTH CARE PROVIDER" MEANS A PERSON LICENSED OR CERTIFIED IN THIS STATE TO PRACTICE MEDICINE, PHARMACY, CHIROPRACTIC, NURSING, PHYSICAL THERAPY, PODIATRY, DENTISTRY, OPTOMETRY, OCCUPATIONAL THERAPY, OR OTHER HEALING ARTS. "HEALTH CARE PROVIDER" ALSO MEANS AN AMBULATORY SURGICAL CENTER, A LICENSED PHARMACY OR PROVIDER OF PHARMACY SERVICES, AND A PROFESSIONAL CORPORATION OR OTHER CORPORATE ENTITY CONSISTING OF LICENSED HEALTH CARE PROVIDERS AS PERMITTED BY THE LAWS OF THIS STATE.

(e) (I) "MATERIAL CHANGE" MEANS A CHANGE TO A CONTRACT THAT DECREASES THE HEALTH CARE PROVIDER'S PAYMENT OR COMPENSATION, CHANGES THE ADMINISTRATIVE PROCEDURES IN A WAY THAT MAY REASONABLY BE EXPECTED TO SIGNIFICANTLY INCREASE THE PROVIDER'S ADMINISTRATIVE EXPENSE, REPLACES THE MAXIMUM ALLOWABLE COST LIST USED WITH A NEW AND DIFFERENT MAXIMUM ALLOWABLE COST LIST BY A PERSON OR ENTITY FOR REIMBURSEMENT OF GENERIC PRESCRIPTION DRUG CLAIMS, OR ADDS A NEW CATEGORY OF COVERAGE. A MATERIAL CHANGE DOES NOT INCLUDE:

(A) A DECREASE IN PAYMENT OR COMPENSATION RESULTING SOLELY FROM A CHANGE IN A PUBLISHED FEE SCHEDULE UPON WHICH THE PAYMENT OR COMPENSATION IS BASED AND THE DATE OF APPLICABILITY IS CLEARLY IDENTIFIED IN THE CONTRACT;

(B) A DECREASE IN PAYMENT OR COMPENSATION RESULTING FROM A CHANGE IN THE FEE SCHEDULE SPECIFIED IN A CONTRACT FOR PHARMACY SERVICES SUCH AS A CHANGE IN A FEE SCHEDULE BASED ON AVERAGE WHOLESALE PRICE OR MAXIMUM ALLOWABLE COST;

(C) A DECREASE IN PAYMENT OR COMPENSATION THAT WAS ANTICIPATED UNDER THE TERMS OF THE CONTRACT, IF THE AMOUNT AND DATE OF APPLICABILITY OF THE DECREASE IS CLEARLY IDENTIFIED IN THE CONTRACT;

(D) AN ADMINISTRATIVE CHANGE THAT MAY SIGNIFICANTLY INCREASE THE

PROVIDER'S ADMINISTRATIVE EXPENSE, THE SPECIFIC APPLICABILITY OF WHICH IS CLEARLY IDENTIFIED IN THE CONTRACT;

(E) CHANGES TO AN EXISTING PRIOR AUTHORIZATION, PRECERTIFICATION, NOTIFICATION, OR REFERRAL PROGRAM THAT DO NOT SUBSTANTIALLY INCREASE THE PROVIDER'S ADMINISTRATIVE EXPENSE; OR

(F) CHANGES TO AN EDIT PROGRAM OR TO SPECIFIC EDITS; HOWEVER, THE HEALTH CARE PROVIDER SHALL BE PROVIDED NOTICE OF THE CHANGES PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH (e), AND THE NOTICE SHALL INCLUDE INFORMATION SUFFICIENT FOR THE HEALTH CARE PROVIDER TO DETERMINE THE EFFECT OF THE CHANGE.

(II) IF A CHANGE TO THE CONTRACT IS ADMINISTRATIVE ONLY AND IS NOT A MATERIAL CHANGE, THE CHANGE SHALL BE EFFECTIVE UPON AT LEAST FIFTEEN DAYS' NOTICE TO THE HEALTH CARE PROVIDER. ALL OTHER NOTICES SHALL BE PROVIDED PURSUANT TO THE CONTRACT.

(f) "PERSON OR ENTITY" MEANS A PERSON OR ENTITY THAT HAS A PRIMARY BUSINESS PURPOSE OF CONTRACTING WITH HEALTH CARE PROVIDERS FOR THE DELIVERY OF HEALTH CARE SERVICES.

(3) (a) EACH CONTRACT SHALL HAVE PROVIDED WITH IT A SUMMARY DISCLOSURE FORM DISCLOSING, IN PLAIN LANGUAGE, THE FOLLOWING:

(I) THE TERMS GOVERNING COMPENSATION AND PAYMENT;

(II) ANY CATEGORY OF COVERAGE FOR WHICH THE HEALTH CARE PROVIDER IS TO PROVIDE SERVICE;

(III) THE DURATION OF THE CONTRACT AND HOW THE CONTRACT MAY BE TERMINATED;

(IV) THE IDENTITY OF THE PERSON OR ENTITY RESPONSIBLE FOR THE PROCESSING OF THE HEALTH CARE PROVIDER'S CLAIMS FOR COMPENSATION OR PAYMENT;

(V) ANY INTERNAL MECHANISM REQUIRED BY THE PERSON OR ENTITY TO RESOLVE DISPUTES THAT ARISE UNDER THE TERMS OR CONDITIONS OF THE CONTRACT; AND

(VI) THE SUBJECT AND ORDER OF ADDENDA, IF ANY, TO THE CONTRACT.

(b) THE SUMMARY DISCLOSURE FORM REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (3) SHALL BE FOR INFORMATIONAL PURPOSES ONLY AND SHALL NOT BE A TERM OR CONDITION OF THE CONTRACT; HOWEVER, SUCH DISCLOSURE SHALL REASONABLY SUMMARIZE THE APPLICABLE CONTRACT PROVISIONS.

(c) IF THE CONTRACT PROVIDES FOR TERMINATION FOR CAUSE BY EITHER PARTY, THE CONTRACT SHALL STATE THE REASONS THAT MAY BE USED FOR

TERMINATION FOR CAUSE, WHICH TERMS SHALL NOT BE UNREASONABLE, AND THE CONTRACT SHALL STATE THE TIME BY WHICH NOTICE OF TERMINATION FOR CAUSE SHALL BE PROVIDED AND TO WHOM THE NOTICE SHALL BE GIVEN.

(d) THE PERSON OR ENTITY SHALL IDENTIFY ANY UTILIZATION REVIEW OR MANAGEMENT, QUALITY IMPROVEMENT, OR SIMILAR PROGRAM THE PERSON OR ENTITY USES TO REVIEW, MONITOR, EVALUATE, OR ASSESS THE SERVICES PROVIDED PURSUANT TO A CONTRACT. THE POLICIES, PROCEDURES, OR GUIDELINES OF SUCH PROGRAM APPLICABLE TO A PROVIDER SHALL BE DISCLOSED UPON REQUEST OF THE HEALTH CARE PROVIDER WITHIN FOURTEEN DAYS AFTER THE DATE OF THE REQUEST.

(4) (a) THE DISCLOSURE OF PAYMENT AND COMPENSATION TERMS PURSUANT TO SUBSECTION (3) OF THIS SECTION SHALL INCLUDE INFORMATION SUFFICIENT FOR THE HEALTH CARE PROVIDER TO DETERMINE THE COMPENSATION OR PAYMENT FOR THE HEALTH CARE SERVICES AND SHALL INCLUDE THE FOLLOWING:

(I) THE MANNER OF PAYMENT, SUCH AS FEE-FOR-SERVICE, CAPITATION, OR RISK SHARING;

(II) (A) THE METHODOLOGY USED TO CALCULATE ANY FEE SCHEDULE, SUCH AS RELATIVE VALUE UNIT SYSTEM AND CONVERSION FACTOR, PERCENTAGE OF MEDICARE PAYMENT SYSTEM, OR PERCENTAGE OF BILLED CHARGES. AS APPLICABLE, THE METHODOLOGY DISCLOSURE SHALL INCLUDE THE NAME OF ANY RELATIVE VALUE SYSTEM; ITS VERSION, EDITION, OR PUBLICATION DATE; ANY APPLICABLE CONVERSION OR GEOGRAPHIC FACTOR; AND ANY DATE BY WHICH COMPENSATION OR FEE SCHEDULES MAY BE CHANGED BY SUCH METHODOLOGY IF ALLOWED FOR IN THE CONTRACT.

(B) THE FEE SCHEDULE FOR CODES REASONABLY EXPECTED TO BE BILLED BY THE HEALTH CARE PROVIDER FOR SERVICES PROVIDED PURSUANT TO THE CONTRACT, AND, UPON REQUEST, THE FEE SCHEDULE FOR OTHER CODES USED BY OR WHICH MAY BE USED BY THE HEALTH CARE PROVIDER. SUCH FEE SCHEDULE SHALL INCLUDE, AS MAY BE APPLICABLE, SERVICE OR PROCEDURE CODES SUCH AS CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES OR HEALTH CARE COMMON PROCEDURE CODING SYSTEM CODES AND THE ASSOCIATED PAYMENT OR COMPENSATION FOR EACH SERVICE CODE.

(C) THE FEE SCHEDULE REQUIRED IN SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH (II) MAY BE PROVIDED ELECTRONICALLY.

(D) A FEE SCHEDULE FOR THE CODES DESCRIBED BY SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH (II) SHALL BE PROVIDED WHEN A MATERIAL CHANGE RELATED TO PAYMENT OR COMPENSATION OCCURS. ADDITIONALLY, A HEALTH CARE PROVIDER MAY REQUEST THAT A WRITTEN FEE SCHEDULE BE PROVIDED UP TO TWICE PER YEAR, AND THE PERSON OR ENTITY MUST PROVIDE SUCH FEE SCHEDULE PROMPTLY.

(III) THE PERSON OR ENTITY SHALL STATE THE EFFECT OF EDITS, IF ANY, ON PAYMENT OR COMPENSATION. A PERSON OR ENTITY MAY SATISFY THIS

REQUIREMENT BY PROVIDING A CLEARLY UNDERSTANDABLE, READILY AVAILABLE MECHANISM, SUCH AS THROUGH A WEB SITE THAT ALLOWS A HEALTH CARE PROVIDER TO DETERMINE THE EFFECT OF EDITS ON PAYMENT OR COMPENSATION BEFORE SERVICE IS PROVIDED OR A CLAIM IS SUBMITTED.

(b) NOTWITHSTANDING ANY PROVISION OF THIS SUBSECTION (4) TO THE CONTRARY, DISCLOSURE OF A FEE SCHEDULE OR THE METHODOLOGY USED TO CALCULATE A FEE SCHEDULE IS NOT REQUIRED:

(I) FROM A PERSON OR ENTITY IF THE FEE SCHEDULE IS FOR A PLAN FOR DENTAL SERVICES, ITS PROVIDERS INCLUDE LICENSED DENTISTS, THE FEE SCHEDULE IS BASED UPON FEES FILED WITH THE PERSON OR ENTITY BY DENTAL PROVIDERS, AND THE FEE SCHEDULE IS REVISED FROM TIME TO TIME BASED UPON SUCH FILINGS. SPECIFIC NUMERICAL PARAMETERS ARE NOT REQUIRED TO BE DISCLOSED.

(II) IF THE FEE SCHEDULE IS FOR PHARMACY SERVICES OR DRUGS SUCH AS A FEE SCHEDULE BASED ON USE OF NATIONAL DRUG CODES.

(5) UPON COMPLETION OF PROCESSING OF A CLAIM, THE PERSON OR ENTITY SHALL PROVIDE INFORMATION TO THE HEALTH CARE PROVIDER STATING HOW THE CLAIM WAS ADJUDICATED AND THE RESPONSIBILITY FOR ANY OUTSTANDING BALANCE OF ANY PARTY OTHER THAN THE PERSON OR ENTITY.

(6) WHEN A PROPOSED CONTRACT IS PRESENTED BY A PERSON OR ENTITY FOR CONSIDERATION BY A HEALTH CARE PROVIDER, THE PERSON OR ENTITY SHALL PROVIDE IN WRITING OR MAKE REASONABLY AVAILABLE THE INFORMATION REQUIRED IN SUBSECTION (4) OF THIS SECTION. IF THE INFORMATION IS NOT DISCLOSED IN WRITING, IT SHALL BE DISCLOSED IN A MANNER THAT ALLOWS THE HEALTH CARE PROVIDER TO TIMELY EVALUATE THE PAYMENT OR COMPENSATION FOR SERVICES UNDER THE PROPOSED CONTRACT. THE DISCLOSURE OBLIGATIONS IN THIS ARTICLE SHALL NOT PREVENT A PERSON OR ENTITY FROM REQUIRING A REASONABLE CONFIDENTIALITY AGREEMENT REGARDING THE TERMS OF A PROPOSED CONTRACT.

(7) (a) A MATERIAL CHANGE TO A CONTRACT SHALL OCCUR ONLY IF THE PERSON OR ENTITY PROVIDES IN WRITING TO THE HEALTH CARE PROVIDER THE PROPOSED CHANGE AND GIVES NINETY DAYS' NOTICE BEFORE THE EFFECTIVE DATE OF THE CHANGE. THE WRITING SHALL BE CONSPICUOUSLY ENTITLED "NOTICE OF MATERIAL CHANGE TO CONTRACT".

(b) IF THE HEALTH CARE PROVIDER OBJECTS IN WRITING TO THE MATERIAL CHANGE WITHIN FIFTEEN DAYS AND THERE IS NO RESOLUTION OF THE OBJECTION, EITHER PARTY MAY TERMINATE THE CONTRACT UPON WRITTEN NOTICE OF TERMINATION PROVIDED TO THE OTHER PARTY NOT LATER THAN SIXTY DAYS BEFORE THE EFFECTIVE DATE OF THE MATERIAL CHANGE.

(c) IF THE HEALTH CARE PROVIDER DOES NOT OBJECT TO THE MATERIAL CHANGE PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (7), THE CHANGE SHALL BE EFFECTIVE AS SPECIFIED IN THE NOTICE OF MATERIAL CHANGE TO THE CONTRACT.

(d) IF A MATERIAL CHANGE IS THE ADDITION OF A NEW CATEGORY OF COVERAGE AND THE HEALTH CARE PROVIDER OBJECTS, THE ADDITION SHALL NOT BE EFFECTIVE AS TO THE HEALTH CARE PROVIDER, AND THE OBJECTION SHALL NOT BE A BASIS UPON WHICH THE PERSON OR ENTITY MAY TERMINATE THE CONTRACT.

(8) NOTWITHSTANDING SUBSECTION (6) OF THIS SECTION, A CONTRACT MAY BE MODIFIED BY OPERATION OF LAW AS REQUIRED BY ANY APPLICABLE STATE OR FEDERAL LAW OR REGULATION, AND THE PERSON OR ENTITY MAY DISCLOSE THIS CHANGE BY ANY REASONABLE MEANS.

(9) NOTHING IN THIS ARTICLE SHALL BE CONSTRUED TO REQUIRE THE RENEGOTIATION OF A CONTRACT IN EXISTENCE BEFORE THE APPLICABLE COMPLIANCE DATE IN THIS ARTICLE, AND ANY DISCLOSURE REQUIRED BY THIS ARTICLE FOR SUCH CONTRACTS MAY BE BY NOTICE TO THE HEALTH CARE PROVIDER.

(10) A PERSON OR ENTITY SHALL NOT ASSIGN, ALLOW ACCESS TO, SELL, RENT, OR GIVE THE PERSON'S OR ENTITY'S RIGHTS TO THE HEALTH CARE PROVIDER'S SERVICES PURSUANT TO THE PERSON'S OR ENTITY'S CONTRACT UNLESS HE OR SHE COMPLIES WITH PARAGRAPH (a), (b), OR (c) OF THIS SUBSECTION (10) AND ALSO COMPLIES WITH PARAGRAPHS (d) AND (e) OF THIS SUBSECTION (10) AS FOLLOWS:

(a) THE THIRD PARTY ACCESSING THE HEALTH CARE PROVIDER'S SERVICES UNDER THE CONTRACT IS AN EMPLOYER OR OTHER ENTITY PROVIDING COVERAGE FOR HEALTH CARE SERVICES TO ITS EMPLOYEES OR MEMBERS AND SUCH EMPLOYER OR ENTITY HAS, WITH THE PERSON OR ENTITY CONTRACTING WITH THE HEALTH CARE PROVIDER, A CONTRACT FOR THE ADMINISTRATION OR PROCESSING OF CLAIMS FOR PAYMENT OR SERVICE PROVIDED PURSUANT TO THE CONTRACT WITH THE HEALTH CARE PROVIDER;

(b) THE THIRD PARTY ACCESSING THE HEALTH CARE PROVIDER'S SERVICES UNDER THE CONTRACT IS AN AFFILIATE OF, SUBSIDIARY OF, OR IS UNDER COMMON OWNERSHIP OR CONTROL WITH THE PERSON OR ENTITY; OR, IS PROVIDING OR RECEIVING ADMINISTRATIVE SERVICES FROM THE PERSON OR ENTITY OR AN AFFILIATE OF, OR SUBSIDIARY OF, OR IS UNDER COMMON OWNERSHIP OR CONTROL WITH THE PERSON OR ENTITY;

(c) THE HEALTH CARE CONTRACT SPECIFICALLY PROVIDES THAT IT APPLIES TO NETWORK RENTAL ARRANGEMENTS AND STATES THAT IT IS FOR THE PURPOSE OF ASSIGNING, ALLOWING ACCESS TO, SELLING, RENTING, OR GIVING THE PERSON'S OR ENTITY'S RIGHTS TO THE HEALTH CARE PROVIDER'S SERVICES;

(d) THE INDIVIDUALS RECEIVING SERVICES UNDER THE HEALTH CARE PROVIDER'S CONTRACT ARE PROVIDED WITH APPROPRIATE IDENTIFICATION STATING WHERE CLAIMS SHOULD BE SENT AND WHERE INQUIRIES SHOULD BE DIRECTED; AND

(e) THE THIRD PARTY ACCESSING THE HEALTH CARE PROVIDER'S SERVICES

THROUGH THE HEALTH CARE PROVIDER'S CONTRACT IS OBLIGATED TO COMPLY WITH ALL APPLICABLE TERMS AND CONDITIONS OF THE CONTRACT; EXCEPT THAT A SELF-FUNDED PLAN RECEIVING ADMINISTRATIVE SERVICES FROM THE PERSON OR ENTITY OR ITS AFFILIATES SHALL BE SOLELY RESPONSIBLE FOR PAYMENT TO THE PROVIDER.

(11) EXCEPT AS PERMITTED BY THIS ARTICLE, A PERSON OR ENTITY SHALL NOT REQUIRE, AS A CONDITION OF CONTRACTING, THAT A HEALTH CARE PROVIDER WAIVE OR FOREGO ANY RIGHT OR BENEFIT TO WHICH THE HEALTH CARE PROVIDER MAY BE ENTITLED UNDER STATE OR FEDERAL LAW OR REGULATION THAT PROVIDES LEGAL PROTECTIONS TO A PERSON SOLELY BASED ON THE PERSON'S STATUS AS A HEALTH CARE PROVIDER PROVIDING SERVICES IN THIS STATE.

(12) UPON SIXTY DAYS' NOTICE, A HEALTH CARE PROVIDER MAY DECLINE TO PROVIDE SERVICE PURSUANT TO A CONTRACT TO NEW PATIENTS COVERED BY THE PERSON OR ENTITY. THE NOTICE SHALL STATE THE REASON OR REASONS FOR THIS ACTION. FOR THE PURPOSES OF THIS SUBSECTION (12), "NEW PATIENTS" MEANS THOSE PATIENTS WHO HAVE NOT RECEIVED SERVICES FROM THE HEALTH CARE PROVIDER IN THE IMMEDIATELY PRECEDING THREE YEARS. A PATIENT SHALL NOT BECOME A "NEW PATIENT" SOLELY BY CHANGING COVERAGE FROM ONE PERSON OR ENTITY TO ANOTHER PERSON OR ENTITY.

(13) A TERM FOR COMPENSATION OR PAYMENT SHALL NOT SURVIVE THE TERMINATION OF A CONTRACT, EXCEPT FOR A CONTINUATION OF COVERAGE REQUIRED BY LAW OR WITH THE AGREEMENT OF THE HEALTH CARE PROVIDER.

(14) A CONTRACT SHALL NOT PRECLUDE ITS USE OR DISCLOSURE TO A THIRD PARTY FOR THE PURPOSE OF ENFORCING THE PROVISIONS OF THIS ARTICLE OR ENFORCING OTHER STATE OR FEDERAL LAW. THE THIRD PARTY SHALL BE BOUND BY THE CONFIDENTIALITY REQUIREMENTS SET FORTH IN THE CONTRACT OR OTHERWISE.

(15) IN ADDITION TO THE PROVISIONS OF PARAGRAPH (e) OF SUBSECTION (2) OF THIS SECTION, A CONTRACT WITH A DURATION OF LESS THAN TWO YEARS SHALL PROVIDE TO EACH PARTY A RIGHT TO TERMINATE THE CONTRACT WITHOUT CAUSE, WHICH TERMINATION SHALL OCCUR WITH AT LEAST NINETY DAYS' WRITTEN NOTICE. FOR CONTRACTS WITH A DURATION OF TWO OR MORE YEARS, TERMINATION WITHOUT CAUSE MAY BE AS SPECIFIED IN THE CONTRACT.

(16) THIS ARTICLE SHALL NOT APPLY TO:

(a) AN EXCLUSIVE CONTRACT WITH A SINGLE MEDICAL GROUP IN A SPECIFIC GEOGRAPHIC AREA TO PROVIDE OR ARRANGE FOR HEALTH CARE SERVICES; HOWEVER, THIS ARTICLE SHALL APPLY TO CONTRACTS FOR HEALTH CARE SERVICES BETWEEN THE MEDICAL GROUP AND OTHER MEDICAL GROUPS;

(b) A CONTRACT OR AGREEMENT FOR THE EMPLOYMENT OF A HEALTH CARE PROVIDER OR A CONTRACT OR AGREEMENT BETWEEN HEALTH CARE PROVIDERS;

(c) A CONTRACT OR ARRANGEMENT ENTERED INTO BY A HOSPITAL OR HEALTH CARE FACILITY THAT IS LICENSED OR CERTIFIED PURSUANT TO SECTION 25-3-101;

(d) A CONTRACT BETWEEN A HEALTH CARE PROVIDER AND THE STATE OR FEDERAL GOVERNMENT OR THEIR AGENCIES FOR HEALTH CARE SERVICES PROVIDED THROUGH A PROGRAM FOR WORKERS' COMPENSATION, MEDICAID, MEDICARE, THE CHILDREN'S BASIC HEALTH PLAN PROVIDED FOR IN ARTICLE 8 OF TITLE 25.5, C.R.S., OR THE COLORADO INDIGENT CARE PROGRAM CREATED IN PART 1 OF ARTICLE 3 OF TITLE 25.5, C.R.S.;

(e) CONTRACTS FOR PHARMACY BENEFIT MANAGEMENT, SUCH AS WITH A PHARMACY BENEFIT MANAGEMENT FIRM AS DEFINED IN SECTION 10-16-102, C.R.S.; EXCEPT THAT THIS EXCLUSION SHALL NOT APPLY TO A CONTRACT FOR HEALTH CARE SERVICES BETWEEN A PERSON OR ENTITY AND A PHARMACY, A PHARMACIST, OR A PROFESSIONAL CORPORATION OR CORPORATE ENTITY CONSISTING OF PHARMACIES OR PHARMACISTS AS PERMITTED BY THE LAWS OF THIS STATE; OR

(f) A CONTRACT OR ARRANGEMENT ENTERED INTO BY A HOSPITAL OR HEALTH CARE FACILITY THAT IS LICENSED OR CERTIFIED PURSUANT TO SECTION 25-3-101, OR ANY OUTPATIENT SERVICE PROVIDER THAT HAS ENTERED INTO A JOINT VENTURE WITH THE HOSPITAL OR IS OWNED BY THE HOSPITAL OR HEALTH CARE FACILITY.

(17) A CONTRACT BETWEEN A PHARMACIST OR A PHARMACY AND A PHARMACY BENEFIT MANAGER, SUCH AS A PHARMACY BENEFIT MANAGEMENT FIRM AS DEFINED IN SECTION 10-16-102, C.R.S., SHALL BE TERMINATED IF THE FEDERAL DRUG ENFORCEMENT AGENCY OR OTHER FEDERAL LAW ENFORCEMENT AGENCY CEASES THE OPERATIONS OF THE PHARMACIST OR PHARMACY DUE TO ALLEGED OR ACTUAL CRIMINAL ACTIVITY.

(18) NOTWITHSTANDING THE APPLICABLE COMPLIANCE DATE REQUIREMENT IN SUBSECTION (1) OF THIS SECTION, A DOMESTIC NONPROFIT HEALTH PLAN SHALL COMPLY WITH THIS ARTICLE WITHIN TWELVE MONTHS AFTER THE APPLICABLE COMPLIANCE DATE.

(19) A CONTRACT SUBJECT TO THIS ARTICLE MAY INCLUDE AN AGREEMENT FOR BINDING ARBITRATION.

(20) (a) WITH RESPECT TO THE ENFORCEMENT OF THIS ARTICLE, INCLUDING ARBITRATION, THERE SHALL BE AVAILABLE:

(I) PRIVATE RIGHTS OF ACTION AT LAW AND IN EQUITY;

(II) EQUITABLE RELIEF, INCLUDING INJUNCTIVE RELIEF;

(III) REASONABLE ATTORNEY FEES WHEN THE HEALTH CARE PROVIDER IS THE PREVAILING PARTY IN AN ACTION TO ENFORCE THIS ARTICLE, EXCEPT TO THE EXTENT THAT THE VIOLATION OF THIS ARTICLE CONSISTED OF A MERE FAILURE

TO MAKE PAYMENT PURSUANT TO A CONTRACT;

(IV) THE OPTION TO INTRODUCE AS PERSUASIVE AUTHORITY PRIOR ARBITRATION AWARDS REGARDING A VIOLATION OF THIS ARTICLE.

(b) ARBITRATION AWARDS RELATED TO THE ENFORCEMENT OF THIS ARTICLE MAY BE DISCLOSED TO THOSE WHO HAVE A BONA FIDE INTEREST IN THE ARBITRATION.

(21) NO PROVISION OF THIS ARTICLE SHALL BE USED TO JUSTIFY ANY ACT OR OMISSION BY A HEALTH CARE PROVIDER THAT IS PROHIBITED BY ANY APPLICABLE PROFESSIONAL CODE OF ETHICS OR STATE OR FEDERAL LAW PROHIBITING DISCRIMINATION AGAINST ANY PERSON.

SECTION 2. Effective date. This act shall take effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution, (August 8, 2007, if adjournment sine die is on May 9, 2007); except that, if a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part, if approved by the people, shall take effect on the date of the official declaration of the vote thereon by proclamation of the governor.

2007 NC H 1590
AUTHOR: England
VERSION: Introduced
VERSION DATE: 04/19/2007

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 1

HOUSE BILL 1590

April 19, 2007

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURERS THAT PROVIDE HEALTH BENEFIT PLANS TO PROVIDE HEALTH CARE PROVIDERS WITH A FISCAL IMPACT REPORT WHEN THE INSURER MAKES A SUBSTANTIAL POLICY CHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

" Section 58-50-47. Insurers provide fiscal impact report to health care providers that provide services covered under the insurer's health benefit plan.

(a) An insurer that provides a health benefit plan as defined in G.S. 58-3-167 shall, prior to implementing a substantial change in the provider policy, prior authorization policy, endorsement of a method of alternative health care delivery model, cost containment policy, or any other cost-saving measures implemented under health plan administration, provide to all enrolled and affected health care providers a full analysis of the direct and indirect fiscal impact of the change on the health care provider's practice or business. The analysis shall comply with the requirements of subsection (b) of this section.

(b) Prior to the implementation of a substantial change in health plan administration designed to produce cost savings, the health benefit plan administrator shall conduct a fiscal analysis and fiscal impact study that provides detailed information regarding the following:

(1) A full description of the proposed cost-saving measure or policy change, including the reason for the change and the intended results.

(2) The anticipated savings accruing to the health benefit plan as a result of implementation of the cost-saving measure or policy change.

(3) The types of health care providers, or groups of providers that will be affected by the proposed cost-saving measure or policy change.

(4) The projected cost savings that will accrue to the health benefit plan immediately upon implementation of the cost-saving measure or policy change, and over the long term.

(5) Anticipated premium reductions or health care cost savings that will be passed along to the health benefit plan's nonprovider customers.

(6) The anticipated amount of savings to be remitted to the providers whose expertise, methods, time, effort, and resources are responsible for generating the savings.

(7) The anticipated cost to the affected providers or provider groups to implement the cost-saving measure or policy change on behalf of the health benefit plan.

(8) The methods for communicating the cost-saving measure or policy change to affected providers or groups of providers.

(9) The adjustments to the rate of payment to the provider required to compensate for the additional costs to the provider incurred during the course of implementation of the cost-saving measure or policy change.

(10) The projected savings that will be distributed to the providers that generate the savings to the health benefit plan.

(c) An insurer that provides a health benefit plan as defined in G.S. 58-3-167, or an entity licensed to administer health care benefits on behalf of any other entity, may not implement a cost-saving measure or policy change that substantially affects the cost of delivery health services by licensed providers or groups of providers without having developed a plan to fully compensate the enrolled health care providers for the costs associated with implementing the cost-saving measure or policy change, including a share of the savings attributable to the providers' actual investment of time, expertise, and expense required to implement the cost-saving measure or policy change on behalf of the health benefit plan. The amount of savings projected shall include any long-term benefits and savings accruing to the health benefit plan realized by the implementation of the cost-saving measure or policy change. "

SECTION 2. This act becomes effective January 1, 2008, and applies to health benefit plans issued, delivered, or renewed on and

2007 TX H 839
AUTHOR: Eiland
VERSION: Introduced
VERSION DATE: 01/24/2007

AN ACT

relating to regulation of the secondary market in certain physician discounts.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle D, Title 8, Insurance Code, is amended by adding Chapter 1302 to read as follows:

CHAPTER 1302. REGULATION OF SECONDARY MARKET IN PHYSICIAN DISCOUNTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1302.001. PURPOSE. (a) The legislature finds that the unregulated secondary market in physician discounts is not only increasingly sophisticated, but has evolved in a part of the system that lacks transparency.

(b) The legislature also finds that the number of intermediary entities involved in the health care claims payment process is increasing dramatically. Rental network preferred provider organizations exist to market a physician's contractually discounted rates primarily to third-party payers, such as insurance brokers, third-party administrators, local or regional preferred provider organizations, or self-insured employers. A rental network preferred provider organization may also rent its networks and associated discounts to entities such as network brokers, repricers, or aggregators, whose sole purpose is finding and applying the lowest discounted rates, often without physician authorization. Many of these entities provide no value and exist for the sole purpose of trafficking in physician discounts.

(c) The legislature also finds that in this era of consumer-driven health care, patients are having an increasingly difficult time assessing the true cost of their health care. While the discounter profits from covertly undercutting the appropriate payment to the physician, it shares little if any information regarding its actions with the patient or the physician. Without this information, it becomes extremely difficult for an individual physician to determine how much the physician is to be paid for a particular health care service and by whom, and for a patient to determine the patient's share of the cost of the patient's health care. As a result, the patient often pays a greater portion of the total bill and the third-party payer ends up paying less.

(d) The legislature declares that regulating the secondary market in physician discounts is the only way to ensure that:

(1) patients have accurate real-time information at their disposal necessary to make

critical well-informed decisions relating to the spending of their health care dollars; and

(2) physicians have more control over their practice environment.

Sec. 1302.002. DEFINITIONS. In this chapter:

(1) "Contracting agent" means a covered entity engaged, for monetary or other consideration, in leasing, selling, transferring, aggregating, assigning, or otherwise conveying a physician or physician panel to provide health care services to beneficiaries.

(2) "Covered entity" means any entity responsible for payment for, or coordination of, health care services. The term includes an entity that pays or administers a claim on behalf of another entity.

(3) "Payer" means a self-insured employer, health benefit plan, insurer, or other entity that assumes the risk for payment of claims by, or reimbursement for services provided by, contracted physicians.

Sec. 1302.003. RETALIATION PROHIBITED. A covered entity may not retaliate against a physician for exercising the rights provided under this chapter or Chapter 1301.

Sec. 1302.004. PRIVATE REMEDIES. A physician is not required to exhaust any remedies provided under this chapter before bringing a claim or private cause of action on a claim that a physician may otherwise bring against a covered entity or contracting agent.

Sec. 1302.005. APPLICABILITY OF OTHER LAW. A contracting agent, and any payer for whom the contracting agent acts, shall comply with Subchapters C and C-1, Chapter 1301, with respect to payment of claims in the same manner as an insurer. [Sections 1302.006-1302.050 reserved for expansion]

SUBCHAPTER B. REGISTRATION; POWERS AND DUTIES OF COMMISSIONER AND DEPARTMENT

Sec. 1302.051. REGISTRATION REQUIRED. Each contracting agent must register with the department in the manner prescribed by the commissioner before engaging in business in this state.

Sec. 1302.052. RULES. The commissioner shall adopt rules as necessary to implement and administer this chapter. [Sections 1302.053-1302.100 reserved for expansion]

SUBCHAPTER C. CONTRACT BETWEEN PHYSICIAN AND CONTRACTING AGENT; CONTRACT REQUIREMENTS

Sec. 1302.101. GENERAL CONTRACT REQUIREMENTS. (a) Each contract

between a physician and a contracting agent must comply with the requirements of this chapter and rules adopted by the commissioner.

(b) The contract must include all terms material to the contract and be consistent with state law. Each amendment made to an original contract must be identified and highlighted.

(c) A contract between a contracting agent and a physician may not supersede the requirements of this chapter or Chapter 1301.

Sec. 1302.102. IDENTIFICATION OF PAYERS. (a) In a separate section of a contract between a physician and a contracting agent, the contract must clearly name each payer eligible to claim a discounted rate under the contract.

(b) To be eligible to claim a discounted rate, directly or indirectly, after execution of a contract, a payer must be added to the contract through a separate amendment to the contract that is signed by the affected physician. The contract amendment must be presented to the physician for the physician's signature not later than the 90th day before the date of any anticipated disclosure, lease, sale, transfer, aggregation, assignment, or conveyance to the payer of the physician's discounted rate.

Sec. 1302.103. RIGHTS OF PHYSICIAN. (a) A contract between a physician and a contracting agent must contain a provision stating the right of the physician, without any penalty, sanction, or retaliation, to affirmatively opt in or opt out of each agreement to lease, sell, transfer, aggregate, assign, or otherwise convey the physician or a physician panel and associated discounts.

(b) The contract must state the physician's contracting and payment rights, as specified by Chapter 1301, other provisions of this code, and commissioner rule.

(c) The contract may not authorize or require the physician to consent to the sale of the physician's name and contracted rates:

(1) for use with more than a single product or line of business; or

(2) more than once.

Sec. 1302.104. OBLIGATION OF PAYER OR COVERED ENTITY. (a) A payer or covered entity may not disclose, lease, sell, transfer, aggregate, assign, or otherwise convey a physician or physician panel and associated discounts obtained under a contract with a contracting agent to any other payer or entity.

(b) A contract entered into between the contracting agent and a payer or other covered entity must state the requirements of Subsection (a) and a contract between a physician and a contracting agent must state that the contracting agent is bound by the requirements of this subsection.

Sec. 1302.105. USE OF PHYSICIAN'S CONTRACTED RATE. A payer, payer representative, administrator of claims payment, or other third party acting on behalf of a payer may not claim or otherwise offer a physician's specific contracted rate for services except to the extent that the rate:

(1) is based on the contract that directly controls payment for services provided to that patient; and

(2) is stated on the explanation of benefits or remittance advice and on any patient identification card issued to the patient.

Sec. 1302.106. TERMINATION OF CONTRACT; NOTICE. (a) On termination of a contract between a physician and a contracting agent, the contracting agent shall notify each payer or covered entity that the payer or covered entity:

(1) is no longer authorized to access the physician's discounted rate; and

(2) may not disclose, lease, sell, transfer, aggregate, assign, or otherwise convey the physician's discounted rate.

(b) A contracting agent shall require each payer or covered entity that is by contract eligible to claim a physician's discounted rates to cease claiming those rates on termination of:

(1) the underlying contract between the contracting agent and the physician; or

(2) the physician's authorization for the payer or covered entity to pay the contracted reimbursement rate as permitted under the terms of the contract between the contracting agent and the physician.

(c) A contract between a physician and a contracting agent must state the requirements of this section. [Sections 1302.107-1302.150 reserved for expansion]

SUBCHAPTER D. RIGHTS AND DUTIES OF CONTRACTING AGENT

Sec. 1302.151. CONTRACTING AGENT RIGHTS AND DUTIES. (a) A contracting agent that proposes to sell, lease, assign, transfer, or otherwise convey a physician's name, discounted rate, or any other information must have a direct contract with the affected physician.

(b) The contract between the contracting agent and a physician must fully disclose any access fee or other remuneration the contracting agent may receive and the specific benefits and service the contracting agent will provide.

(c) A contracting agent shall ensure through contract terms that each payer or covered entity to which the agent has leased, sold, transferred, aggregated, assigned, or otherwise

conveyed a physician or physician panel and any associated discounts:

(1) complies with the underlying contract between the contracting agent and the physician; and

(2) pays the physician according to the rates of payment and methodology established in the underlying contract.

Sec. 1302.152. PROHIBITED CONVEYANCE. A contracting agent may not lease, sell, transfer, aggregate, assign, or otherwise convey a physician, physician panel, or any associated discounts or any other contractual obligation to any entity that is not a payer or covered entity.

Sec. 1302.153. CONTRACTING AGENT DUTIES ON NONCOMPLIANCE. After receiving written notice from a contracted physician that a payer or covered entity to whom a contracting agent has leased, sold, transferred, aggregated, assigned, or otherwise conveyed a physician, physician panel, and any associated discounts is not complying with the terms of the underlying contract between the contracting agent and a physician, including compliance with statutory requirements for timely and accurate payment of claims, and the contracted physician has fulfilled the applicable appeal or grievance process without satisfaction, the contracting agent shall, not later than the 45th day after the date of receipt of the physician's notice:

(1) ensure the payer or covered entity:

(A) causes correct payment to be made to the physician; and

(B) otherwise complies with the terms of the underlying contract; or

(2) terminate the contracting agent's agreement with that payer or covered entity and assume direct responsibility for the payment of the claim in question by paying the physician the amount owed under the contract in the manner required by state law.
[Sections 1302.154-1302.199 reserved for expansion]

SUBCHAPTER E. DISCLOSURE REQUIREMENTS

Sec. 1302.200. IMPLEMENTATION. (a) This subchapter takes effect January 1, 2008.

(b) This section expires January 2, 2008.

Sec. 1302.201. IDENTIFICATION OF ENTITY MAKING CONVEYANCE. An explanation of benefits or remittance advice in an electronic or paper format must include the identity of the contracting agent or other entity authorized to have leased, sold, transferred, aggregated, assigned, or otherwise conveyed the physician's name and associated discounts.

Sec. 1302.202. IDENTIFICATION OF ENTITY ASSUMING FINANCIAL RISK; CONTRACTING AGENT. (a) A payer, representative of a payer, or covered entity, that processes claims or claims payments shall clearly identify in an electronic or paper format on the explanation of benefits or remittance advice:

(1) the payer that assumes the risk for payment of claims or reimbursement for services; and

(2) the identity of the contracting agent through which the payment rate and any discount are claimed.

(b) A copy of the contract between the contracting agent and payer or covered entity must be provided to the physician on request.

Sec. 1302.203. INFORMATION ON IDENTIFICATION CARDS. If a covered entity, contracting agent, or payer issues member or subscriber identification cards, the identification cards must identify, in a clear and legible manner, any third-party entity, including any contracting agent:

(1) who is responsible for paying claims; or

(2) whose contract with a payer or covered entity controls or otherwise affects reimbursement for claims filed according to the subscriber contract. [Sections 1302.204-1302.250 reserved for expansion]

SUBCHAPTER F. ENFORCEMENT

Sec. 1302.251. CEASE AND DESIST ORDER; ADMINISTRATIVE PENALTIES. On determining that a contracting agent, insurer, or other entity is operating in violation of this chapter, the commissioner may:

(1) issue and enforce a cease and desist order in the manner prescribed by Subchapters B and C, Chapter 83, to prevent the violation; and

(2) impose administrative penalties under Chapter 84.

Sec. 1302.252. ADMINISTRATIVE PROCEDURE; REMEDIES. (a) A person aggrieved by a violation of this chapter may apply to the department for relief for a violation of the person's rights under this chapter. The person is entitled to an administrative hearing in the manner prescribed by Subchapter A, Chapter 40.

(b) Remedies under this section may include the recoupment of payments lost by a physician due to an unauthorized agreement to lease, sell, transfer, aggregate, assign, or otherwise convey the physician, a physician panel, and associated discounts in violation of this chapter.

SECTION 2. Section 1301.004, Insurance Code, is amended to read as follows:

Sec. 1301.004. COMPLIANCE ~~WITH CHAPTER~~ REQUIRED. Each preferred provider benefit plan offered in this state must comply with this chapter and Chapter 1302 .

SECTION 3. The commissioner of insurance shall adopt rules as necessary to implement Chapter 1302, Insurance Code, as added by this Act, not later than December 1, 2007.

SECTION 4. This Act applies only to a contract entered into or renewed on or after January 1, 2008. A contract entered into or renewed before January 1, 2008, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2007.

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2007 CO S 130
AUTHOR: Boyd
VERSION: Enacted
VERSION DATE: 05/31/2007

AN ACT

SENATE BILL 07-130

BY SENATOR(S) Boyd, Bacon, Fitz-Gerald, Gordon, Groff, Hagedorn, Keller, Mitchell S., Morse, Romer, Sandoval, Schwartz, Shaffer, Spence, Tochtrop, Tupa, Williams, Windels, and Ward;

also REPRESENTATIVE(S) Carroll M., Borodkin, Casso, Fischer, Frangas, Gibbs, Hicks, Hodge, Kefalas, Kerr A., Labuda, Madden, McGihon, Primavera, Riesberg, Roberts, Solano, Stafford, Stephens, Todd, and White.

CONCERNING MEDICAL HOMES FOR CHILDREN, AND MAKING AN APPROPRIATION THEREFOR.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 25.5-1-103, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25.5-1-103. Definitions. As used in this title, unless the context otherwise requires:

(5.5) "MEDICAL HOME" MEANS AN APPROPRIATELY QUALIFIED MEDICAL SPECIALTY, DEVELOPMENTAL, THERAPEUTIC, OR MENTAL HEALTH CARE PRACTICE THAT VERIFIABLY ENSURES CONTINUOUS, ACCESSIBLE, AND COMPREHENSIVE ACCESS TO AND COORDINATION OF COMMUNITY-BASED MEDICAL CARE, MENTAL HEALTH CARE, ORAL HEALTH CARE, AND RELATED SERVICES FOR A CHILD. A MEDICAL HOME MAY ALSO BE REFERRED TO AS A HEALTH CARE HOME. IF A CHILD'S MEDICAL HOME IS NOT A PRIMARY MEDICAL CARE PROVIDER, THE CHILD MUST HAVE A PRIMARY MEDICAL CARE PROVIDER TO ENSURE THAT A CHILD'S PRIMARY MEDICAL CARE NEEDS ARE APPROPRIATELY ADDRESSED. ALL MEDICAL HOMES SHALL ENSURE, AT A MINIMUM, THE FOLLOWING:

(a) HEALTH MAINTENANCE AND PREVENTATIVE CARE;

(b) ANTICIPATORY GUIDANCE AND HEALTH EDUCATION;

(c) ACUTE AND CHRONIC ILLNESS CARE;

(d) COORDINATION OF MEDICATIONS, SPECIALISTS, AND THERAPIES;

(e) PROVIDER PARTICIPATION IN HOSPITAL CARE; AND

(f) TWENTY-FOUR-HOUR TELEPHONE CARE.

SECTION 2. Part 1 of article 1 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-1-123. Medical homes for children - legislative declaration - duties of the department - reporting requirements. (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT:

(a) THE BEST MEDICAL CARE FOR INFANTS, CHILDREN, AND ADOLESCENTS IS PROVIDED THROUGH A MEDICAL HOME, AS DEFINED IN SECTION 25.5-1-103, AND THAT IS CONSISTENT WITH THE JOINT PRINCIPLES OF A PATIENT-CENTERED MEDICAL HOME. THOSE PRINCIPLES SHALL INCLUDE A WHOLE PERSON ORIENTATION, CARE THAT IS COORDINATED AND INTEGRATED ACROSS ALL ELEMENTS OF THE COMPLEX HEALTH CARE SYSTEM AND THE PATIENT'S COMMUNITY, AND CARE THAT PROVIDES FOR QUALITY AND SAFETY OF THE PATIENT WHERE QUALIFIED HEALTH CARE PRACTITIONERS PROVIDE PRIMARY CARE AND HELP MANAGE AND FACILITATE ALL ASPECTS OF MEDICAL CARE;

(b) INFANTS, CHILDREN, AND ADOLESCENTS AND THEIR FAMILIES WORK BEST WITH A HEALTH CARE PRACTITIONER WHO KNOWS THE FAMILY AND WHO DEVELOPS A PARTNERSHIP OF MUTUAL RESPONSIBILITY AND TRUST;

(c) MEDICAL CARE PROVIDED THROUGH EMERGENCY DEPARTMENTS, WALK-IN CLINICS, AND OTHER URGENT-CARE FACILITIES IS OFTEN MORE COSTLY AND LESS EFFECTIVE THAN CARE GIVEN BY A PHYSICIAN WITH PRIOR KNOWLEDGE OF THE CHILD AND HIS OR HER FAMILY; AND

(d) THE STATE DEPARTMENT SHOULD STRIVE TO FIND A MEDICAL HOME FOR EACH CHILD RECEIVING SERVICES THROUGH THE STATE MEDICAL ASSISTANCE PROGRAM, ARTICLES 4, 5, AND 6 OF THIS TITLE, OR THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF THIS TITLE.

(2) ON OR BEFORE JULY 1, 2008, THE STATE DEPARTMENT, IN CONJUNCTION WITH THE COLORADO MEDICAL HOME INITIATIVE IN THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, SHALL DEVELOP SYSTEMS AND STANDARDS TO MAXIMIZE THE NUMBER OF CHILDREN ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM OR THE CHILDREN'S BASIC HEALTH PLAN WHO HAVE A MEDICAL HOME. THE SYSTEMS AND STANDARDS DEVELOPED SHALL INCLUDE, BUT NEED NOT

BE LIMITED TO, WAYS TO ENSURE THAT A MEDICAL HOME SHALL OFFER FAMILY-CENTERED, COMPASSIONATE, CULTURALLY EFFECTIVE CARE AND SENSITIVE, RESPECTFUL COMMUNICATION TO A CHILD AND HIS OR HER FAMILY.

(3) ON OR BEFORE JANUARY 30, 2008, AND EVERY JANUARY 30 THEREAFTER, THE STATE DEPARTMENT SHALL REPORT TO THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND THE SENATE, OR ANY SUCCESSOR COMMITTEES, ON PROGRESS MADE TOWARD MAXIMIZING THE NUMBER OF CHILDREN WITH A MEDICAL HOME WHO ARE ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM OR THE CHILDREN'S BASIC HEALTH PLAN.

SECTION 3. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of health care policy and financing, for allocation to the executive director's office, for the fiscal year beginning July 1, 2007, the sum of forty-four thousand nine hundred sixty-five dollars ($44,965) and 1.0 FTE, or so much thereof as may be necessary, for the implementation of this act. Said sum shall be subject to the "(M)" notation as defined in the general appropriation act. In addition to said appropriation, the general assembly anticipates that, for the fiscal year beginning July 1, 2007, the department of health care policy and financing will receive the sum of seventy-three thousand one hundred sixty-three dollars ($73,163) in federal funds for the implementation of this act. Although the federal funds are not appropriated in this act, they are noted for the purpose of indicating the assumptions used relative to these funds in developing state appropriation amounts.

SECTION 4. Effective date. (1) This act shall take effect only if:

(a) House Bill 07-1021 is enacted at the first regular session of the sixty-sixth general assembly and becomes law;

(b) The final fiscal estimate for House Bill 07-1021, determined from the appropriations enacted in said bill, shows a net reduction in the amount of general fund expenditures appropriated for the state fiscal year 2007-08, that is equal to or greater than the amount of the general fund appropriation made for the implementation of this act for the state fiscal year 2007-08, as reflected in section 3 of this act; and

(c) The staff director of the joint budget committee files written notice with the revisor of statutes no later than July 15, 2007, that the requirement set forth in paragraph (b) of this subsection (1) has been met.

SECTION 5. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

2006 FL H 587
AUTHOR: Galvano
VERSION: Chaptered
VERSION DATE: 06/13/2006

CHAPTER 2006-207

House Bill No. 587

An act relating to health care practitioners; providing legislative findings and intent; amending s. 456.072, F.S., relating to grounds for discipline, penalties, and enforcement applicable to health care practitioners; providing that a practitioner's failure to identify the type of license under which he or she is practicing constitutes grounds for disciplinary action; providing exceptions; authorizing certain entities to determine compliance with a disclosure requirement; providing penalties; specifying that a reference to the section constitutes a general reference under the doctrine of incorporation by reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. The Legislature finds that there exists a compelling state interest in patients being informed of the credentials of the health care practitioners who treat them and in the public being protected from misleading health care advertising. The Legislature further finds that the areas of licensure for the practice of health care can be extremely confusing for patients and that health care practitioners can easily mislead patients into believing that the practitioner is better qualified than other health care practitioners simply by creating a sham practice designation. Therefore, the Legislature has determined that the most direct and effective manner in which to protect patients from this identifiable harm is to ensure that patients and the public be informed of the training of health care practitioners and intends by this act to require the provision of the information.

Section 2. Section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(a) Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession.

(b) Intentionally violating any rule adopted by the board or the department, as appropriate.

(c) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere

to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, a licensee's profession.

(d) Using a Class III or a Class IV laser device or product, as defined by federal regulations, without having complied with the rules adopted under ~~pursuant to~~ s. 501.122(2) governing the registration of the ~~such~~ devices.

(e) Failing to comply with the educational course requirements for human immunodeficiency virus and acquired immune deficiency syndrome.

(f) Having a license or the authority to practice any regulated profession revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions, for a violation that would constitute a violation under Florida law. The licensing authority's acceptance of a relinquishment of licensure, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of charges against the license, shall be construed as action against the license.

(g) Having been found liable in a civil proceeding for knowingly filing a false report or complaint with the department against another licensee.

(h) Attempting to obtain, obtaining, or renewing a license to practice a profession by bribery, by fraudulent misrepresentation, or through an error of the department or the board.

(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board.

(j) Aiding, assisting, procuring, employing, or advising any unlicensed person or entity to practice a profession contrary to this chapter, the chapter regulating the profession, or the rules of the department or the board.

(k) Failing to perform any statutory or legal obligation placed upon a licensee. For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan or failing to comply with service scholarship obligations shall be considered a failure to perform a statutory or legal obligation, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund.

(l) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, or willfully impeding or obstructing another person to do so. Such reports or records shall include

only those that are signed in the capacity of a licensee.

(m) Making deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession.

(n) Exercising influence on the patient or client for the purpose of financial gain of the licensee or a third party.

(o) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee knows, or has reason to know, the licensee is not competent to perform.

(p) Delegating or contracting for the performance of professional responsibilities by a person when the licensee delegating or contracting for performance of the ~~such~~ responsibilities knows, or has reason to know, the ~~such~~ person is not qualified by training, experience, and authorization when required to perform them.

(q) Violating a lawful order of the department or the board, or failing to comply with a lawfully issued subpoena of the department.

(r) Improperly interfering with an investigation or inspection authorized by statute, or with any disciplinary proceeding.

(s) Failing to comply with the educational course requirements for domestic violence.

(t) Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds. This paragraph does not apply to a practitioner while the practitioner is providing services in a facility licensed under chapter 394, chapter 395, or chapter 400. Each board, or the department where there is no board, is authorized by rule to determine how its practitioners may comply with this disclosure requirement.

(u) ~~(t)~~ Failing to comply with the requirements of ss. 381.026 and 381.0261 to provide patients with information about their patient rights and how to file a patient complaint.

(v) ~~(u)~~ Engaging or attempting to engage in sexual misconduct as defined and prohibited in s. 456.063(1).

(w) ~~(v)~~ Failing to comply with the requirements for profiling and credentialing, including, but not limited to, failing to provide initial information, failing to timely provide updated information, or making misleading, untrue, deceptive, or fraudulent representations on a profile, credentialing, or initial or renewal licensure application.

(x) ~~(w)~~ Failing to report to the board, or the department if there is no board, in writing within 30 days after the licensee has been convicted or found guilty of, or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction. Convictions, findings, adjudications, and pleas entered into prior to the enactment of this paragraph must be reported in writing to the board, or department if there is no board, on or before October 1, 1999.

(y) ~~(x)~~ Using information about people involved in motor vehicle accidents which has been derived from accident reports made by law enforcement officers or persons involved in accidents under ~~pursuant to~~ s. 316.066, or using information published in a newspaper or other news publication or through a radio or television broadcast that has used information gained from such reports, for the purposes of commercial or any other solicitation whatsoever of the people involved in the ~~such~~ accidents.

(z) ~~(y)~~ Being unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the secretary or the secretary's designee that probable cause exists to believe that the licensee is unable to practice because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the licensee refuses to comply with the ~~such~~ order, the department's order directing the ~~such~~ examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or does business. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice of his or her profession with reasonable skill and safety to patients.

(aa) ~~(z)~~ Testing positive for any drug, as defined in s. 112.0455, on any confirmed preemployment or employer-ordered drug screening when the practitioner does not have a lawful prescription and legitimate medical reason for using the ~~such~~ drug.

(bb) ~~(aa)~~ Performing or attempting to perform health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing or attempting to perform health care services includes the preparation of the patient.

(cc) ~~(bb)~~ Leaving a foreign body in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or other diagnostic procedures. For the purposes of this paragraph, it shall be legally presumed that retention of a foreign body is not in the best interest of the patient and is not within the standard of care of the profession, regardless of the intent of the professional.

(dd) ~~(cc)~~ Violating any provision of this chapter, the applicable practice act, or any

rules adopted pursuant thereto.

(ee) ~~(dd)~~ With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill that has been "upcoded" as defined in s. 627.732.

(ff) ~~(ee)~~ With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill for payment of services that were not rendered.

(gg) ~~(ff)~~ Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter, a violation of the applicable practice act, or a violation of any rules adopted under ~~pursuant to~~ this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

(hh) ~~(gg)~~ Being terminated from a treatment program for impaired practitioners, which is overseen by an impaired practitioner consultant as described in s. 456.076, for failure to comply, without good cause, with the terms of the monitoring or treatment contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.

(2) When the board, or the department when there is no board, finds any person guilty of the grounds set forth in subsection (1) or of any grounds set forth in the applicable practice act, including conduct constituting a substantial violation of subsection (1) or a violation of the applicable practice act which occurred prior to obtaining a license, it may enter an order imposing one or more of the following penalties:

(a) Refusal to certify, or to certify with restrictions, an application for a license.

(b) Suspension or permanent revocation of a license.

(c) Restriction of practice or license, including, but not limited to, restricting the licensee from practicing in certain settings, restricting the licensee to work only under designated conditions or in certain settings, restricting the licensee from performing or providing designated clinical and administrative services, restricting the licensee from practicing more than a designated number of hours, or any other restriction found to be necessary for the protection of the public health, safety, and welfare.

(d) Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.

(e) Issuance of a reprimand or letter of concern.

(f) Placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department when there is no board, may specify. Those conditions may include, but are not limited to, requiring the licensee to undergo treatment, attend continuing education courses, submit to be reexamined, work under the supervision of another licensee, or satisfy any terms which are reasonably tailored to the violations found.

(g) Corrective action.

(h) Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding patient rights.

(i) Refund of fees billed and collected from the patient or a third party on behalf of the patient.

(j) Requirement that the practitioner undergo remedial education.

In determining what action is appropriate, the board, or department when there is no board, must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs associated with compliance with orders issued under this subsection are the obligation of the practitioner.

(3)(a) Notwithstanding subsection (2), if the ground for disciplinary action is the first-time failure of the licensee to satisfy continuing education requirements established by the board, or by the department if there is no board, the board or department, as applicable, shall issue a citation in accordance with s. 456.077 and assess a fine, as determined by the board or department by rule. In addition, for each hour of continuing education not completed or completed late, the board or department, as applicable, may require the licensee to take 1 additional hour of continuing education for each hour not completed or completed late.

(b) Notwithstanding subsection (2), if the ground for disciplinary action is the first-time violation of a practice act for unprofessional conduct, as used in ss. 464.018(1)(h), 467.203(1)(f), 468.365(1)(f), and 478.52(1)(f), and no actual harm to the patient occurred, the board or department, as applicable, shall issue a citation in accordance with s. 456.077 and assess a penalty as determined by rule of the board or department.

(4) In addition to any other discipline imposed through final order, or citation, entered on or after July 1, 2001, under ~~pursuant to~~ this section or discipline imposed through final order, or citation, entered on or after July 1, 2001, for a violation of any practice act, the board, or the department when there is no board, shall assess costs related to the investigation and prosecution of the case. The ~~Such~~ costs related to the investigation and

prosecution include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by the attorney and other personnel working on the case, and any other expenses incurred by the department for the case. The board, or the department when there in no board, shall determine the amount of costs to be assessed after its consideration of an affidavit of itemized costs and any written objections thereto. In any case where the board or the department imposes a fine or assessment and the fine or assessment is not paid within a reasonable time, the ~~such~~ reasonable time to be prescribed in the rules of the board, or the department when there is no board, or in the order assessing the ~~such~~ fines or costs, the department or the Department of Legal Affairs may contract for the collection of, or bring a civil action to recover, the fine or assessment.

(5) In addition to, or in lieu of, any other remedy or criminal prosecution, the department may file a proceeding in the name of the state seeking issuance of an injunction or a writ of mandamus against any person who violates any of the provisions of this chapter, or any provision of law with respect to professions regulated by the department, or any board therein, or the rules adopted pursuant thereto.

(6) If ~~In the event~~ the board, or the department when there is no board, determines that revocation of a license is the appropriate penalty, the revocation shall be permanent. However, the board may establish by rule requirements for reapplication by applicants whose licenses have been permanently revoked. The ~~Such~~ requirements may include, but are ~~shall~~ not ~~be~~ limited to, satisfying current requirements for an initial license.

(7) The purpose of this section is to facilitate uniform discipline for those actions made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 3. This act shall take effect July 1, 2006.

Approved by the Governor June 13, 2006.

Filed in Office Secretary of State June 13, 2006.

2007 NM HJM 71
AUTHOR: Gardner
VERSION: Adopted
VERSION DATE: 03/15/2007

HOUSE JOINT MEMORIAL 71

48TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2007

A JOINT MEMORIAL REQUESTING THE INTERIM LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE TO ESTABLISH AN UNBIASED AND FAIR PROCESS TO REVIEW SCOPES OF PRACTICE OF THE HEALTH CARE PROFESSIONS.

WHEREAS, the legislature seeks objective information on proposed changes to health care scopes of practice or the creation of new scopes of practice; and

WHEREAS, the reasons for scope of practice changes should have a foundational basis within four areas: an established history of the practice scope within the profession, education and training, supporting evidence and an appropriate regulatory environment; and

WHEREAS, the purpose of any review and subsequent change of any scope of practice is to promote better consumer care across professions and providers, improve access to care and recognize the inevitability of overlapping scopes of practice; and

WHEREAS, some practice changes are the result of changes already occurring in education or practice due to research, advances in technology and changes in societal health care demands;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the interim legislative health and human services committee study and recommend to the legislature an unbiased and fair process to review proposed changes to scopes of practice of licensed health professions and new health professions requesting licensure; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the interim legislative health and human services committee, each of the health-related licensing or certification boards, the board of nursing and the New Mexico medical board.

2007 GA SB 90
AUTHOR: Thomas, Reed, Schaefer, Miles

VERSION DATE: 05/2005

Senate Bill 90
By: Senators Thomas of the 54th, Reed of the 35th, Unterman of the 45th, Schaefer of the 50th, Miles of the 43rd and others **AS PASSED**

AN ACT

To amend Chapter 12 of Title 16 and Title 31 of the Official Code of Georgia Annotated, relating to offenses against public health and morals and to health, respectively, so as to provide comprehensive changes and additions to the prohibition on smoking in this state; to amend certain provisions relating to the prohibition against smoking in public places; to enact the "Georgia Smokefree Air Act of 2005"; to provide for definitions; to prohibit smoking in certain facilities and areas; to provide for exceptions; to provide that entire establishments, facilities, or outdoor areas shall be nonsmoking; to provide for posting of signs and removal of ashtrays; to provide for an informational program; to provide for enforcement; to provide that this prohibition shall be cumulative to other general or local acts, rules, and regulations; to provide for statutory construction; to provide for related matters; to provide for effective dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 12 of Title 16 of the Official Code of Georgia Annotated, relating to offenses against public health and morals, is amended by striking Code Section 16-12-2, relating to prohibited smoking in public places, and inserting in lieu thereof the following:
"16-12-2.
(a) A person smoking tobacco in violation of Chapter 12A of Title 31 shall be guilty of a misdemeanor and, if convicted, shall be punished by a fine of not less than $100.00 nor more than $500.00.
(b) This Code section shall be cumulative to and shall not prohibit the enactment of any other general and local laws, rules and regulations of state or local agencies, and local ordinances prohibiting smoking which are more restrictive than this Code section."

SECTION 2.

Title 31 of the Official Code of Georgia Annotated, relating to health, is amended by adding after Chapter 12 a new Chapter 12A to read as follows:
"CHAPTER 12A

31-12A-1.
This chapter shall be known and may be cited as the "Georgia Smokefree Air Act of 2005."

31-12A-2.
As used in this chapter, the term:
(1) 'Bar' means an establishment that is devoted to the serving of alcoholic beverages for consumption by guests on the premises and in which the serving of food is only incidental to the consumption of those beverages, including, but not limited to, taverns, nightclubs, cocktail lounges, and cabarets.
(2) 'Business' means any corporation, sole proprietorship, partnership, limited partnership, limited liability corporation, limited liability partnership, professional corporation, enterprise, franchise, association, trust, joint venture, or other entity, whether for profit or nonprofit.
(3) 'Employee' means an individual who is employed by a business in consideration for direct or indirect monetary wages or profit.
(4) 'Employer' means an individual or a business that employs one or more individuals.
(5) 'Enclosed area' means all space between a floor and ceiling that is enclosed on all sides by solid walls or windows, exclusive of doorways, which extend from the floor to the ceiling.
(6) 'Health care facility' means an office or institution providing care or treatment of diseases, whether physical, mental, or emotional, or other medical, physiological, or psychological conditions, including, but not limited to, hospitals, rehabilitation hospitals or other clinics, including weight control clinics, homes for the chronically ill, laboratories, and offices of surgeons, chiropractors, physical therapists, physicians, dentists, and all specialists within these professions. This definition shall include all waiting rooms, hallways, private rooms, semiprivate rooms, and wards within health care facilities. This definition shall not include long-term care facilities as defined in paragraph (3) of Code Section 31-8-81.
(7) 'Infiltrate' means to permeate an enclosed area by passing through its walls, ceilings, floors, windows, or ventilation systems to the extent that an individual can smell secondhand smoke.
(8) 'Local governing authority' means a county or municipal corporation of the state.
(9) 'Place of employment' means an enclosed area under the control of a public or private employer that employees utilize during the course of employment, including, but not limited to, work areas, employee lounges, restrooms, conference rooms, meeting rooms, classrooms, employee cafeterias, and hallways. A private residence is not a place of employment unless it is used as a licensed child care, adult day-care, or health care facility. This term shall not include vehicles used in the course of employment.
(10) 'Public place' means an enclosed area to which the public is invited or in which the public is permitted, including, but not limited to, banks, bars, educational facilities, health care facilities, laundromats, public transportation facilities, reception areas, restaurants, retail food production and marketing establishments, retail service establishments, retail stores, shopping malls, sports arenas, theaters, and waiting rooms. A private residence is not a public place unless it is used as a licensed child care, adult day-care, or health care facility.
(11) 'Restaurant' means an eating establishment, including, but not limited to, coffee shops, cafeterias, sandwich stands, and private and public school cafeterias, which gives or offers for sale food to the public, guests, or employees, as well as kitchens and catering

facilities in which food is prepared on the premises for serving elsewhere. The term shall include a bar area within any restaurant.
(12) 'Retail tobacco store' means a retail store utilized primarily for the sale of tobacco products and accessories and in which the sale of other products is merely incidental.
(13) 'Secondhand smoke' means smoke emitted from lighted, smoldering, or burning tobacco when the person smoking is not inhaling, smoke emitted at the mouthpiece during puff drawing, and smoke exhaled by the person smoking.
(14) 'Service line' means an indoor line in which one or more persons are waiting for or receiving service of any kind, whether or not the service involves the exchange of money.
(15) 'Shopping mall' means an enclosed public walkway or hall area that serves to connect retail or professional establishments.
(16) 'Smoking' means inhaling, exhaling, burning, or carrying any lighted tobacco product including cigarettes, cigars, and pipe tobacco.
(17) 'Smoking area' means a separately designated enclosed room which need not be entered by an employee in order to conduct business that is designated as a smoking area and, when so designated as a smoking area, shall not be construed as to deprive employees of a nonsmoking lounge, waiting area, or break room.
(18) 'Sports arena' means enclosed stadiums and enclosed sports pavilions, gymnasiums, health spas, boxing arenas, swimming pools, roller and ice rinks, bowling alleys, and other similar places where members of the general public assemble to engage in physical exercise, participate in athletic competition, or witness sports or other events.

31-12A-3.
Smoking shall be prohibited in all enclosed facilities of, including buildings owned, leased, or operated by, the State of Georgia, its agencies and authorities, and any political subdivision of the state, municipal corporation, or local board or authority created by general, local, or special Act of the General Assembly or by ordinance or resolution of the governing body of a county or municipal corporation individually or jointly with other political subdivisions or municipalities of the state.

31-12A-4.
Except as otherwise specifically authorized in Code Section 31-12A-6, smoking shall be prohibited in all enclosed public places in this state.

31-12A-5.
(a) Except as otherwise specifically provided in Code Section 31-12A-6, smoking shall be prohibited in all enclosed areas within places of employment, including, but not limited to, common work areas, auditoriums, classrooms, conference and meeting rooms, private offices, elevators, hallways, medical facilities, cafeterias, employee lounges, stairs, restrooms, and all other enclosed facilities.
(b) Such prohibition on smoking shall be communicated to all current employees by July 1, 2005, and to each prospective employee upon their application for employment.

31-12A-6.
(a) Notwithstanding any other provision of this chapter, the following areas shall be exempt from the provisions of Code Sections 31-12A-4 and 31-12A-5:

(1) Private residences, except when used as a licensed child care, adult day-care, or health care facility;
(2) Hotel and motel rooms that are rented to guests and are designated as smoking rooms; provided, however, that not more than 20 percent of rooms rented to guests in a hotel or motel may be so designated;
(3) Retail tobacco stores, provided that secondhand smoke from such stores does not infiltrate into areas where smoking is prohibited under the provisions of this article;
(4) Long-term care facilities as defined in paragraph (3) of Code Section 31-8-81;
(5) Outdoor areas of places of employment;
(6) Smoking areas in international airports, as designated by the airport operator;
(7) All workplaces of any manufacturer, importer, or wholesaler of tobacco products, of any tobacco leaf dealer or processor, all tobacco storage facilities, and any other entity set forth in Code Section 10-13A-2;
(8) Private and semiprivate rooms in health care facilities licensed under Title 31 that are occupied by one or more persons, all of whom have written authorization by their treating physician to smoke;
(9) Bars and restaurants, as follows:
(A) All bars and restaurants to which access is denied to any person under the age of 18 and that do not employ any individual under the age of 18; or
(B) Private rooms in restaurants and bars if such rooms are enclosed and have an air handling system independent from the main air handling system that serves all other areas of the building and all air within the private room is exhausted directly to the outside by an exhaust fan of sufficient size;
(10) Convention facility meeting rooms and public and private assembly rooms contained within a convention facility not wholly or partially owned, leased, or operated by the State of Georgia, its agencies and authorities, or any political subdivision of the state, municipal corporation, or local board or authority created by general, local, or special Act of the General Assembly while these places are being used for private functions and where individuals under the age of 18 are prohibited from attending or working as an employee during the function;
(11) Smoking areas designated by an employer which shall meet the following requirements:
(A) The smoking area shall be located in a nonwork area where no employee, as part of his or her work responsibilities, shall be required to enter, except such work responsibilities shall not include custodial or maintenance work carried out in the smoking area when it is unoccupied;
(B) Air handling systems from the smoking area shall be independent from the main air handling system that serves all other areas of the building and all air within the smoking area shall be exhausted directly to the outside by an exhaust fan of sufficient size and capacity for the smoking area and no air from the smoking area shall be recirculated through or infiltrate other parts of the building; and
(C) The smoking area shall be for the use of employees only.
The exemption provided for in this paragraph shall not apply to restaurants and bars; and
(12) Common work areas, conference and meeting rooms, and private offices in private places of employment, other than medical facilities, that are open to the general public by

appointment only; except that smoking shall be prohibited in any public reception area of such place of employment.
(13) Private clubs, military officer clubs and noncommissioned officer clubs.
(b) In order to qualify for exempt status under subsection (a) of this Code section, any area described in subsection (a) of this Code section, except for areas described in paragraph (1) of subsection (a) of this Code section, shall post conspicuously at every entrance a sign indicating that smoking is permitted.

31-12A-7.
Notwithstanding any other provision of this chapter, an owner, operator, manager, or other person in control of an establishment, facility, or outdoor area may declare that entire establishment, facility, or outdoor area as a nonsmoking place. Smoking shall be prohibited in any place in which a sign conforming to the requirements of subsection (a) of Code Section 31-12A-8 is posted.

31-12A-8.
(a) 'No Smoking' signs or the international 'No Smoking' symbol consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it may be clearly and conspicuously posted by the owner, operator, manager, or other person in control in every public place and place of employment where smoking is prohibited by this article.
(b) All ashtrays shall be removed from any area where smoking is prohibited by this chapter by the owner, operator, manager, or other person in control of the area, unless such ashtray is permanently affixed to an existing structure.

31-12A-9.
The Department of Human Resources and the agency designated by each local governing authority in this state may engage in a continuing program to explain and clarify the purposes and requirements of this chapter to citizens affected by it and to guide owners, operators, and managers in their compliance with it. The program may include publication of a brochure for affected businesses and individuals explaining the provisions of this chapter.

31-12A-10.
The Department of Human Resources and the county boards of health and their duly authorized agents are authorized and empowered to enforce compliance with this chapter and the rules and regulations adopted and promulgated under this chapter and, in connection therewith, to enter upon and inspect the premises of any establishment or business at any reasonable time and in a reasonable manner, as provided in Article 2 of Chapter 5 of this title.

31-12A-11.
The county boards of health may annually request other governmental and educational agencies having facilities within the area of the local government to establish local operating procedures in cooperation and compliance with this chapter.

31-12A-12.
This chapter shall be cumulative to and shall not prohibit the enactment of any other general or local laws, rules, and regulations of state or local governing authorities or local ordinances prohibiting smoking which are more restrictive than this chapter or are not in direct conflict with this chapter.

31-12A-13.
(a) This chapter shall not be construed to permit smoking where it is otherwise restricted by other applicable laws.
(b) Nothing in this chapter shall be construed as to repeal the provisions of Code Section 16-12-2.
(c) This chapter shall be liberally construed so as to further its purposes."

SECTION 3.

This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval only for purposes of promulgating rules and regulations; for all other purposes, this Act shall become effective on July 1, 2005.

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.

2007 MD H 140
AUTHOR: Busch
VERSION: Enrolled
VERSION DATE: 04/06/2007

By: The Speaker (By Request - Administration) and Delegates Barnes, Busch, Haynes, and Morhaim

AN ACT concerning

Statewide Advisory Commission on ~~Immunization~~ Immunizations -

~~Universal Vaccine Purchasing System~~ Duties and Sunset Extension

FOR the purpose of expanding certain duties of the Statewide Advisory Commission on Immunizations; including a representative from a health insurance carrier on the Commission; extending the termination date of the Commission; requiring the Commission to make certain recommendations in a certain annual report by a certain date; providing for the termination of a certain provision of this Act; and generally relating to the Statewide Advisory Commission on Immunizations.

BY repealing and reenacting, with amendments, Article - Health - General Section 18-214 Annotated Code of Maryland (2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments, Chapter 337 of the Acts of the General Assembly of 2002, as amended by Chapter 200 of the Acts of the General Assembly of 2005 Section 2

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health - General

18-214.

(a) In this section, "vaccine" means a product intended to elicit, in humans, active or passive immunity against an infectious agent or product of an infectious agent.

(b) There is a Statewide Advisory Commission on Immunizations.

(c) The Commission consists of at least the following members:

(1) One physician member of the Medical and Chirurgical Faculty Public Health Council;

(2) The chairperson of the Maryland Childhood Immunization Partnership;

(3) Two physician members of the Maryland Chapter of the American Academy of Pediatrics with experience in private practice and infectious diseases;

(4) One physician member of the Maryland Academy of Family Physicians;

(5) One physician member of the American College of Physicians - Internal Medicine Society of Maryland;

(6) The executive director of the Maryland Partnership for Prevention;

(7) One local health officer;

(8) One representative from the Department's Vaccines for Children Program;

(9) One representative of the Maryland school system with knowledge of the immunizations required of children entering schools;

(10) The Maryland State Epidemiologist;

(11) One representative from a public health consumer advocacy group; ~~and~~

(12) One nurse practitioner <u>; AND</u>

<u>(13) ONE REPRESENTATIVE FROM A HEALTH INSURANCE CARRIER</u> .

(d) The Secretary of the Department of Health and Mental Hygiene shall appoint the membership of the Commission, based on the recommendation of the appropriate medical society or agency.

(e) The physician member of the Medical and Chirurgical Faculty Public Health Council shall:

(1) Chair the Commission;

(2) Establish subcommittees to facilitate the work of the Commission; and

(3) Appoint subcommittee chairs from among the Commission members.

(f) A member of the Commission may not receive compensation but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) The Department of Health and Mental Hygiene shall provide the staffing for the Commission.

(h) The Commission shall:

(1) Determine where community vaccine shortages exist and which vaccines are in short supply;

(2) Develop a recommendation for a plan to effectuate the equitable distribution of vaccines; and

(3) Study and make recommendations about other related issues as determined by the Commission, including but not limited to:

(i) Immunizations required of children entering schools in times of vaccine shortage;

(ii) All available options for the purchasing of vaccines , INCLUDING THE DEVELOPMENT OF A UNIVERSAL VACCINE PURCHASING SYSTEM, OR A SIMILAR PROGRAM TO INCREASE ACCESS TO NECESSARY VACCINES, FOR THE STATE ;

(III) AN UPDATE ON THE STATUS OF THE USE OF THIMEROSAL IN VACCINES, INCLUDING THE AVAILABILITY AND AFFORDABILITY OF THIMEROSAL-FREE VACCINES, AND ANY OTHER ISSUE RELATED TO THE USE OF THIMEROSAL IN VACCINES THAT IS IDENTIFIED BY THE COMMISSION;

~~(iii)~~ (IV) Elimination of any vaccine distribution disparities;

~~(iv)~~ (V) A public education campaign in the event of a vaccine shortage;

~~(v)~~ (VI) The availability and affordability of adult and childhood vaccines; and

~~(vi)~~ (VII) Strategies to increase immunizations among those adults and children recommended to receive immunizations, including catch-up immunizations.

(i) On or before December 15 of each year, the Commission shall submit a report on its findings and recommendations to the Governor and, in accordance with Section 2-1246 of the State Government Article, to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee.

Chapter 337 of the Acts of 2002, as amended by Chapter 200 of the Acts of 2005

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2002. It shall remain effective for a period of ~~6~~ 8 years and, at the end of May 31, ~~2008,~~ 2010, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The report of the Statewide Advisory Commission on Immunizations that is due on December 15, 2007, shall contain recommendations on whether the State should consider implementing a Universal Vaccine Purchasing System or take other appropriate action to increase access to necessary vaccines.

(b) In developing its recommendations, the Commission shall:

(1) consult with all interested stakeholders;

(2) review the structure, cost, scope, success, and implementation issues of similar programs in other states;

(3) consider any existing State or federal programs or funds, or any other source of funds, that may be available to mitigate the cost and administrative burden of any proposed new program; ~~and~~

(4) provide a range of policy, structure, cost, and scope options to be considered in any proposed new program ;

(5) consider the feasibility and advisability of requiring the Department of Health and Mental Hygiene to reimburse for vaccine administration on a per-antigen basis as an alternative to reimbursing on a per-dosage basis; and

(6) (i) consider all available options for requiring carriers to reimburse providers adequately for the full cost of immunizations including acquisition and overhead costs; and

(ii) consider the feasibility of publicizing a list of wholesale vendors and the prices charged by each vendor for vaccines .

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2007. Section 2 of this Act shall remain effective for a period of 1 year and 6 months and, at the end of December 31, 2008, with no further action required by the General Assembly, Section 2 of this Act shall be abrogated and of no further force and effect.

2007 HI S 976
AUTHOR: Ige
VERSION: Senate Draft 1
VERSION DATE: 02/15/2007

THE SENATE , S.B. NO. 976
TWENTY-FOURTH LEGISLATURE, S.D. 1
2007 STATE OF HAWAII

A BILL FOR AN ACT

Relating to rural primary healthcare and workforce development in the short-term.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that, aside from Oahu, most of the State is federally designated as Medically Underserved Areas, Medically Underserved Populations, or Health Professions Shortage Areas. Physicians are choosing to relocate out of rural areas and Hawaii. There is an urgent need to provide high quality primary care services to already underserved populations with disparate health indicators. Maternal and child health risk, cardiovascular risk, and socio-economic risk are greatest in rural Hawaii. According to the department of health's 1999 statistics, the top ten highest risk areas are all located in rural communities. The need for physicians in rural areas will only increase with the aging population and projected population growth on the neighbor islands.

National studies have demonstrated that substantial residency training in rural areas increases placement and retention of physicians in rural practices. Additionally, adults with a primary care physician, rather than a specialist as their personal physician, have been shown to have a thirty three per cent lower cost of care and were nineteen per cent less likely to die (after controlling for age, gender, income, insurance, smoking, and many other health conditions).

There are approximately three thousand five hundred licensed physicians in Hawaii, but some of these physicians are not actively practicing in Hawaii. Forty-two per cent of these physicians are primary care physicians but most of these physicians are clustered around Honolulu. Currently, there are one hundred ten family physicians working on the neighbor islands and many of their practices are not accepting new patients because of very high demand or insurance considerations, or both.

Currently, the University of Hawaii John A. Burns school of medicine (UH JABSOM) family medicine residency program (FMRP) conducts the only civilian FMRP in the State. This program's mission is to provide well-trained primary care doctors to meet the needs of rural and underserved areas of Hawaii and over eighty per cent of its graduates meet this mission. Family medicine is the only discipline that provides primary medical care to the entire life span - caring for children, adults, and the elderly - in the outpatient, inpatient, and long-term care settings. The scope of services for a well-trained family

physician also includes maternity care, women's health, and mental health care in the outpatient settings. Family medicine also emphasizes using a systems-based and interdisciplinary team approach to health care. The UH JABSOM FMRP has an outstanding accreditation, a solid curriculum, a diverse faculty, and academically strong residents. The precarious financial situation at Wahiawa general hospital, the primary sponsoring hospital in the area has the potential to further disrupt clinical services in Central and Northern Oahu. An interruption of the residency program on Oahu would end the development of a rural training track in Hilo and further deplete the primary care workforce, resulting in diminished health care access in the State.

The residency training curriculum for family medicine emphasizes continuity of care across the different health care settings during the three-year residency-training period. Residents care for a panel of patients and their families and also provide education and outreach in local high schools and at community events. The curriculum also emphasizes delivery of culturally appropriate, cost effective, community-based care. Resident and faculty research projects examine health disparities and develop curricula or propose enhancements to existing systems to ultimately reduce those disparities.

The current base FMRP at UH JABSOM trains eighteen residents in a program that trains six residents per year for three years. Wahiawa general hospital supports the salaries of eighteen residents but receives Graduate Medical Education (GME) funding from the Centers for Medicare and Medicaid Services (CMS) for only fourteen residents. The salary shortfall adds to the financial strain on Wahiawa general hospital. Of the three years of training, two months are presently spent in Hilo where residents rotate among private physician offices, emergency departments, and provide outreach and education to the community. This CMS-funded demonstration project and resident rotation started in Hilo in January 2006. In a "rural training track," residents do the bulk of their tertiary and specialty training in their first year at the base program on Oahu, then physically relocate to the rural site for the remaining two years of training. To realize a full rural residency track in Hilo, a full-time Hilo-based faculty is required to work in close conjunction with the Oahu based residency program to develop the Hawaii island family medicine rural training track.

When the family medicine rural training track is fully developed on the island of Hawaii, there will be eight residents living and working on the island that include rotations to other neighbor island sites. The first graduates would enter practice in 2011. The aim is to replicate a rural training track on Kauai once the Hawaii Island model is successfully implemented. While in training, residents will have approximately six thousand patient encounters over their two years of training. By partnering with community organizations, community health centers, and other health professions training programs to conduct residency training, the impact on the health of the neighbor island population is anticipated to be substantial.

Residency training programs tend to provide care to those with limited or no access to health care. Community medicine and community based participatory research will be a major focus of the curriculum so that residents can begin to collaborate with communities

to address priority issues while they are in training. With an interdisciplinary approach to caring for medically or socially complex families, or both, more cost effective and culturally appropriate care can be anticipated. This expanded statewide model of family medicine rural training aims to double the number of family medicine graduates practicing in rural and underserved areas in the State in the next ten years. Perhaps more importantly, it is anticipated that many of these physicians will be "homegrown" since an increasing number of JABSOM medical students are from the neighbor islands and many of them choose family medicine as a specialty.

To attain a successful model of family medicine training to meet the health workforce needs of the State, the base program on Oahu must be stabilized. If not, the present Hilo initiative, which is the springboard for the larger family medicine rural training initiative, will die. In addition to supporting four "unfunded" resident positions, Wahiawa general hospital also funds approximately two and nine-tenths full-time equivalent (2.9 FTE) faculty salaries to operate the residency program that consists of inpatient and outpatient care and teaching. To maintain the present excellent level of training of residents and medical students, eight full-time equivalent (8 FTE) faculty members are required. If financial support from Wahiawa general hospital cease, clinical services will drastically decrease, and education of future physicians will also be severely impacted.

The purpose of this Act is to appropriate funds in the short-term to:

(1) Stabilize the FMRP on Oahu for the next two years while further program transition is occurring; and

(2) Provide short-term financial support to begin development of the Hawaii island family medicine rural training track that will expand the opportunities for family physician training in the State.

Additional legislation is being requested to support development of the larger family medicine rural training initiative which will be more sustainable in the long-term. It should be noted that states such as Texas and Washington presently fund portions of their family medicine residency programs through legislative line items to guarantee a sustainable primary care physician workforce.

Funding of $150,000 for fiscal year 2007-2008, and $150,000 for fiscal year 2008-2009, is being requested directly for the Hawaii Residency Programs, Inc., for two resident positions per year for the next two years.

Funding of $360,000 for fiscal year 2007-2008, and $360,000 for fiscal year 2008-2009, is being requested directly for the university clinical, educational and research associates, which is the faculty practice plan of UH JABSOM to secure two and nine-tenths full-time equivalent (2.9 FTE) faculty positions for two years. Additionally, funding of $150,000 is requested for one full-time equivalent (1.0 FTE) faculty member, based in Hilo, to work with the Oahu-based faculty in developing a full family medicine rural training track. In the second year, funding of $225,000 is requested in anticipation

that one and one half full-time equivalent (1.5 FTE) facility members will be needed to support the increase in clinical volume and academic responsibilities.

SECTION 2. There is appropriated out of the general revenues of the State of Hawaii the sum of $, or so much thereof as may be necessary for the fiscal year 2007-2008, and the sum of $, or so much thereof as may be necessary for fiscal year 2008-2009, to stabilize the University of Hawaii John A. Burns school of medicine department of family medicine and community health rural primary health care services on Oahu and expand workforce development to the island of Hawaii.

The sums appropriated shall be expended by the department of health for the purposes of this Act.

SECTION 3. This Act shall take effect on July 1, 2007.