House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

Signature of Sponsor

AMEND Senate Bill No. 558* **House Bill No. 1132**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 9, Chapter 4, is amended by adding Section 2 as a new, appropriately designated part.

SECTION 2.

(a) The opioid abatement fund is established and funded pursuant to this section.

(b) The opioid abatement fund shall operate as an irrevocable trust that the state treasurer shall administer. Amounts in the opioid abatement fund shall not revert to the general fund of the state. The treasurer and attorney general and reporter shall approve the terms of the trust instrument. The terms of the trust instrument shall not be substantively amended except by unanimous approval of the trustees, the opioid abatement council established pursuant to SECTION 6 of this act, and the attorney general and reporter.

(c)

(1) Funds in the opioid abatement fund shall be spent only for the following purposes:

(A) Prospective opioid abatement and remediation;

(B) Expenses incurred in administering the opioid abatement council;

(C) Related expenses as provided in SECTION 7(b); and

(D) Expenses associated with administering, investing, and disbursing funds held in the opioid abatement fund.

(2) Funds in the opioid abatement fund shall not be used to reimburse expenditures incurred prior to the effective date of this act.

(3) Any opioid abatement fund disbursements must be made at the direction of the opioid abatement council. Except to the extent required by law, the trustees of the opioid abatement fund shall not make or refuse to make any disbursement contrary to the direction of the opioid abatement council.

(d)

(1) The trustees of the opioid abatement fund are:

(A) The commissioner of finance and administration;

(B) The state treasurer; and

(C) The chair of the opioid abatement council.

(2) The state treasurer shall serve as the chair of the trustees and shall preside over all meetings and proceedings of the trustees.

(3) To the extent not prohibited by law, the trustees shall not act contrary to the direction of the opioid abatement council and shall uphold the decisions the council renders regarding disbursement of funds from the opioid abatement fund. The trustees have only a ministerial role and not a discretionary role in the distribution of funds, as directed by the opioid abatement council. The trustees have no duties concerning the opioid abatement fund other than those duties set forth in the opioid abatement fund's trust instrument and in this part.

(e) The opioid abatement fund is the designated repository of funds that are either dedicated to opioid abatement or remediation or are otherwise directed to abatement or remediation by the attorney general and reporter and that are received by the state pursuant to a judgment on opioid-related claims, a recovery in bankruptcy on opioid-related claims, or a settlement of opioid-related claims. This subsection (e) does

not prevent the opioid abatement fund from also receiving funds from other sources if the funds will be dedicated to abatement.

(f)

(1) The trustees shall adopt, in writing, an investment policy or policies authorizing how assets in the trust may be invested prior to investments being made.

(2) Funds in the opioid abatement fund may be invested and reinvested for the benefit of the fund by the state treasurer pursuant to § 9-4-603. The trustees shall delegate to the state treasurer the responsibility for the investment and reinvestment of trust funds in accordance with the policies and guidelines established by the trustees.

(3) All or a portion of the trust may be invested, reinvested, and coinvested with other funds, not a part of the trust, which are held by the state treasurer, including, but not limited to, assets of the state pooled investment fund established pursuant to part 6 of this chapter. The state treasurer shall account for the trust funds in one (1) or more separate accounts in accordance with this section or other law.

SECTION 3. Tennessee Code Annotated, Title 33, is amended by adding Sections 4 through 9 as a new, appropriately designated chapter.

SECTION 4. This chapter is known and may be cited as the "Opioid Abatement Council Act."

SECTION 5. As used in this chapter:

(1) "Commissioner" means the commissioner of mental health and substance abuse services;

(2) "Council" means the Tennessee opioid abatement council;

(3) "Department" means the department of mental health and substance abuse services;

(4) "Director" means the executive director of the council;

(5) "Opioid abatement and remediation purposes" means programs, strategies, expenditures, and other actions designed to prevent and address the misuse and abuse of opioid products and treat or mitigate opioid use or related disorders or other effects of the opioid epidemic;

(6) "Opioid abatement fund" means the fund created by SECTION 2 of this act;

(7) "State-subdivision opioid abatement agreement" means an agreement entered into by the state and one (1) or more political subdivisions of the state that addresses the allocation of funds dedicated to opioid abatement and remediation; and

(8) "Statewide opioid settlement agreement" means a settlement agreement entered into by the state and one (1) or more entities involved in activities related to the manufacture, marketing, distribution, dispensing, or sale of opioids in which political subdivision claims are addressed. A copy of the agreement, including any amendments thereto, must be kept on the website of the attorney general and reporter.

SECTION 6.

(a) There is created the Tennessee opioid abatement council.

(b) The council is composed of fifteen (15) voting members. Members must be residents of this state and have expertise and a minimum of ten (10) years of experience in public health policy, medicine, substance use disorder and addiction treatment, mental health services, drug misuse prevention programs, or drug court diversion or other programs in which people with substance use disorders interact with first responders, law enforcement, or the criminal justice system. A member shall not serve more than two (2) terms consecutively but may be reappointed to the council after not serving as a member for two (2) or more years.

(c) There are nine (9) statewide members of the council. The governor shall appoint three (3) members, including the chair. The speaker of the senate and the speaker of the house of representatives shall each appoint three (3) members. The

commissioner or the commissioner's designee shall serve as a nonvoting ex-officio member.

(d)

(1) There are six (6) regional members of the council, who shall be nominated by the state's political subdivisions, acting through the Tennessee County Services Association and the Tennessee Municipal League. Within ninety (90) days of the effective date of this act, the Tennessee County Services Association shall submit fifteen (15) persons for consideration, including five (5) persons from each grand division. At least two (2) of the nominees from each grand division shall represent the interests of counties with populations of sixty thousand (60,000) or less and at least one (1) shall represent the interests of counties with populations greater than sixty thousand (60,000). Within ninety (90) days of the effective date of this act, the Tennessee Municipal League shall submit three (3) persons for consideration, one (1) from each grand division. The governor, speaker of the senate, and speaker of the house of representatives shall each select from the nominees two (2) members, with the governor selecting one (1) member from the middle grand division and one (1) member from the west grand division, the speaker of the senate selecting one (1) member from the east grand division and one (1) member from the west grand division and the speaker of the house of representatives selecting one (1) member from the east grand division and one (1) member from the middle grand division. When a regional member is replaced due to the expiration of the member's term or otherwise, the new member selected shall be from the same grand division and appointed by the same appointing authority as the member being replaced.

(2) After initial member selection pursuant to subdivision (d)(1), regional member positions shall be filled by the governor, the speaker of the senate, and speaker of the house of representatives from a pool of nominees for which, for

every open position, the Tennessee County Services Association has nominated two (2) persons who represent the interests of counties with populations of sixty thousand (60,000) or less and one (1) person who shall represent the interests of counties with populations greater than sixty thousand (60,000) and the Tennessee Municipal League has nominated one (1) person. After the initial member selection pursuant to subdivision (d)(1), the director must provide formal written notice to the Tennessee County Services Association and the Tennessee Municipal League when there will be vacancies because of the expiration of terms or if a vacancy has otherwise occurred and the organizations will have sixty (60) days from the formal written notice date to submit nominations.

(3) For both initial appointments and the filling of vacancies, if a full pool of nominees has not been provided by the applicable deadline, the respective appointing authority may fill positions with persons who have not been nominated, though the appointing authority must select persons from the appropriate grand divisions.

(e) Upon creation of the council, the chair, one (1) other statewide member, and the regional member from the west grand division appointed by the governor, one (1) statewide member and the regional member from the east grand division appointed by the speaker of the senate, and one (1) statewide member and the regional member from the middle grand division appointed by the speaker of the house of representatives shall serve an initial four-year term to enable the staggering of terms.

(f) With the exception of the seven (7) initial appointments established in subsection (e), each appointed member of the council shall serve a three-year term, with terms ending on June 30 of each year. Solely for the purpose of determining the term of the fifteen (15) initially appointed members, the beginning of an initial term shall be deemed to be July 1 of the calendar year in which the appointment occurs, regardless of whether the actual appointment date occurs before or after July 1 of that year.

(g) The respective appointing authority may remove a member for failure to attend at least one-half (1/2) of the scheduled meetings in any one-year period or for other cause.

(h) If a vacancy on the council occurs, the respective appointing authority shall fill the vacancy for the unexpired term. Notwithstanding the expiration of a member's term, each member shall serve until a successor is duly appointed.

(i)

(1) The members shall serve without compensation, but each member shall be entitled to reimbursement for the member's actual and necessary expenses incurred in the performance of the member's official duties.

(2) All reimbursement for travel expenses shall be in accordance with the comprehensive travel regulations promulgated by the department of finance and administration.

(3) All actual and necessary expenses incurred in the performance of members' official duties shall be paid from the opioid abatement fund and not the general fund.

(j) The council shall meet at the call of the chair and not less than four (4) times per year. The meeting location shall rotate among locations in each of the three (3) grand divisions. Members may attend meetings in person or remotely by audiovisual means, as provided in § 8-44-108.

(k) Meetings of the council must comply with the open meeting requirements of title 8, chapter 44. Notwithstanding the open meeting requirements of title 8, chapter 44, the council is permitted to meet in a closed executive session for the purpose of obtaining advice from counsel and discussing personnel-related issues in addition to any other purposes allowed by title 8, chapter 44.

(l) Records of the council are deemed to be public records for purposes of the open records law, compiled in title 10, chapter 7, subject to the confidentiality provisions of § 10-7-504 and other laws or doctrines.

(m) The annual report, financial statements, all books, accounts, and financial records of the council shall be subject to annual audit by the comptroller of the treasury.

(n) Written minutes covering all meetings and actions of the council shall be prepared by the director and shall be maintained by the department and open to public inspection.

(o) The council shall not be subject to the Tennessee Governmental Entity Review Law, compiled in title 4, chapter 29, but instead will terminate when all opioid abatement monies being paid pursuant to existing settlements, judgments, or court orders have been received and disbursed unless the attorney general and reporter certifies that additional funds are anticipated within one (1) year.

(p) The council shall not be subject to the contested case procedures set forth in title 4, chapter 5, part 3. If a court has entered a consent judgment agreed to by the state through the approval of the attorney general and reporter that incorporates a statewide opioid settlement agreement or a state-subdivision opioid abatement agreement, and such an agreement provides for the court in which the consent judgment was filed to determine particular disputes, the court that entered the consent judgment shall have exclusive jurisdiction over such disputes.

SECTION 7.

(a)

(1) The department shall serve as staff to the council and shall recommend to the council a candidate to serve as executive director of the council.

(2) If a majority of the council votes to decline the department's recommendation within fourteen (14) calendar days of receiving the recommendation, the department shall submit a new candidate.

(3) If a majority of the council either votes in favor of the department's recommendation or does not decline the recommendation in accordance with subdivision (a)(2), the candidate may be hired as the director and shall be an employee of the department.

(b) The director must be a full-time position. The commissioner may recommend that a current department employee serve as the director, subject to subsection (a). The commissioner shall establish the director's salary and other compensation, which shall be no more than the department's highest-paid assistant commissioner. The director's salary and compensation shall be paid from the opioid abatement fund, as shall the salaries and compensation of other council staff and department employees the commissioner deems necessary to administer the council. The commissioner may hire two (2) full-time employees to staff the council in addition to the director and hire additional staff upon approval of the council. Salaries and compensation levels shall be comparable to department employees doing similar work. New or additional department costs and all expenditures related to the council shall be paid from the opioid abatement fund and not the general fund. The commissioner shall provide reports as the council may require on staffing, salaries, compensation, and other costs and expenditures related to the council.

SECTION 8. The duties and responsibilities of the council include the following:

(a) Subject to the terms of a state-subdivision opioid abatement agreement or a statewide opioid settlement agreement concerning funds paid pursuant to such agreement, the council shall direct the disbursement of funds held in the opioid abatement fund with these disbursement decisions having been approved by a majority of the entire membership of the council. These disbursement directives shall be limited

to funding or supporting opioid abatement and remediation purposes and related administrative costs. Before rendering decisions regarding the disbursement of funds, the council shall receive input from the department's statewide planning and policy council's need assessment process, which is conducted with the assistance of seven (7) regional planning and policy councils, and allow for comment and input from community stakeholders, local governments, state and local public health officials, public health advocates, law enforcement and judiciary representatives, opioid remediation service providers, and other parties interested and actively involved in addressing the opioid crisis and its abatement. The council shall develop policies to provide reasonable opportunity to receive input from these parties.

(b) The council shall create and the director shall deliver to the governor, the speaker of the senate, the speaker of the house of representatives, the chairs of the government operations committees of the senate and house of representatives, and the chairs of the finance, ways and means committees of the senate and house of representatives on or before September 30 of each year an annual report for the prior fiscal year that details the total funds deposited into the opioid abatement fund, the abatement strategies funded, and any disbursement or expenses paid from the opioid abatement fund.

SECTION 9. The council is exempt from the requirements of title 12, chapter 3, related to procurement.

SECTION 10. Tennessee Code Annotated, Title 47, is amended by adding Sections 11 through 15 as a new, appropriately designated chapter.

SECTION 11. This chapter is known and may be cited as the "Tennessee Opioid Abatement Act."

SECTION 12. The general assembly finds and declares the following:

(1) The opioid crisis presents serious health and safety concerns throughout the state and is a threat to the general welfare of the people of this state;

(2) The provision of care, rehabilitation, and treatment for opioid abuse and dependency creates a substantial drain on governmental resources;

(3) It is the intention of the general assembly to facilitate statewide opioid settlement agreements that provide a coordinated resolution of state and local governmental claims against entities involved in the manufacture, marketing, distribution, dispensing, or sale of opioids, or related activities, in order to generate funds for opioid abatement programs and remediation; and

(4) A statewide coordinated resolution of state and local claims against entities involved in activities related to the manufacture, marketing, distribution, dispensing, or sale of opioids, or related activities, is critical to resolving current litigation and other claims regarding the opioid crisis and maximizing the financial commitment of those entities.

SECTION 13. As used in this chapter, unless the context requires otherwise:

(1) "Declaration of a statewide opioid settlement agreement release" means a written release approved by the attorney general and reporter for a statewide opioid settlement agreement, which must include or reference the approval of the governor and comptroller of the treasury;

(2) "District" means the governmental districts in the state, including, but not limited to, school districts, judicial districts, hospital districts, health districts, utility districts, fire districts, development districts, special districts, and other public districts;

(3) "Governmental entity" means:

(A) The state and each of its departments, agencies, divisions, boards, commissions, and other instrumentalities;

(B) Any political or governmental subdivision or other public entity within the boundaries of the state, including, but not limited to, counties, municipalities, districts, and towns and any department, agency, division, board, commission, and other instrumentalities thereof; and

(C) Any governmental official, officer, or employee of the state or of a political or governmental subdivision or other public entity within the boundaries of the state acting in an official capacity;

(4) "Released claims" means the causes of action and other claims that are released in a statewide opioid settlement agreement, including matters identified as released claims as that term or a comparable term is defined in a statewide opioid settlement agreement;

(5) "Released entities" means the entities released in a statewide opioid settlement agreement, including those identified as released entities as that term or a comparable term is defined in a statewide opioid settlement agreement;

(6) "State-subdivision opioid abatement agreement" means an agreement entered into by the state and one (1) or more subdivisions of the state that addresses the allocation of funds dedicated to opioid abatement; and

(7) "Statewide opioid settlement agreement" means a settlement agreement entered into by the state and one (1) or more entities involved in activities related to the manufacture, marketing, distribution, dispensing, or sale of opioids in which subdivision claims are addressed.

SECTION 14. The funds obtained pursuant to a statewide opioid settlement agreement must be distributed pursuant to the agreement and any relevant provisions of a state-subdivision opioid abatement agreement. The funds dedicated to abatement and remediation will be paid into the opioid abatement fund pursuant to SECTION 2 of this act. Copies of statewide opioid settlement agreements, including any amendments to such agreements, must be kept on the website of the attorney general and reporter.

SECTION 15. Upon the approval of the attorney general and reporter of a declaration of a statewide opioid settlement agreement release, a governmental entity shall not have the authority to bring a released claim against a released entity. Any pending or future litigation brought by a governmental entity asserting released claims against released entities shall be

dismissed with prejudice. Copies of declarations of a statewide opioid settlement agreement release must be kept on the website of the attorney general.

SECTION 16. Tennessee Code Annotated, Title 20, Chapter 13, is amended by adding Sections 17 through 20 as a new, appropriately designated part.

SECTION 17. The general assembly finds and declares the following:

(1) The opioid crisis presents serious health and safety concerns throughout the state and is a threat to the general welfare of the people of this state;

(2) The provision of care, rehabilitation, and treatment for opioid abuse and dependency creates a substantial drain on governmental resources;

(3) It is the intention of the general assembly to facilitate statewide opioid settlement agreements that provide a coordinated resolution of state and local governmental claims against entities involved in the manufacture, marketing, distribution, dispensing, or sale of opioids, or related activities, in order to generate funds for opioid abatement programs and remediation; and

(4) A statewide coordinated resolution of state and local claims against entities involved in activities related to the manufacture, marketing, distribution, dispensing, or sale of opioids, or related activities, is critical to resolving current litigation and other claims regarding the opioid crisis and maximizing the financial commitment of those entities.

SECTION 18. As used in this part, unless the context requires otherwise:

(1) "District" means all governmental districts in the state, including, but not limited to, school districts, judicial districts, hospital districts, health districts, utility districts, fire districts, development districts, special districts, and other public districts; and

(2) "Governmental entity" means:

(A) The state and each of its departments, agencies, divisions, boards, commissions, and other instrumentalities;

(B) Any political or governmental subdivision or other public entity within the boundaries of the state, including, but not limited to, counties, municipalities, districts, and towns and any department, agency, division, board, commission, and other instrumentalities thereof; and

(C) Any governmental official, officer, or employee of the state or of a political or governmental subdivision or other public entity within the boundaries of the state acting in an official capacity.

SECTION 19. Upon written approval of the governor and comptroller of the treasury, the attorney general and reporter has the authority to release any pending or future claim of governmental entities against the entities involved in activities related to the manufacture, marketing, distribution, dispensing, or sale of opioids, or related activities, if the attorney general deems the release necessary to the interest of the state in the resolution of the opioid crisis.

SECTION 20. This part shall not be construed as a restriction or a limitation upon the powers that the attorney general and reporter might otherwise have under the laws of this state but must be construed as cumulative of and supplemental to these powers.

SECTION 21. If any provision of this act or the application of any provision of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end, the provisions of this act are declared to be severable.

SECTION 22. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED	
Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 570* **House Bill No. 980**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 68-11-1607, is amended by adding the following as a new subsection:

( ) Notwithstanding this part to the contrary, a certificate of need is not required for an action to establish or operate a mental health hospital or other healthcare institution that operates primarily to provide mental health and substance abuse treatment services, if the hospital or institution is:

(1) Licensed under title 33; and

(2) Located in a county that is, at the time the action is initiated:

(A) Designated as a tier 3 or tier 4 enhancement county by the department of economic and community development pursuant to § 67-4-2109; or

(B) Designated as a rural county by the United States census bureau.

SECTION 2. This act takes effect July 1, 2021, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED	
Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 1068 **House Bill No. 974***

by deleting all language after the caption and substituting:

WHEREAS, from 2006 to 2014, there were 3,315,502,327 prescription pain pills supplied to Tennesseans; and

WHEREAS, approximately 70,000 Tennesseans are addicted to opioids; and

WHEREAS, Tennessee ranks third in the nation for prescription drug abuse; and

WHEREAS, settlement of lawsuits filed by local governments against manufacturers and distributors of opioid prescription drugs are expected to result in settlements resulting in distributions to states and local governments over the next eighteen years; and

WHEREAS, opioid abuse and addiction have placed a tremendous strain on local resources throughout the State; and

WHEREAS, local governments have incurred significant expense, have developed local infrastructure and programs, and have significant experience and knowledge of local concerns and needs for addressing opioid abuse and addiction and the resources needed to implement such practices at the local level; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 1, Part 1, is amended by adding the following as a new section:

(a) Notwithstanding another law to the contrary, the treasurer shall distribute fifty percent (50%) of all proceeds received by this state or a political subdivision of this state in a settlement or judgment against McKesson Corporation, Cardinal Health, AmerisourceBergen Corporation, or Johnson & Johnson, or an affiliate or subsidiary of

those entities, related to opioid manufacturing or distribution to the county governments of this state in accordance with an agreement entered into by those counties governing the division of proceeds.

(b) Each county receiving moneys pursuant to subsection (a) shall submit to the department of health on or before June 30 of each year a certification that at least seventy percent (70%) of the funds were used during the previous calendar year for abatement of opioid-related matters in accordance with the definitions and purposes described in subsection (d).

(c) Funds from a settlement described in subsection (a) must be distributed no later than June 30 of the year following receipt of the funds.

(d) The moneys from an opioid settlement described in this section must be used for the following purposes:

(1) To fund projects related to opioid use disorder (OUD) or co-occurring substance use disorder or mental health (SUD/MH) issues; or

(2) As reimbursement for the following:

(A) Any portion of the cost related to outpatient and residential treatment services, including:

(i) Services provided to incarcerated individuals;

(ii) Medication-assisted treatment;

(iii) Abstinence-based treatment; and

(iv) Treatment, recovery, or other services provided by community health centers or nonprofit providers;

(B) Emergency response services provided by law enforcement or other first responders;

(C) Any portion of the cost of administering naloxone;

(D) Funding for a project that:

(i) Supports intervention, treatment, and recovery services provided to persons:

(*a*) With OUD or co-occurring SUD/MH issues; or

(*b*) Who have experienced an opioid overdose; or

(ii) Supports detoxification services, including:

(*a*) Medical detoxification;

(*b*) Referral to treatment; or

(*c*) Connections to other services;

(E) Providing access to opioid-abatement-related housing, including:

(i) Supportive housing; or

(ii) Recovery housing;

(F) Providing or supporting transportation to treatment or recovery programs or services;

(G) Providing employment training or educational services for persons in treatment or recovery;

(H) Creating or supporting centralized call centers that provide information and connections to appropriate services;

(I) Supporting crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and co-occurring SUD/MH issues, or persons that have experienced an opioid overdose;

(J) Improving oversight of opioid treatment programs to ensure evidence-based and evidence-informed practices;

(K) Providing scholarships and support for certified addiction counselors and other mental and behavioral health providers, including:

(i) Training scholarships;

(ii) Fellowships;

(iii) Loan repayment programs; and

(iv) Incentives for providers to work in rural or underserved areas of this state;

(L) Providing training on medication-assisted treatment for healthcare providers, students, or other supporting professionals;

(M) Supporting efforts to prevent over-prescribing and ensuring appropriate prescribing and dispensing of opioids;

(N) Supporting enhancements or improvements consistent with state law for prescription drug monitoring programs;

(O) Supporting the education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with opioids or individuals with OUD or co-occurring SUD/MH issues;

(P) Supporting opioid-related emergency response services provided by law enforcement or first responders;

(Q) Treating mental health trauma issues resulting from the traumatic experiences of opioid users or their family members;

(R) Engaging nonprofits, the faith community, and community coalitions to support prevention and treatment, and to support family members in their efforts to care for opioid users in their family;

(S) Providing recovery services, support, and prevention services for women who are pregnant, may become pregnant, or who are parenting with OUD or co-occurring SUD/MH issues;

(T) Training healthcare providers that work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of care;

(U) Addressing Neonatal Abstinence Syndrome, including prevention, education, and treatment of OUD and co-occurring SUD/MH issues;

(V) Offering home-based wrap-around services to persons with OUD and co-occurring SUD/MH issues, including parent-skills training;

(W) Offering supportive positions and services, including supportive housing and other residential services, relating to children being removed from the home or placed in foster care due to custodial opioid use;

(X) Providing public education about opioids or opioid disposal;

(Y) Providing drug take-back disposal or destruction programs;

(Z) Covering the cost of administering naloxone;

(AA) Supporting pre-trial services that connect individuals with OUD and co-occurring SUD/MH issues to evidence-informed treatment and related services;

(BB) Supporting treatment and recovery courts for persons with OUD and co-occurring SUD/MH issues, but only if the courts provide referrals to evidence-informed treatment;

(CC) Providing evidence-informed treatment, recovery support, harm reduction, or other appropriate services to individuals with OUD and co-occurring SUD/MH issues who are incarcerated, leaving jail or prison, have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities;

(DD) Meeting the criteria included in a settlement agreement or judgment between the parties listed in subsection (a); or

(EE) Another project deemed appropriate for opioid-abatement purposes by the commissioner of health.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

AMEND Senate Bill No. 671* **House Bill No. 1080**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 4-29-242(a)(10), is amended by deleting the subdivision.

SECTION 2. Tennessee Code Annotated, Section 4-29-246(a), is amended by adding the following as a new subdivision:

Board of physician assistants, created by § 63-19-103;

SECTION 3. Tennessee Code Annotated, Section 49-4-939(i), is amended by deleting "committee on physician assistants" and substituting "board of physician assistants".

SECTION 4. Tennessee Code Annotated, Section 53-10-303(a)(1)(H), is amended by deleting "board of medical examiners' committee on physician assistants" and substituting "board of physician assistants".

SECTION 5. Tennessee Code Annotated, Section 63-1-162(a)(7), is amended by deleting "board of medical examiners' committee on physician assistants" and substituting "board of physician assistants".

SECTION 6. Tennessee Code Annotated, Title 63, Chapter 19, Part 1, is amended by deleting the part and substituting:

63-19-101. Short title.

This part is known and may be cited as the "Physician Assistants Act."

63-19-102. Part definitions.

As used in this part:

(1) "Board" means the board of physician assistants, created by § 63-19-103 ;

(2) "Orthopedic physician assistant" (OPA-C) means an individual who renders service in collaboration with a licensed orthopedic physician or surgeon and who has been licensed by the board of physician assistants pursuant to this chapter as an orthopedic physician assistant;

(3) "Physician" means an individual lawfully licensed to practice medicine and surgery pursuant to chapter 6 of this title, osteopathic medicine pursuant to chapter 9 of this title, or podiatry pursuant to chapter 3 of this title; and

(4) "Physician assistant" means an individual who is licensed to render services, whether diagnostic or therapeutic, that are acts constituting the practice of medicine or osteopathic medicine and who meets the qualifications defined in this part.

63-19-103. Board of physician assistants.

(a) There is established the board of physician assistants to regulate physician assistants. The board must consist of nine (9) members appointed by the governor, each of whom is a resident of this state, seven (7) of whom are physician assistants who meet the criteria for licensure as established by this part, one (1) of whom is a physician licensed under chapter 6 or 9 of this title, and one (1) of whom is a public member who is not licensed under this title.

(b) Each regular appointment is for a term of four (4) years. The governor shall fill any vacant term for the balance of the unexpired term. A member shall not serve more than two (2) consecutive four-year terms and each member shall serve on the board until a successor is appointed. In making appointments to the board, the governor shall strive to ensure that at least one (1) person serving on the board is sixty (60) years

of age or older and that at least one (1) person serving on the board is a member of a racial minority.

(c) While engaged in the business of the board, board members shall receive a per diem of one hundred dollars ($100) and shall also receive compensation for actual expenses to be paid in accordance with comprehensive travel regulations promulgated by the commissioner of finance and administration and approved by the attorney general and reporter.

(d) The board shall elect a chair and secretary from among its members at the first meeting held in each fiscal year. A board meeting may be called upon reasonable notice in the discretion of the chair and must be called at any time upon reasonable notice by a petition of three (3) board members to the chair.

63-19-104. Powers and duties of board.

The board has the duty to:

(1) Unless otherwise specified in this chapter, promulgate, in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, all rules that are reasonably necessary for the implementation of this chapter, including, but not limited to, rules that implement the administrative functions of the board and that specify the acts and offenses that subject the license holder to disciplinary action by the board pursuant to subdivision (a)(7);

(2) Set fees, subject to the maximum limitations prescribed by this part, relative to the examination, licensure, and licensure renewal of physician assistants in an amount sufficient to pay all of the expenses of the board and establish and collect a late renewal fee from those physician assistants who fail to renew their licenses in a timely manner;

(3) Review the qualifications of, and approve or reject each applicant for initial licensure as a physician assistant;

(4) Biennially review the qualifications of, and approve or reject each applicant for biennial licensure renewal. The board shall condition approval for renewal on the receipt of evidence satisfactory to the board of the applicant's successful completion, within a two-year period prior to the application for license renewal, of one hundred (100) hours of continuing medical education approved by the American Academy of Physician Assistants, the American Medical Association, or the Accreditation Council for Continuing Medical Education. The two-year period within which an applicant must have obtained the required continuing medical education hours is either the twenty-four (24) months prior to submitting the application for renewal or the most recent two-year period utilized by the National Commission on Certification of Physician Assistants to determine whether that person has obtained sufficient continuing medical education hours to maintain that person's professional certification. The board may, in its discretion, waive or modify the continuing medical education requirement in cases of retirement, illness, disability, or other undue hardship;

(5) Issue all approved physician assistant licenses and renewals;

(6) Collect or receive all fees, fines, and moneys owed pursuant to this part and to pay the same into the general fund of the state. For the purpose of implementing subdivision (a)(2), all fees, fines, and moneys collected pursuant to the regulation of physician assistants shall be so designated; and

(7) Deny, suspend, or revoke the license of, or to otherwise discipline by a fine, or by reprimand, a license holder who is guilty of violating any of the provisions of this part or who is guilty of violating the rules of the board promulgated pursuant to subdivision (a)(1). When sanctions are imposed on a license holder pursuant to this subdivision (a)(7), the license holder may, in addition, be required to pay the actual and reasonable costs of the investigation

and prosecution of the case, including the costs incurred and assessed for the time of the prosecuting attorney or attorneys, the investigator or investigators and any other persons involved in the investigation, prosecution and hearing of the case. The board may limit, restrict, or impose one (1) or more conditions on a license at the time it is issued, renewed, or reinstated or as a sanction imposed at the conclusion of a disciplinary hearing.

63-19-105. Qualifications and licensure.

(a)

(1) An individual shall not represent to be or function as a physician assistant under this part unless the individual holds a valid physician assistant license or temporary license issued by the board. The board shall not license an individual as a physician assistant unless the individual:

(A) Has successfully completed a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc., or its successor accrediting agency; or prior to 2001 either by the Committee on Allied Health Education and Accreditation, or the Commission on Accreditation of Allied Health Education Programs;

(B) Has passed the examination of the National Commission on Certification of Physician Assistants, or its successor agency;

(C) Submits an application on forms approved by the board;

(D) Pays the appropriate fees as determined by the board;

(E) Is mentally and physically able to engage safely in practice as a physician assistant;

(F) Has no license as a physician assistant under current discipline, revocation, suspension, or probation for cause resulting from

the applicant's practice as a physician assistant, unless the board considers the condition and agrees to licensure; and

(G) Submits to the board other information the board deems necessary to evaluate the applicant's qualifications.

(2) Notwithstanding subdivisions (a)(1)(A) and (B), the board may license a person qualified as a physician assistant prior to April 26, 1983, and who has continued to represent to be or functioned as a physician assistant since that time. However, the board shall not license any person as a physician assistant after July 1, 1991, unless the person meets the requirements of subdivisions (a)(1)(A) and (B); provided, the board may continue to issue license renewals to any person who was licensed as a physician assistant prior to July 1, 1991.

(b) An individual licensed, registered, or certified as a physician assistant in another jurisdiction may be licensed as a physician assistant by the board if the individual meets the requirements and standards of this part. The board shall charge an applicant with any reasonable expense incurred by the board in verifying the licensure, registration, or certification by another jurisdiction of the applicant for licensure under this chapter.

(c) The board may issue a temporary license to an individual that allows the individual to function as a physician assistant under this part:

(1) For a period of twelve (12) months immediately following graduation to allow the individual an opportunity to attempt the examination;

(2) For a period of one (1) additional year thereafter in which to attempt and successfully complete the examination if the individual is not successful on the first attempt; or

(3) As provided in § 63-1-104, for an individual who has been out of clinical practice or inactive in their practice for an extended period of time, or who

has been or is at the time of their application engaged exclusively in administrative practice.

(d) While an individual's application is pending, the board may issue a temporary license to that individual if the individual is licensed, registered, or certified as a physician assistant in another jurisdiction and if the board finds that the application is complete. The temporary license allows the individual to function as a physician assistant under this chapter. A temporary license issued under this subsection (d) is valid for a period of six (6) months and is not renewable. The board may require that an applicant for licensure as a physician assistant appear before the board to answer any questions regarding the applicant's fitness for licensure.

(e)

(1) The board may authorize any of its members or its consultant to conduct a review of the qualifications of an applicant for a license to practice as a physician assistant in this state and to make an initial determination as to whether the applicant has met all the requirements for licensure. If the board member or board consultant determines that the applicant has met all the requirements for licensure, then the applicant is authorized to practice as a physician assistant in this state until the board makes a final decision on the application for licensure. The board may authorize the use of this procedure with respect to applicants for license renewal or reinstatement as well. A temporary authorization issued pursuant to a determination made by the board member or board consultant must not be effective for longer than a six-month period measured from the date of issuance. The applicant shall not utilize this process more than once.

(2) If temporary authorization pursuant to subdivision (e)(1) is issued to an applicant for a license to practice as a physician assistant in this state and if

the subsequent decision of the board is to deny the application based upon a good faith determination that the applicant has not, in fact, complied with all the requirements for licensure, then the doctrine of estoppel does not apply against the state based upon its issuance of temporary authorization and its subsequent denial of licensure.

63-19-106. Authorized services – Collaboration.

(a)

(1) A physician assistant is authorized to perform selected medical services only in collaboration with a licensed physician.

(2) Collaboration requires active and continuous overview of the physician assistant's activities to ensure that the physician's directions and advice are in fact implemented, but does not require the continuous and constant physical presence of the collaborating physician. The board of medical examiners and board of physician assistants shall adopt regulations governing the collaborating physician's personal review of historical, physical, and therapeutic data contained in the charts of patients examined by the physician assistant. Until the rules are jointly adopted by the board of physician assistants and the board of medical examiners, the rules jointly adopted by the committee on physician assistants and the board of medical examiners in effect as of December 31, 2021, remain in effect.

(3) The range of services that may be provided by a physician assistant must be set forth in a written protocol, jointly developed by the collaborating physician and the physician assistant. The protocol must also contain a discussion of the problems and conditions likely to be encountered by the physician assistant and the appropriate treatment for these problems and conditions. The physician assistant shall maintain the protocol at the physician

assistant's practice location and shall make the protocol available upon request by the board of medical examiners, board of physician assistants, or the authorized agents of the boards.

(4) A physician assistant may perform only those tasks that are within the physician assistant's range of skills and competence, that are within the usual scope of practice of the collaborating physician, and that are consistent with the protection of the health and well-being of the patients.

(5) The physician assistant may render emergency medical service in accordance with guidelines previously established by the collaborating physician pending the arrival of a responsible physician in cases where immediate diagnosis and treatment are necessary to avoid disability or death.

(b) A physician assistant shall, at all times, practice in collaboration with a licensed physician who has control of and responsibility for the services provided by the physician assistant and the duty of assuring that there is a proper collaboration with the physician and that the activities of the physician assistant are otherwise appropriate.

(c) Rules that purport to regulate the collaboration of physician assistants with physicians must be jointly adopted by the board of medical examiners and the board of physician assistants.

(d) A physician assistant practicing in collaboration with a licensed podiatrist:

(1) Shall not provide services that are outside of the scope of practice of a podiatrist as set forth in § 63-3-101;

(2) Shall comply with the requirements of, and rules adopted pursuant to, this section and § 63-19-107 governing the collaboration with a physician assistant; and

(3) May prescribe only drugs that are rational to the practice of podiatry.

63-19-107. Practices for collaboration with physician assistants.

A licensed physician collaborating with physician assistants shall comply with the following practices:

(1) More than one (1) physician may collaborate with the same physician assistant; provided, each physician assistant has a primary collaborating physician and may have additional alternate collaborating physicians who collaborate with the physician assistant in the absence or unavailability of the primary collaborating physician. Each physician assistant shall notify the board of physician assistants of the name, address, and license number of the physician assistant's primary collaborating physician and shall notify the board of physician assistants of a change in the primary collaborating physician within fifteen (15) days of the change. The number of physician assistants for whom a physician may serve as the collaborating physician must be determined by the physician at the practice level, consistent with good medical practice. The collaborating physician shall designate one (1) or more alternate physicians who have agreed to accept the responsibility of collaborating with the physician assistant on a prearranged basis in the collaborating physician's absence;

(2)

(A) In accordance with rules adopted by the board of medical examiners and the board of physician assistants, a collaborating physician may delegate to a physician assistant working in collaboration with the physician the authority to prescribe or issue legend drugs and controlled substances listed in Schedules II, III, IV, and V of title 39, chapter 17, part 4. The rules adopted prior to March 19, 1999, by the board of medical examiners and the committee on physician assistants governing the prescribing of legend drugs by physician assistants remain

effective after March 19, 1999, and may be revised from time to time as deemed appropriate by the board of medical examiners and the board of physician assistants. The board of medical examiners and the board of physician assistants may adopt additional rules governing the prescribing of controlled substances by physician assistants. A physician assistant to whom is delegated the authority to prescribe or issue controlled substances must register and comply with all applicable requirements of the drug enforcement administration;

(B)

(i) A physician assistant to whom the authority to prescribe legend drugs and controlled substances has been delegated by the collaborating physician shall file a notice with the board of physician assistants containing the name of the physician assistant, the name of the licensed physician collaborating with the physician assistant who has responsibility for and control of prescription services rendered by the physician assistant, and a copy of the formulary describing the categories of legend drugs and controlled substances to be prescribed or issued, by the physician assistant. The physician assistant is responsible for updating this information;

(ii) Notwithstanding another rule or law, a physician assistant shall not prescribe Schedules II, III, and IV controlled substances unless the prescription is specifically authorized by the formulary or expressly approved after consultation with the collaborating physician before the initial issuance of the prescription or dispensing of the medication;

(iii) A physician assistant to whom the authority to prescribe controlled drugs has been delegated by the collaborating physician may only prescribe or issue a Schedule II or III opioid listed on the formulary for a maximum of a nonrefillable, thirty-day course of treatment, unless specifically approved after consultation with the collaborating physician before the initial issuance of the prescription or dispensing of the medication. This subdivision (2)(B)(iii) does not apply to prescriptions issued in a hospital, a nursing home licensed under title 68, or inpatient facilities licensed under title 33;

(C) The prescriptive practices of physician assistants and the collaborating physicians with whom the physician assistants are rendering services must be monitored by the board of medical examiners and the board of physician assistants. As used in this section, "monitor" does not include the regulation of the practice of medicine or the regulation of the practice of a physician assistant, but may include site visits by members of the board of medical examiners and the board of physician assistants;

(D) Complaints against physician assistants or collaborating physicians must be reported to the director of the division of health related boards, board of medical examiners, and the board of physician assistants, as appropriate;

(E)

(i) Every prescription order issued by a physician assistant pursuant to this section must be entered in the medical records of the patient and must be written on a preprinted prescription pad bearing the name, address, and telephone number of the

collaborating physician and of the physician assistant, and the physician assistant shall sign each prescription order so written. If the preprinted prescription pad contains the names of more than one (1) physician, then the physician assistant shall indicate on the prescription which of those physicians is the physician assistant's primary collaborating physician by placing a checkmark beside or a circle around the name of that physician;

(ii) A handwritten prescription order for a drug prepared by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription. The handwritten prescription order must contain the name of the prescribing physician assistant, the name and strength of the drug prescribed, the quantity of the drug prescribed, handwritten in letters or in numerals, instructions for the proper use of the drug and the month and day that the prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant shall sign the handwritten prescription order on the day it is issued, unless it is a standing order issued in a hospital, a nursing home, or an assisted care living facility as defined in § 68-11-201;

(iii) A typed or computer-generated prescription order for a drug issued by a physician assistant who is authorized by law to prescribe a drug must be legible so that it is comprehensible by the pharmacist who fills the prescription order. The typed or computer-generated prescription order must contain the name of the prescribing physician assistant, the name and strength of the

drug prescribed, the quantity of the drug prescribed, recorded in letters or in numerals, instructions for the proper use of the drug, and the month and day that the typed or computer-generated prescription order was issued, recorded in letters or in numerals or a combination thereof. The prescribing physician assistant shall sign the typed or computer-generated prescription order on the day it is issued, unless it is a standing order issued in a hospital, nursing home, or an assisted care living facility as defined in § 68-11-201;

(iv) This section does not prevent a physician assistant from issuing a verbal prescription order;

(v)

(a) Handwritten, typed, or computer-generated prescription orders must be issued on either tamper-resistant prescription paper or printed utilizing a technology that results in a tamper-resistant prescription that meets the current centers for medicare and medicaid service guidance to state medicaid directors regarding § 7002(b) of the federal United States Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (P.L. 110-28), and meets or exceeds specific TennCare requirements for tamper-resistant prescriptions;

(b) Subdivision (2)(E)(v)*(a)* does not apply to prescriptions written for inpatients of a hospital, outpatients of a hospital where the doctor or other person authorized

to write prescriptions writes the order into the hospital medical record and then the order is given directly to the hospital pharmacy and the patient never has the opportunity to handle the written order, a nursing home or an assisted care living facility as defined in § 68-11-201, or inpatients or residents of a mental health hospital or residential facility licensed under title 33 or individuals incarcerated in a local, state, or federal correctional facility;

(F) Drugs must not be dispensed by a physician assistant except under the control and responsibility of the collaborating physician;

(G) [Deleted by 2018 amendment.]

(H) A physician assistant authorized to prescribe drugs under this subdivision (2), who provides services in a free or reduced fee clinic under the Volunteer Healthcare Services Act, compiled in chapter 6, part 7 of this title, may arrange for required personal review of the physician assistant's charts by a collaborating physician in the office or practice site of the physician or remotely via HIPAA-compliant electronic means rather than at the site of the clinic. For purposes of this subdivision (2)(H), "HIPAA-compliant" means that the entity has implemented technical policies and procedures for electronic information systems that meet the requirements of 45 C.F.R. 164.312;

(I) A physician assistant authorized to prescribe drugs under this subdivision (2), who provides services in a community

mental health center as defined in § 33-1-101, may arrange for the required personal review of the physician assistant's charts by a collaborating physician, with the same authority to render prescriptive services that the physician assistant is authorized to render, in the office or practice site of the physician, or the required visit by a collaborating physician to any remote site, or both, via HIPAA-compliant electronic means rather than at the site of the clinic. For purposes of this subdivision (2)(l), "HIPAA-compliant" means that the entity has implemented technical policies and procedures for electronic information systems that meet the requirements of 45 C.F.R. § 164.312;

(3) The patient of a physician receiving services from that physician assistant shall be fully informed that the individual is a physician assistant or a sign must be conspicuously placed within the office of the physician indicating that certain services may be rendered by a physician assistant;

(4) A physician who does not normally provide patient care is not authorized to collaborate with or utilize the services of a physician assistant; and

(5)

(A) A physician assistant shall only perform invasive procedures involving any portion of the spine, spinal cord, sympathetic nerves of the spine, or block of major peripheral nerves of the spine in any setting not licensed under title 68, chapter 11, under the direct supervision of a Tennessee physician licensed pursuant to chapter 6 or 9 of this title who is actively

practicing spinal injections and has current privileges to do so at a facility licensed pursuant to title 68, chapter 11. The direct supervision provided by a physician in this subdivision (5)(A) must only be offered by a physician who meets the qualifications established in § 63-6-244(a)(1) or (a)(3) or § 63-9-121(a)(1) or (a)(3);

(B) For purposes of this subdivision (5), "direct supervision" means being physically present in the same building as the physician assistant at the time the invasive procedure is performed; and

(C) This subdivision (5) does not apply to a physician assistant performing major joint injections except sacroiliac injections, or to performing soft tissue injections or epidurals for surgical anesthesia or labor analgesia in unlicensed settings.

63-19-108. Unprofessional conduct by physician collaborating with a physician assistant.

When a licensed physician collaborates with a physician assistant or orthopedic physician assistant in a manner that is inconsistent with this chapter, it constitutes grounds for a finding of unprofessional conduct and the physician is subject to disciplinary action by the board of medical examiners in accordance with § 63-6-214, the board of osteopathic examination in accordance with § 63-9-111, or the board of podiatric medical examiners in accordance with § 63-3-119. As used in this section, "disciplinary action" includes, but is not limited to, the suspension of privileges to collaborate with a physician assistant or an orthopedic physician assistant or the suspension or revocation of a physician's license to practice medicine, osteopathic medicine, or podiatry in this state.

63-19-109. Exclusions of limitations on employment.

This part does not limit the employment arrangement of a physician assistant licensed under this part.

63-19-110. Grounds for denial, suspension, or revocation of licenses.

(a) The board has the power to deny, revoke, or suspend the license of, and to assess a civil penalty for, each separate violation against the holder of a license to practice medicine as a physician assistant upon proof that the person has:

(1) Been convicted of a crime;

(2) Committed fraud in procuring or attempting to procure a license to practice medicine as a physician assistant;

(3) Been found guilty of unprofessional or unethical conduct;

(4) Been addicted to the use of alcohol, narcotics, or other drugs;

(5) Engaged in inappropriate prescribing, dispensing, or otherwise distributing a controlled substance or other drug in the course of professional practice;

(6) Had their license suspended or revoked in another state for disciplinary reasons; or

(7) Failed to comply with the lawful order or duly promulgated rules of the board.

(b) Upon issuing disciplinary action to a licensee, the board shall notify the board of medical examiners, board of osteopathic examination, or board of podiatry, as appropriate, of the disciplinary action and the licensee's primary collaborating physician of record.

(c) A disciplinary action issued by the board for a violation involving the prescribing, dispensing, or otherwise issuing of controlled substances by a physician assistant must also be approved by the board of medical examiners, and the board shall

give notice to the appropriate licensing board of the primary collaborating physician of record.

63-19-111. Exemptions.

(a) This part does not:

(1) Modify or supersede any existing laws relating to other paramedical professions or services;

(2) Permit a physician assistant to:

(A) Measure the powers or range of human vision, or determine the refractive state of the human eye or the scope of its functions in general or prescribe or direct the use of ophthalmic lenses or prisms to remedy or relieve defects of vision or muscular anomalies;

(B) Prescribe or fit or adapt contact lenses to or for the human eye; or

(C) Practice chiropractic or to analyze or palpate the articulations of the spinal column for the purposes of giving a spinal adjustment; or

(3) Prohibit a physician assistant from testing visual acuity or performing routine vision screening.

(b) This part does not apply to registered nurses or licensed practical nurses utilized by a physician under § 63-6-204 or § 63-9-113, or to technicians, other assistants, or employees of a physician not rendering services as a physician assistant and who perform delegated tasks in the office of a physician or to students enrolled in physician assistant training programs accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc., or its successor entity.

63-19-112. Administrative proceedings.

The board shall conduct all administrative proceedings for disciplinary action against a license holder under this part in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

63-19-113. Licensure renewal by retired physician assistants.

A person licensed by the board as a physician assistant who has retired or may retire from practice in this state is not required to biennially renew the person's license as required by this part, if the person files with the board an affidavit on a form to be furnished by the board, which affidavit states the date on which the person retired from practice and any other facts, as the board considers necessary, that tend to verify the retirement. If the person thereafter reengages in practice in this state, then the person must apply for licensure by the board as provided by this part and is not liable for payment of licensure renewal fees that accrued during the period of retirement.

63-19-114. Use of title "physician assistant" or abbreviation "PA."

(a) A person who holds a valid license or temporary license from the board has the right to use the title "physician assistant," the abbreviation "PA," or the abbreviation "PA-C." No other person may assume that title or use those abbreviations, or any words, signs, letters, or devices to indicate that the person using them is a physician assistant.

(b) A person who meets the qualifications for licensure under this chapter but does not possess a current license may use the title "PA," "physician assistant," or "PA-C," but may not act or practice as a PA unless licensed under this chapter.

(c) This section does not apply to public accountants or certified public accountants. This section does not prevent a public accountant from using the abbreviation "P.A.".

63-19-115. Special volunteer license for practice in free health clinic — Exemption from fees — Renewal.

A physician assistant licensed pursuant to this chapter under a special volunteer license who is a medical practitioner, as defined by § 63-1-201, engaged in practice at a free health clinic is not subject to license fees under this chapter. The board may issue a special volunteer license, as defined in § 63-1-201, to qualified applicants without fee or charge. The license is for a period of two (2) years and may be renewed on a biennial basis.

SECTION 7. Tennessee Code Annotated, Section 63-19-201, is amended by deleting the section and substituting:

(a) Licensed orthopedic physician assistants are under the jurisdiction of the board of physician assistants created by § 63-19-103.

(b) The board of physician assistants has the duty to:

(1) Promulgate, in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, all rules that are reasonably necessary for the performance of the duties of orthopedic physician assistants, including, but not limited to, rules that specify the acts and offenses that subject the license holder to disciplinary action by the board pursuant to subdivision (b)(7);

(2) Set fees relative to the examination, licensure, and licensure renewal of orthopedic physician assistants in an amount sufficient to pay all of the expenses of the board, and to establish and collect a late renewal fee from those orthopedic physician assistants who fail to renew their licenses in a timely manner;

(3) Review and approve or reject the qualifications of each applicant for initial licensure as an orthopedic physician assistant;

(4) Biennially review and approve or reject the qualifications of each applicant for biennial licensure renewal. The board shall condition approval for

renewal on the receipt of evidence satisfactory to the board of the applicant's successful completion of sixty (60) hours of continuing medical education approved by the American Medical Association or other appropriate professional association. The board may, in its discretion, waive or modify the continuing medical education requirement in cases of retirement, illness, disability, or other undue hardship;

(5) Issue all approved orthopedic physician assistant licenses and renewals;

(6) Collect or receive all fees, fines, and moneys owed pursuant to this part and pay the fees, fines, and moneys into the general fund of the state. For the purpose of implementing subdivision (b)(2), all fees, fines, and moneys collected pursuant to the regulation of orthopedic physician assistants must be so designated; and

(7) Deny, suspend, or revoke the license of, or otherwise discipline by a fine not to exceed five hundred dollars ($500), or by reprimand, a license holder who is guilty of violating this part or who is guilty of violating the rules of the board promulgated pursuant to subdivision (b)(1). If sanctions are imposed on a licensee pursuant to this subdivision (b)(7), then the licensee may, in addition, be required to pay the actual and reasonable costs of the investigation and prosecution of the case, including the costs incurred and assessed for the time of the prosecuting attorney or attorneys, the investigator or investigators, and any other persons involved in the investigation, prosecution, and hearing of the case. The board may limit, restrict, or impose one (1) or more conditions on a license at the time it is issued, renewed, or reinstated or as a sanction imposed at the conclusion of a disciplinary hearing.

(c) Actions taken under this section are only effective after adoption by majority vote of the members of the board of physician assistants.

(d) For purposes of this part, unless the context requires otherwise, "physician" means a person lawfully licensed to practice orthopedic medicine and surgery pursuant to chapter 6 of this title, or osteopathic medicine pursuant to chapter 9 of this title.

SECTION 8. Tennessee Code Annotated, Section 63-19-202, is amended by deleting the section and substituting:

(a) A person shall not claim to be or function as an orthopedic physician assistant unless the person holds a valid orthopedic physician assistant license issued by the board.

(b) The board shall not license a person as an orthopedic physician assistant or renew the license of an orthopedic physician assistant unless:

(1) The person is a graduate of an orthopedic physician assistant training program approved by the board;

(2) The person has successfully completed the examination of the National Board for Certification of Orthopedic Physician Assistants; and

(3) The person was performing services as an orthopedic physician assistant in this state on January 1, 2021.

(c) The board may require that an applicant for licensure as an orthopedic physician assistant appear before the board to answer any questions regarding the applicant's fitness for licensure.

SECTION 9. Tennessee Code Annotated, Section 68-1-101(a)(8)(O), is amended by deleting "Board of medical examiners' committee on physician assistants" and substituting "Board of physician assistants".

SECTION 10. Tennessee Code Annotated, Section 68-11-222(b)(4), is amended by deleting "Board of medical examiners' committee on physician assistants" and substituting "Board of physician assistants".

SECTION 11. Tennessee Code Annotated, Section 71-5-201(b), is amended by deleting the subsection.

SECTION 12. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 13. Rules promulgated pursuant to this chapter to effectuate the purposes of this act must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 14. For purposes of establishing the board and promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect January 1, 2022, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

Signature of Sponsor

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

AMEND Senate Bill No. 410* **House Bill No. 565**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 63, is amended by adding the following as a new chapter:

63-20-101. Chapter definitions.

As used in this chapter:

(1) "COVID-19" means an infectious respiratory disease caused by the coronavirus named SARS-CoV-2, or any mutation of that coronavirus;

(2) "Dentist" means a person licensed to practice dentistry in this state under chapter 5 of this title; and

(3) "Nurse" means a person licensed as a professional nurse pursuant to chapter 7 of this title.

63-20-102. Professionals also authorized to administer COVID-19 vaccinations.

(a) Notwithstanding a law to the contrary, a person licensed under this title who draws blood at a nonprofit blood bank or blood center, or a dentist, may administer a vaccination against COVID-19 as long as the person or dentist has received appropriate training on how to administer the vaccination as deemed appropriate by the department of health by rule, including by emergency rule.

(b) This section does not apply to nurses.

SECTION 2. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 3. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED	
Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

_____

Signature of Sponsor

AMEND Senate Bill No. 1104* **House Bill No. 1509**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 71-1-130(b), is amended by deleting the language "from the market rate study" and substituting the language "from the market rate study or utilizing an alternative methodology".

SECTION 2. Tennessee Code Annotated, Section 71-1-130(c), is amended by deleting the language "results of the market rate study" and substituting the language "results of the market rate study; the results of an alternative methodology utilized, if applicable;".

SECTION 3. Tennessee Code Annotated, Section 71-1-130, is amended by adding the following as a new subsection:

(h) For purposes of this section, "alternative methodology":

(1) Means a method of determining the costs of day care other than by a market rate study; and

(2) Includes cost-of-quality studies and cost estimation models.

SECTION 4. Tennessee Code Annotated, Section 71-1-105, is amended by adding the following as a new subsection:

(c) The department is authorized to take actions necessary to support the development of shared services alliances and family child care networks to improve the quality of child care in this state, give child care providers access to innovative child care business resource platforms, and provide a means of cost savings to child care providers through negotiated discounts. The department may contract with one (1) or more entities as necessary to implement this subsection (c).

SECTION 5. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED	
Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

_____

Signature of Sponsor

AMEND Senate Bill No. 1105 **House Bill No. 996***

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 71-1-130, is amended by adding the following as a new subsection:

(1) The department may utilize an enrollment-based child care subsidy payments program that complies with all applicable federal funding requirements and legal authority and that seeks to provide adequate, stable payments to providers of child care services under this section by establishing effective payment practices based upon accurate time and attendance systems.

(2) The department shall consider program standards, such as, but not limited to, the following:

(A) The child's developmental and educational goals when authorizing care periods eligible for reimbursement;

(B) Accommodation of variable parent schedules;

(C) Authorizing pay based upon enrollment rather than attendance;

(D) Using a range of hours to determine authorized care amounts; and

(E) Simplifying and streamlining payment processes with providers.

(3) The department shall publish on the department's publicly accessible website an overview of child care services and the methodology used to issue payments to providers of child care services, including any changes to the methodology during the previous year, if applicable.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

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House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

_____

Signature of Sponsor

AMEND Senate Bill No. 1281 **House Bill No. 948***

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 11, Part 16, is amended by deleting the part and substituting:

68-11-1601. Short title.

This part is known and may be cited as the "Tennessee Health Services and Planning Act of 2021."

68-11-1602. Part definitions.

As used in this part:

(1) "Agency" and "health services and development agency" mean the agency created by this part to develop the criteria and standards to guide the agency when issuing certificates of need; to conduct studies related to health care, including needs assessments; and to administer the certificate of need program and related activities;

(2) "Certificate of need" means a permit granted by the health services and development agency to a person for those services specified as requiring a certificate of need under § 68-11-1607 at a designated location;

(3) "Conflict of interest" means a matter before the agency in which the member or employee of the agency has a direct interest or indirect interest that is in conflict or gives the appearance of conflict with the discharge of the member's or employee's duties;

(4) "Department" means the department of health;

(5) "Direct interest" means a pecuniary interest in the persons involved in a matter before the agency, and applies to the agency member or employee, the agency member's or employee's relatives, or an individual with whom or business in which the member or employee has a pecuniary interest. As used in this subdivision (5), "relative" means a spouse, parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, or nephew by blood, marriage, or adoption;

(6) "Ex parte communications" means communications in violation of § 4-5-304 or § 68-11-1607(d);

(7) "Facility" means real property owned, leased, or used by a healthcare institution for any purpose, other than as an investment;

(8) "Health service" means clinically related services, such as diagnostic, treatment, or rehabilitative services, and includes those services specified as requiring a certificate of need under § 68-11-1607;

(9) "Healthcare institution":

(A) Means an agency, institution, facility, or place, whether publicly or privately owned or operated, that provides health services and that is one (1) of the following:

(i) A nursing home;

(ii) A hospital;

(iii) An ambulatory surgical treatment center;

(iv) An intellectual disability institutional habilitation facility;

(v) A home care organization, or a category of service provided by a home care organization for which authorization is required under part 2 of this chapter;

(vi) An outpatient diagnostic center;

(vii) A rehabilitation facility;

(viii) A residential hospice; or

(ix) A nonresidential substitution-based treatment center for opiate addiction; and

(B) Does not include:

(i) A ground ambulance;

(ii) A home for the aged;

(iii) A premises occupied exclusively as the professional practice office of a:

(*a*) Physician licensed pursuant to title 63, chapter 6, part 2 or title 63, chapter 9; or

(*b*) Dentist licensed by this state and controlled by the physician or dentist;

(iv) An administrative office building of a public agency related to healthcare institutions;

(v) A Christian Science sanatorium operated, or listed and certified, by the First Church of Christ Scientist, Boston, Massachusetts;

(vi) A mental health residential treatment facility; or

(vii) A mental health hospital;

(10) "Home care organization" means an entity licensed as such by the department that is staffed and organized to provide "home health services" or "hospice services," as defined by § 68-11-201, to patients in either the patient's regular or temporary place of residence;

(11) "Indirect interest" means a personal interest in the persons involved in a matter before the agency that is in conflict with the discharge of the agency member's or employee's duties;

(12) "Letter of intent" means the form prescribed by the agency that requires a brief project description, location, estimated project cost, owner of the project, and description of services to be performed;

(13) "Licensed beds" means the number of beds licensed by the agency having licensing jurisdiction over the facility in which the beds are located;

(14) "Needs assessment" means an annual report that measures access to health care in this state, particularly as to emergency and primary care; identifies access gaps; and serves to inform the criteria and standards for the issuance of certificates of need;

(15) "Nonresidential substitution-based treatment center for opiate addiction" includes, but is not limited to, stand-alone clinics offering methadone, products containing buprenorphine such as Subutex and Suboxone, or products containing any other formulation designed to treat opiate addiction by preventing symptoms of withdrawal;

(16) "Nursing home" has the same meaning as defined in § 68-11-201;

(17) "Nursing home bed" means:

(A) A licensed bed within a nursing home, regardless of whether the bed is certified for medicare or medicaid services; and

(B) A bed at a healthcare institution used as a swing bed under 42 C.F.R. § 485.645;

(18) "Patient" includes, but is not limited to, a person who has an acute or chronic physical or mental illness or injury; who is convalescent, infirm, or has an intellectual or physical disability; or who is in need of obstetrical, surgical, medical, nursing, psychiatric, or supervisory care;

(19) "Pediatric patient" means a patient who is fourteen (14) years of age or younger;

(20) "Person":

(A) Means an individual, a trust or an estate, a firm, a partnership, an association, a stockholder, a joint venture, a corporation or other form of business organization, the state of Tennessee and its political subdivisions or parts of political subdivisions, and any combination of persons specified in this subdivision (20), public or private; and

(B) Does not include the United States or an agency or instrumentality of the United States, except in the case of voluntary submission to the rules established pursuant to this part;

(21) "Planning division" and "state health planning division" mean the state health planning division of the department, which is created by this part to develop the state health plan and conduct other related studies;

(22) "Rehabilitation facility" means an inpatient or residential facility that is operated for the primary purpose of assisting in the rehabilitation of physically disabled persons through an integrated program of medical and other services that is provided under professional supervision;

(23) "Review cycle" means the timeframe set for the review and initial decision on applications for certificate of need applications that have been deemed complete, with the fifteenth day of the month being the first day of the review cycle; and

(24) "State health plan" means the plan that is developed by the state health planning division pursuant to this part.

68-11-1603. Policy.

It is declared to be the public policy of this state that the establishment and modification of healthcare institutions, facilities, and services must be accomplished in a manner that promotes access to necessary, high quality, and cost-effective services for the health care of the people of this state. To this end, this section applies equitably to

all healthcare entities, regardless of ownership or type, except those owned and operated by the United States government.

68-11-1604. Health services and development agency — Creation — Composition — Appointments — Terms — Compensation — Officers — Meetings — Conflict of interest.

(a) There is created a health services and development agency that has jurisdiction and powers relating to the certificate of need program; the development of the criteria and standards to guide the agency when issuing certificates of need; conducting of studies related to health care, which must include a needs assessment; and related reporting of healthcare institutions subject to this chapter.

(b)

(1) The agency consists of eleven (11) members, including:

(A) The comptroller of the treasury, or an employee of the office of the comptroller of the treasury designated by the comptroller;

(B) The state director of TennCare, or its successor, or an employee of the division of TennCare, or its successor, designated by the director;

(C) The commissioner of commerce and insurance, or an employee of the department of commerce and insurance designated by the commissioner;

(D) One (1) consumer member appointed by the speaker of the senate;

(E) One (1) consumer member appointed by the speaker of the house of representatives; and

(F) Six (6) members appointed by the governor, to include:

(i) One (1) person who has recent experience as an executive officer of a hospital or hospital system who may be

appointed from lists of qualified persons submitted by interested hospital groups, including, but not limited to, the Tennessee Hospital Association;

(ii) One (1) representative of the nursing home industry who may be appointed from lists of qualified persons submitted by interested healthcare groups, including, but not limited to, the Tennessee Health Care Association;

(iii) One (1) duly licensed physician who may be appointed from lists of qualified persons submitted by interested medical groups, including, but not limited to, the Tennessee Medical Association;

(iv) One (1) representative of the home care industry who may be appointed from lists of qualified persons submitted by interested home care groups, including, but not limited to, the Tennessee Association for Home Care. The initial term for the home care industry representative is two (2) years. Upon the expiration of that term, the home care industry representative is appointed for a three-year term pursuant to subsection (c);

(v) One (1) consumer member; and

(vi) One (1) representative of the ambulatory surgical treatment center industry.

(2) The governor shall consult with interested groups, including, but not limited to, the organizations listed in subdivision (b)(1) to determine qualified persons to fill positions with the agency.

(3) In making appointments to the health services and development agency, the governor and the speakers shall strive to ensure that racial

minorities, females, persons sixty (60) years of age and older, and the three (3) grand divisions are represented.

(4) The consumer members must be persons who are knowledgeable of health needs and services and who are further knowledgeable by training or experience in healthcare facility design or construction, financing of healthcare services or construction, reimbursement of healthcare services, or general healthcare economics. The consumer members shall not be a direct provider of healthcare goods or services.

(c)

(1) A member of the agency shall not serve beyond the expiration of the member's term, whether or not a successor has been appointed by the governor or the speakers of the senate and the house of representatives.

(2) Except for the comptroller of the treasury, the commissioner of commerce and insurance, and the director of TennCare, or their respective designees, agency members are appointed for three-year terms, and a member shall not serve more than two (2) consecutive three-year terms.

(3) If a member is absent from three (3) consecutive, regularly scheduled public meetings of the agency, then the individual's membership is automatically terminated, and the position is considered as vacant.

(d)

(1) Each member of the agency shall receive fifty dollars ($50.00) per diem when actually engaged in the discharge of the member's official duties, and in addition, shall be reimbursed for all travel and other necessary expenses. However, agency members who are state employees shall not receive per diem, but must be reimbursed for all travel and other necessary expenses.

(2) Expenditures must be claimed and paid in accordance with the comprehensive travel regulations as promulgated by the department of finance and administration, and approved by the attorney general and reporter.

(e)

(1) At the first meeting in each fiscal year, the agency shall elect officers. The chair of the agency must be a consumer member to serve a term of two (2) years. A member of the agency may serve as vice chair, which is a term of one (1) year. A member shall not serve two (2) consecutive terms as vice chair.

(2) Meetings of the agency must be held as frequently as its duties may require.

(3) Six (6) members constitute a quorum, but a vacancy on the agency does not impair its power to act.

(4) An action of the agency is not effective unless the action is concurred in by a majority of agency members present and voting.

(5) In the event of a tie vote, the action is considered disapproved.

(6) The agency shall record by name the votes taken on all actions of the agency.

(7)

(A) All agency members shall annually review and sign a statement acknowledging the statute, rules, and policies concerning conflicts of interest.

(B)

(i) A member, upon determining that a matter scheduled for consideration by the agency results in a conflict with a direct interest, shall immediately notify the executive director and is recused from any deliberation of the matter, from making any recommendation, from testifying concerning the matter, or from

voting on the matter. The member shall join the public during the proceedings.

(ii) A member with an indirect interest shall publicly acknowledge such interest.

(iii) All members shall make every reasonable effort to avoid even the appearance of a conflict of interest. If a member is uncertain whether the relationship justifies recusal, then the member shall follow the determination by the legal counsel for the agency.

(iv) A determination by the agency or a court that a member of the agency with a direct interest failed to provide notice and be recused from deliberations of the matter, from making any recommendation, from testifying concerning the matter, or from voting on the matter, results in the member's automatic termination from the agency and the position is considered vacant. The member is not eligible for appointment to any agency, board, or commission of this state for a period of two (2) years.

(v) The executive director, upon determining that a conflict exists for the executive director or a member of the staff, shall notify the chair of the agency and take such action as the chair prescribes and pursuant to this part.

68-11-1605. Powers and duties of agency.

In addition to the powers granted elsewhere in this part, the agency has the duty and responsibility to:

(1) Develop criteria and standards to guide the agency when issuing certificates of need that are:

(A) Based, in whole or in part, upon input the agency received during development of the criteria and standards from the division of TennCare, or its successor; the departments of health, mental health and substance abuse services, and intellectual and developmental disabilities; the health and welfare committee of the senate; and the health committee of the house of representatives;

(B) Evaluated and updated not less than once every five (5) years; and

(C) Developed by rule in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5;

(2) Receive and consider applications for certificates of need, to review recommendations on certificates of need, and to grant or deny certificates of need on the basis of the merits of the applications within the context of the local, regional, and state health needs, including, but not limited to, the criteria and standards developed in accordance with this part;

(3) Conduct studies related to health care, including a needs assessment that must be updated at least annually;

(4) Promulgate rules and policies deemed necessary by the agency for the fulfillment of its duties and responsibilities under this part, including a procedure for the issuance of a certificate of need upon an emergency application if an unforeseen event necessitates the issuance of a certificate of need to protect the public health, safety, and welfare, and if the public health, safety, and welfare would be unavoidably jeopardized by compliance with the procedures established under this part;

(5) Contract when necessary for the development of criteria and standards to guide the agency when issuing certificates of need and for the implementation of the certificate of need program described in this part;

(6) Weigh and consider access to quality health care and the healthcare needs of consumers, particularly those in underserved communities; those who are uninsured or underinsured; women and racial and ethnic minorities; TennCare or medicaid recipients; and low-income groups whenever the agency performs its duties or responsibilities assigned by law; and

(7) Issue exemptions from the voiding of a certificate of need and an activity authorized by the certificate of need pursuant to § 68-11-1609(i), if the actions the certificate of need authorizes are not performed for a continuous period of one (1) year after the date the certificate of need is implemented.

68-11-1606. Executive director of agency — Appointment — Salary — Duties — Delegation of authority — Review.

(a) The agency shall appoint an executive director qualified by education and experience. The executive director must demonstrate knowledge and experience in the areas of public administration and health policy development.

(b) The agency shall fix the salary of the executive director, who serves at the pleasure of the agency. The executive director is the chief administrative officer of the agency and the appointing authority, exercising general supervision over all persons employed by the agency.

(c) The executive director has the following duties:

(1) Administering the development of criteria and standards to guide the agency when issuing certificates of need;

(2) Administering the certificate of need program;

(3) Conducting studies related to health care;

(4) Representing the agency before the general assembly;

(5) Overseeing the issuance of responses to requests for determination regarding the applicability of this part;

(6) Issuing exemptions from the requirement that a certificate of need be obtained for the relocation of existing or certified facilities providing healthcare services and healthcare institutions under § 68-11-1607(a)(4);

(7) Keeping a written record of proceedings and transactions of the agency, which must be open to public inspection during regular office hours;

(8) Preparing the agenda, including consent and emergency calendars, and notice to the general public of all meetings and public hearings of the agency;

(9) Employing personnel, within the agency's budget, to assist in carrying out this part;

(10) Carrying out policies and rules that are promulgated by the agency and supervising the expenditure of funds;

(11) Submitting an annual report, no later than January 15 of each year, to the chairs of the health and welfare committee of the senate and the health committee of the house of representatives that includes, but is not limited to, a comparison of the actual payer mix and uncompensated care provided by certificate of need holders with the projections the holders submitted in the holder's certificate of need application; and

(12) Submitting to the chairs of the health and welfare committee of the senate and health committee of the house of representatives no later than January 1, 2023, a plan:

(A) Developed by the executive director;

(B) To consolidate into a health facilities commission the powers and duties of the agency with those of the board for licensing health care facilities established under part 2 of this chapter; and

(C) For which agencies of this state shall provide assistance to the executive director following a request by the executive director.

(d) In addition to the duties provided in subsection (c), the agency has the authority to delegate, and it is the intent of the general assembly that the agency exercise the authority to delegate the following responsibilities and duties to the executive director:

(1) Granting deferral of applications for certificates of need in accordance with § 68-11-1609; and

(2) Granting approval or denial of modifications, changes of conditions or ownership, and extensions of certificates of need in accordance with this part.

(e) A delegation of authority pursuant to subsection (d) continues until specifically revoked by the agency as a result of a determination that revocation is necessary to ensure the proper and orderly operation of the agency.

(f) The executive director shall, within two (2) business days, notify the agency of an action taken pursuant to a delegation of authority under subsection (d).

(g)

(1) The agency shall review an action by the executive director, if:

(A) The executive director receives a written request for agency review; or

(B) An agency member requests agency review.

(2)

(A) If a request for agency review pursuant to subdivision (g)(1) is received within fifteen (15) days of the date the executive director provides notice of the action pursuant to subsection (f), then the action does not become final until the agency has rendered its final decision.

(B) If a request for agency review is not received pursuant to subdivision (g)(1), then the executive director's action becomes final as if the action was taken by the agency.

(h)

(1) An agency review of an action taken by the executive director must be conducted at the next regularly scheduled agency meeting that is scheduled for a date no less than two (2) weeks after the date the request for review is received pursuant to subsection (g).

(2) Agency review of an action by the executive director is de novo.

(3) The agency shall use the then-current edition of Robert's Rules of Order as the rules of parliamentary procedure applicable to an agency review of an action taken by the executive director.

68-11-1607. Certificate of need — Applications — Exemptions — Registration of equipment — Critical access hospital designation.

(a) A person shall not perform the following actions in this state, except after applying for and receiving a certificate of need for the action:

(1) The construction, development, or other establishment of any type of healthcare institution as described in this part;

(2) In the case of a healthcare institution, a change in the bed complement, regardless of cost, that:

(A) Increases by one (1) or more the number of nursing home beds;

(B) Redistributes beds from any category to acute, rehabilitation, child and adolescent psychiatric, adult psychiatric, or long-term care; or

(C) Relocates beds to another facility or site;

(3) Initiation of the following healthcare services:

(A) Burn unit;

(B) Neonatal intensive care unit;

(C) Open heart surgery;

(D) Organ transplantation;

(E) Cardiac catheterization;

(F) Linear accelerator;

(G) Home health;

(H) Hospice; or

(I) Opiate addiction treatment provided through a nonresidential substitution-based treatment center for opiate addiction;

(4)

(A) Except as provided in subdivision (a)(4)(B), a change in the location of existing or certified facilities providing healthcare services and healthcare institutions. However, the executive director may issue an exemption for the relocation of existing healthcare institutions and approved services if the executive director determines that:

(i)

(a) At least seventy-five percent (75%) of patients to be served are reasonably expected to reside in the same zip codes as the existing patient population; and

(b) The relocation will not reduce access to consumers, particularly those in underserved communities; those who are uninsured or underinsured; women and racial and ethnic minorities; TennCare or medicaid recipients; and low-income groups;

(ii) The executive director must notify the agency of an exemption granted pursuant to subdivision (a)(4)(A)(i) within two (2) business days of the date the executive director grants the exemption;

(iii) An exemption granted by the executive director pursuant to subdivision (a)(4)(A)(i) is subject to agency review in the same manner as described in § 68-11-1606(g) and (h);

(B) The relocation of the principal office of a home health agency or hospice within its licensed service area does not require a certificate of need;

(5) Except as otherwise provided in subdivision (m)(2) and subsection (u), the following actions in a county with a population of one hundred seventy-five thousand (175,000) or less, according to the 2010 federal census or any subsequent federal census:

(A) Initiation of magnetic resonance imaging services; or

(B) Increasing the number of magnetic resonance imaging machines, except for replacing or decommissioning an existing machine;

(6) Establishing a satellite emergency department facility or a satellite inpatient facility by a hospital at a location other than the hospital's main campus; and

(7) Except as otherwise provided in subsection (u), the initiation of positron emission tomography in a county with a population of one hundred seventy-five thousand (175,000) or less, according to the 2010 federal census or any subsequent federal census.

(b) An agency of this state, or of a county or municipal government, shall not approve a grant of funds for, or issue a license to, a healthcare institution for a portion or activity of the healthcare institution that is established, modified, relocated, changed, or resumed, or that constitutes a covered healthcare service, in violation of this part. If an agency of this state, or of a county or municipal government, approves a grant of funds for, or issues a license to, a person or institution for which a certificate of need was required but was not granted, then the license is void and the person or institution shall refund the funds to the state within ninety (90) days. The health services and development agency has the authority to impose civil penalties and petition a circuit or chancery court having jurisdiction to enjoin a person who is in violation of this part.

(c)

(1) For each application, a letter of intent must be filed between the first day of the month and the fifteenth day of the month prior to the application's submission. At the time of filing, the applicant shall cause the letter of intent to be published in a newspaper of general circulation in the proposed service area of the project. The published letter of intent must contain a statement that any:

(A) Healthcare institution wishing to oppose the application must file written notice with the agency no later than fifteen (15) days before the agency meeting at which the application is originally scheduled; and

(B) Other person wishing to oppose the application may file a written objection with the agency at or prior to the consideration of the application by the agency, or may appear in person to express opposition.

(2) Persons desiring to file a certificate of need application seeking a simultaneous review regarding a similar project for which a letter of intent has been filed shall file with the agency a letter of intent between the sixteenth day of the month and the last day of the month of publication of the first filed letter of intent. A copy of a letter of intent filed after the first letter of intent must be mailed or delivered to the first filed applicant and must be published in a newspaper of general circulation in the proposed service area of the first filed applicant. The health services and development agency shall consider and decide the applications simultaneously. However, the agency may refuse to consider the applications simultaneously if it finds that the applications do not meet the requirements of "simultaneous review" under the rules of the agency.

(3) Applications for a certificate of need, including simultaneous review applications, must be filed by the first business day of the month following the date of publication of the letter of intent.

(4) If there are two (2) or more applications to be reviewed simultaneously in accordance with this part and the rules of the agency, and one (1) or more of those applications is not deemed complete by the deadline to be considered at the next agency meeting, then the other applications that are deemed complete by the deadline must be considered at the next agency meeting. The application or applications that are not deemed complete by the deadline to be considered at the next agency meeting will not be considered with the applications deemed complete by the deadline to be considered at the next agency meeting.

(5) Review cycles begin on the fifteenth day of each month. Review cycles are thirty (30) days. The first meeting at which an application can be considered by the agency is the meeting following the application's review cycle. If an application is not deemed complete within sixty (60) days after initial written notification is given to the applicant by agency staff that the application is deemed incomplete, then the application is void. If the applicant decides to resubmit the application, then the applicant shall comply with all procedures as set out by this part and pay a new filing fee when submitting the application. Prior to deeming an application complete, the executive director shall ensure independent review and verification of information submitted to the agency in applications, presentations, or otherwise. The purpose of the independent review and verification is to ensure that the information is accurate, complete, comprehensive, timely, and relevant to the decision to be made by the agency. The independent review and verification must be applied to, but not necessarily be limited to, applicant-provided information as to the number of available beds within a region, occupancy rates, the number of individuals on waiting lists, the demographics of a region, the number of procedures, and other critical information submitted or requested concerning an application; and staff

examinations of data sources, data input, data processing, and data output, and verification of critical information.

(6) An application filed with the agency must be accompanied by a nonrefundable examination fee fixed by the rules of the agency.

(7) Information provided in the application or information submitted to the agency in support of an application must be true and correct. Substantive amendments to the application, as defined by rule of the agency, are not allowed.

(8) An applicant shall designate a representative as the contact person for the applicant and shall notify the agency, in writing, of the contact person's name, address, and telephone number. The applicant shall immediately notify the agency in writing of any change in the identity or contact information of the contact person. In addition to any other method of service permitted by law, the agency may serve by registered or certified mail any notice or other legal document upon the contact person at the person's last address of record in the files of the agency. Notwithstanding a law to the contrary, service in the manner specified in this subdivision (c)(8) constitutes actual service upon the applicant.

(9)

(A) Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located; the state representative and senator representing the house district and the senate district in which the facility is proposed to be located; and the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing those officials that an application for a nonresidential

substitution-based treatment center for opiate addiction has been filed with the agency by the applicant.

(B) If an application involves a healthcare facility in which a county or municipality is the lessor of the facility or real property on which it sits, then within ten (10) days of filing the application, the applicant shall notify the chief executive officer of the county or municipality of the filing, by certified mail, return receipt requested.

(C) An application subject to the notification requirements of this subdivision (c)(9) is not complete if the applicant has not provided proof of compliance with this subdivision (c)(9) to the agency.

(d) Communications with the members of the agency are not permitted once the letter of intent initiating the application process is filed with the agency. Communication between agency members and agency staff is not prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application must be reported to the executive director, and a written summary of the communication must be made part of the certificate of need file.

(e) For purposes of this part, agency action is the same as administrative action defined in § 3-6-301.

(f)

(1) Notwithstanding this section to the contrary, Tennessee state veterans' homes under title 58, chapter 7, are not required to obtain a certificate of need pursuant to this section.

(2) Notwithstanding this section to the contrary, the beds located in a Tennessee state veterans' home pursuant to title 58, chapter 7, must not be considered by the health services and development agency when granting a certificate of need to a healthcare institution due to a change in the number of licensed beds, redistributing beds, or relocating beds pursuant to this section.

(g) After a person holding a certificate of need has completed the actions for which the certificate of need was granted, the time to complete activities authorized by the certificate of need expires.

(h) The owners of the following types of equipment shall register the equipment with the health services and development agency: computerized axial tomographers, magnetic resonance imagers, linear accelerators, and positron emission tomography. The registration must be in a manner and on forms prescribed by the agency and must include ownership, location, and the expected useful life of the equipment. Registration must occur within ninety (90) days of acquisition of the equipment. All such equipment must be filed on an annual inventory survey developed by the agency. The survey must include, but not be limited to, the identification of the equipment and utilization data according to source of payment. The survey must be filed no later than thirty (30) days following the end of each state fiscal year. The agency may impose a penalty not to exceed fifty dollars ($50.00) for each day the survey is late.

(i) Notwithstanding this section to the contrary, an entity, or its successor, that was formerly licensed as a hospital, and that has received from the commissioner of health a written determination that it will be eligible for designation as a critical access hospital under the medicare rural hospital flexibility program, is not required to obtain a certificate of need to establish a hospital qualifying for that designation, if it meets the requirements of this subsection (i). In order to qualify for the exemption set forth in this subsection (i), the entity proposing to establish a critical access hospital shall publish notice of its intent to do so in a newspaper of general circulation in the county where the hospital will be located and in contiguous counties. The notice must be published at least twice within a fifteen-day period. The written determination from the department of health and proof of publication required by this subsection (i) must be filed with the agency within ten (10) days after the last date of publication. If no healthcare institution within the same county or contiguous counties files a written objection to the proposal

with the agency within thirty (30) days of the last publication date, then the exemption set forth in this subsection (i) applies. However, this exemption applies only to the establishment of a hospital that qualifies as a critical access hospital under the medicare rural flexibility program and not to any other activity or service. If a written objection by a healthcare institution within the same county or contiguous counties is filed with the agency within thirty (30) days from the last date of publication, then the exemption set forth in this subsection (i) does not apply.

(j)

(1) A nursing home may increase its total number of licensed beds by the lesser of ten (10) beds or ten percent (10%) of its licensed capacity over any period of one (1) year without obtaining a certificate of need. The nursing home shall provide written notice of the increase in beds to the agency on forms provided by the agency prior to the request for licensing by the board for licensing health care facilities.

(2) For new nursing homes, the ten-bed or ten-percent increase cannot be requested until one (1) year after the date all of the new beds were initially licensed.

(3) When determining projected county nursing home bed need for certificate of need applications, all notices filed with the agency pursuant to subdivision (j)(1), with written confirmation from the board for licensing health care facilities that a request and application for license has been received and a review has been scheduled, must be considered with the total of licensed nursing home beds, plus the number of beds from approved certificates of need, but yet unlicensed.

(4) During the time § 68-11-1619 applies, this subsection (j) is suspended.

(k) This part does not require a certificate of need for a home care organization that is authorized to provide only professional support services as defined in § 68-11-201.

(l) A home care organization may only initiate hospice services after applying for and receiving a certificate of need for providing hospice services.

(m)

(1) A person who provides magnetic resonance imaging services shall file with the agency an annual report no later than thirty (30) days following the end of each state fiscal year that details the mix of payers by percentage of cases for the prior calendar year for its patients, including private pay, private insurance, uncompensated care, charity care, medicare, and medicaid.

(2) In a county with a population in excess of one hundred seventy-five thousand (175,000), according to the 2010 federal census or a subsequent federal census, a person who initiates magnetic resonance imaging services shall notify the agency in writing that imaging services are being initiated and shall indicate whether magnetic resonance imaging services will be provided to a patient who is fourteen (14) years of age or younger on more than five (5) occasions per year.

(n)

(1) An application for certificate of need for organ transplantation must separately:

(A) Identify each organ to be transplanted under the application; and

(B) State, by organ, whether the organ transplantation recipients will be adult patients or pediatric patients.

(2) After an initial application for transplantation has been granted, the addition of a new organ to be transplanted or the addition of a new recipient category requires a separate certificate of need. The application must:

(A) Identify the organ to be transplanted under the application; and

(B) State whether the organ transplantation recipients will be adult patients or pediatric patients.

(3)

(A) For the purposes of certificate of need approval for organ transplantation programs under this part, a program submitted to the United Network for Organ Sharing (UNOS) by January 1, 2017, is not required to obtain a certificate of need.

(B) If the organ transplantation program ceases to be a UNOS-approved program, then a certificate of need is required.

(o)

(1) Within two (2) years after the date of receiving a certificate of need, an outpatient diagnostic center must become accredited by the American College of Radiology in the modalities provided by that facility as a condition of receiving the certificate of need.

(2) An outpatient diagnostic center that fails to comply with the accreditation requirement of subdivision (o)(1) is subject to licensure sanction under § 68-11-207 as a violation of part 2 of this chapter or of the rules, regulations, or minimum standards issued pursuant to part 2 of this chapter.

(p)

(1) Notwithstanding this title to the contrary, a certificate of need is not required for a hospital to operate a nonresidential substitution-based treatment

center for opiate addiction if the treatment center is located on the same campus as the operating hospital and the hospital is licensed under title 33 or this title.

(2) For purposes of this subsection (p), "campus" has the same meaning as defined in 42 CFR § 413.65.

(q)

(1) This part does not require a certificate of need for actions in a county that, as of January 1, 2021:

(A) Is designated as an economically distressed eligible county by the department of economic and community development pursuant to § 67-6-104, as updated annually; and

(B) Has no hospital that is actively licensed under this title located within the county.

(2)

(A) A person that provides positron emission tomography services or magnetic resonance imaging services pursuant to this subsection (q) must be accredited by the Joint Commission or American College of Radiology in the modalities provided by that person and submit proof of the accreditation to the agency within two (2) years of the initiation of service.

(B) A person that provides positron emission tomography services or magnetic resonance imaging services pursuant to this subsection (q) and that fails to comply with the accreditation requirement of subdivision (q)(2)(A) is subject to licensure sanction under § 68-11-207 as a violation of part 2 of this chapter or of the rules, regulations, or minimum standards issued pursuant to part 2 of this chapter.

(r)

(1) This part does not require a certificate of need to establish a home health agency limited to providing home health services under the federal Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) (42 U.S.C. § 7384, et seq.), or a subsequent amendment, revision, or modification to the EEOICPA. A license issued by the department pursuant to this subsection (r) for services under the EEOICPA must be limited to the provision of only those services. A home health agency providing home health services without a certificate of need pursuant to this subsection (r) must be accredited by the Joint Commission, the Community Health Accreditation Partner, or the Accreditation Commission for Health Care and submit proof of such accreditation to the agency within two (2) years of the initiation of service.

(2) A home health agency that provides home health services without a certificate of need pursuant to this subsection (r) and that fails to comply with the accreditation requirement of subdivision (r)(1) is subject to licensure sanction under § 68-11-207 as a violation of part 2 of this chapter or of the rules, regulations, or minimum standards issued pursuant to part 2 of this chapter.

(s)

(1) This part does not require a certificate of need to establish a home health agency limited to providing home health services to patients less than eighteen (18) years of age. A license issued by the department pursuant to this subsection (s) for the provision of home health services to patients under eighteen (18) years of age must be limited to the provision of only those services.

(2) The agency may permit a home health agency providing home health services to patients under eighteen (18) years of age to continue providing home health services to the patient until the patient reaches twenty-one (21) years of age if:

(A) The patient received home health services from the home health agency prior to the date the patient reached eighteen (18) years of age; and

(B) The home health services are provided under a TennCare program.

(3)

(A) A home health agency that provides home health services without a certificate of need pursuant to this subsection (s) must, within two (2) years of the initiation of service, be accredited by and submit proof to the agency of the accreditation from:

(1) An accrediting organization with deeming authority from the federal centers for medicare and medicaid services;

(2) The Joint Commission;

(3) The Community Health Accreditation Partner; or

(4) The Accreditation Commission for Health Care.

(B) A home health agency that provides home health services without a certificate of need pursuant to this subsection (s) and that fails to comply with the accreditation requirement of subdivision (s)(3)(A) is subject to licensure sanction under § 68-11-207 as a violation of part 2 of this chapter or of the rules, regulations, or minimum standards issued pursuant to part 2 of this chapter.

(t) This part does not require a certificate of need in order for an existing hospital licensed by the department of mental health and substance abuse services to become licensed by the department of health as a satellite of an affiliated general acute care hospital as provided by § 33-2-403(b)(8)(B).

(u)

(1) This part does not require a certificate of need to establish or operate the following in a county with a population in excess of one hundred seventy-five thousand (175,000), according to the 2010 federal census or a subsequent federal census:

(A) Initiation of magnetic resonance imaging services, or increasing the number of magnetic resonance imaging machines used, as long as magnetic resonance imaging services are not provided to a patient who is fourteen (14) years of age or younger on more than five (5) occasions per year; or

(B) Initiation of positron emission tomography.

(2)

(A) A provider of positron emission tomography established without a certificate of need pursuant to this subsection (u) must become accredited by the American College of Radiology and provide to the agency proof of the accreditation within two (2) years of the date of licensure.

(B) A provider of positron emission tomography established without a certificate of need pursuant to this subsection (u) and that fails to comply with the accreditation requirement of subdivision (u)(3)(A) is subject to licensure sanction under § 68-11-207 as a violation of part 2 of this chapter or of the rules, regulations, or minimum standards issued pursuant to part 2 of this chapter.

(v)

(1) A person who performs the following actions shall file an annual report as described in this subsection (v) with the health services and development agency:

(A) Cardiac catheterization;

(B) Open heart surgery;

(C) Organ transplantation;

(D) Operation of a burn unit;

(E) Operation of a neonatal intensive care unit;

(F) Provision of home health services; or

(G) Provision of hospice services.

(2) The annual report required by subdivision (v)(1) must be submitted in a manner and on forms prescribed by the agency, and must include utilization data according to source of payment and zip codes of patient origin.

(3) A person required to submit an annual report by this subsection (v) must submit the annual report for the period coinciding with the state fiscal year ending June 30, 2021, on or before September 30, 2021. The annual report for each subsequent fiscal year must be submitted to the agency no later than thirty (30) days following the end of each state fiscal year.

(4) The agency may impose a civil penalty not to exceed fifty dollars ($50.00) per day, for each day an annual report required by this subsection (v) is late.

68-11-1608. Review of applications — Report.

(a) The executive director may place applications to be considered on a consent or emergency calendar established in accordance with agency rule.

(b) The rule must provide that, in order to qualify for the consent calendar, an application must not be opposed by a person with legal standing to oppose and the application must appear to be necessary to provide needed health care in the area to be served, provide health care that meets appropriate quality standards, and demonstrate that the effects attributed to competition or duplication would be positive for consumers. If opposition is stated in writing prior to the application being formally considered by the

agency, then the application must be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

(c)

(1) If an unforeseen event necessitates action of a type requiring a certificate of need, and the public health, safety, or welfare would be unavoidably jeopardized by compliance with the standard procedures for the application for and granting of a certificate of need, then the agency may issue an emergency certificate of need.

(2) An emergency certificate of need may be issued upon request of the applicant if the executive director and officers of the agency concur, after consultation with the appropriate reviewing agency. Prior to an emergency certificate of need being granted, the applicant must publish notice of the application in a newspaper of general circulation, and agency members must be notified by agency staff of the request.

(3) A decision regarding whether to issue an emergency certificate of need must be considered at the next regularly scheduled agency meeting unless the applicant's request is necessitated by an event that has rendered its facility, equipment, or service inoperable. In that case, the agency's chair and vice chair may act immediately, on behalf of the agency, to consider the application for an emergency certificate of need.

(4) An emergency certificate of need is valid for a period not to exceed one hundred twenty (120) days. However, if the applicant has applied for a certificate of need under standard agency procedures, then an extension of the emergency certificate of need may be granted.

68-11-1609. Decision on application.

(a) The agency shall, upon consideration of an application and review of the evaluation and other relevant information:

(1) Approve part or all of the application and grant a certificate of need, upon lawful conditions that the agency deems appropriate and enforceable on the grounds that those parts of the proposal appear to meet applicable criteria. However:

(A) A condition that is placed on a certificate of need, and that appears on the face of the certificate of need when issued, must also be made a condition of any corresponding license issued by the department of health or department of mental health and substance abuse services. Notwithstanding a law to the contrary, the condition survives the expiration of the certificate of need and remains effective until removed or modified by the agency. The condition becomes a requirement of licensure and must be enforced by the respective licensing entity; and

(B) The holder of a license or certificate of need that has a condition placed on it by the agency may subsequently request that the condition be removed or modified, for good cause shown. The agency shall consider the request and determine whether or not to remove or modify the condition. The procedure for requesting a determination must be done as provided by agency rules. If the holder of the license or certificate of need is aggrieved by the agency's decision, then the holder may request a contested case hearing as permitted by this part;

(2) Disapprove part or all of the application and deny a certificate of need on the grounds that the applicant has not affirmatively demonstrated that those parts of the proposal meet the applicable criteria; or

(3) Defer making a decision for no more than ninety (90) days to obtain a clarification of information concerning applications properly before the agency, if there are no simultaneous review applications being concurrently considered by the agency with the deferred application.

(b) A certificate of need shall not be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, will provide health care that meets appropriate quality standards, and the effects attributed to competition or duplication would be positive for consumers. In making these determinations, the agency shall use as guidelines the goals, objectives, criteria, and standards adopted to guide the agency in issuing certificates of need. Until the agency adopts its own criteria and standards by rule, those in the state health plan apply. Additional criteria for review of applications must also be prescribed by the rules of the agency.

(c) Activity authorized by a certificate of need must be completed within a period not to exceed three (3) years for hospital projects, and two (2) years for all other projects, from the date of its issuance and after such time the certificate of need authorization expires. However, the agency may, in granting the certificate of need, allow longer periods of validity for certificates of need for good cause shown. Subsequent to granting the certificate of need, the agency may extend a certificate of need for a period upon application and good cause shown, accompanied by a nonrefundable reasonable filing fee, as prescribed by rule. A certificate of need authorization that has been extended expires at the end of the extended time period. The decision whether to grant an extension is within the sole discretion of the agency and is not subject to review, reconsideration, or appeal.

(d) If the time period authorized by a certificate of need has expired, then the certificate of need authorization is void. A revocation proceeding is not required. A license or occupancy approval shall not be issued by the department of health or the department of mental health and substance abuse services for an activity for which a certificate of need has become void.

(e) The agency's decision to approve or deny an application is final and shall not be reconsidered after the adjournment of the meeting in which the matter was

considered. This subsection (e) does not limit the right to file a petition for a contested case hearing pursuant to § 68-11-1610, nor does it limit the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, pertaining to contested case hearings.

(f) Written notice of the agency decision approving, disapproving, or deferring an application, or parts of an application, must be transmitted to the applicant, simultaneous review applicants, the department of health, the department of mental health and substance abuse services, the department of intellectual and developmental disabilities, and others upon request.

(g)

(1) A healthcare institution wishing to oppose a certificate of need application must be located within a thirty-five-mile radius of the location of the action proposed. A healthcare institution wishing to oppose an application for the establishment of a home care organization, the modification of a certificate of need issued to a home care organization, or the addition of counties to the licensed service area of an existing home care organization must have served patients in at least one (1) of the counties in the application's proposed service area within the seven hundred thirty (730) days immediately preceding the filing date of the certificate of need application, rather than demonstrate proximity within a thirty-five-mile radius of the location.

(2) Subject to subdivision (g)(1), a healthcare institution wishing to oppose a certificate of need application must file a written objection with the agency specifying reasons why one (1) or more of the criteria of subsection (b) are not satisfied. A healthcare institution wishing to oppose a certificate of need application must serve a copy to the contact person for the applicant, not later than fifteen (15) days before the agency meeting at which the application is originally scheduled. An application for which the agency has received

opposition must be designated on the agency's agenda as an opposed application.

(3)

(A) Subject to subdivision (g)(1), a healthcare institution wishing to oppose a certificate of need application may appear before the agency and express opposition to the application as long as the healthcare institution has submitted written opposition in accordance with subdivision (g)(2).

(B) This subsection (g) does not prohibit an individual acting in the individual's capacity as a private citizen from appearing before the agency and expressing opposition to an application.

(4) A healthcare institution or other person expressing opposition to an application does not have a veto over an application. The merits of opposition may be considered by the agency while determining whether to approve or deny a certificate of need application in whole or in part.

(h) The agency shall maintain continuing oversight over a certificate of need that it approves on or after July 1, 2016. Oversight by the agency includes requiring annual reports concerning appropriate quality measures as determined by the agency. The agency may impose conditions on a certificate of need that require the demonstration of compliance with quality measures as long as the conditions for quality measures are not more stringent than those measures identified by the applicant in the applicant's submitted application.

(i)

(1) Notwithstanding a law to the contrary, and except as provided in subdivision (i)(2), a certificate of need and activity the certificate authorizes becomes void if the actions the certificate authorizes have not been performed for a continuous period of one (1) year after the date the certificate of need is

implemented. With respect to a home care organization, this subsection (i) applies to each county for which the home care organization is licensed. A revocation proceeding is not required. The department of health and the department of mental health and substance abuse services shall not issue or renew a license for an activity for which certificate of need authorization has become void.

(2)

(A) The agency may issue a temporary exemption to subdivision (i)(1) upon finding that sufficient cause for the temporary cessation of the activity has been presented to the agency along with a plan to resume the activity in the future.

(B) The agency shall prescribe the procedures for issuing temporary exemptions by rule.

(C) The agency's approval or denial of a temporary exemption is a final agency decision subject to appeal in the chancery court of Davidson County.

(3) This subsection (i) does not apply to the establishment of a healthcare institution or a healthcare institution's number of licensed beds if the healthcare institution has a license issued under this title, whether active or inactive.

(j) If an applicant's application is denied by the agency, then the agency shall provide to the applicant written documentation with an explanation of the factual and legal basis upon which the agency denied the certificate of need.

68-11-1610. Contested case hearings— Petition — Procedure — Arbitration and mediation alternatives — Orders — Costs.

(a) Within fifteen (15) days of the approval or denial by the agency of an application, an applicant, a healthcare institution that satisfied the requirements set forth

in § 68-11-1609(g), or another person who objected to the application pursuant to § 68-11-1609(g)(2) or (g)(3), may petition the agency in writing for a hearing. The petition must be filed with the executive director. Notwithstanding another law, all persons are barred from filing a petition for a contested case hearing after the fifteen-day period, and the agency has no jurisdiction to consider a late-filed petition. Upon receipt of a timely filed petition, the agency shall initiate a contested case proceeding as provided in this section. At the hearing, no issue may be raised or evidence considered concerning the merits of an applicant considered by simultaneous review, unless the applicant met the requirements of this part, of concurrent consideration with the application that is the subject of the hearing.

(b) The contested case hearing required by this section must be conducted in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, except as otherwise provided in this section.

(c) Contested cases initiated pursuant to this section must be heard by an administrative law judge sitting alone. Petitions for contested cases received by the agency must be forwarded immediately to the administrative division of the secretary of state's office for assignment to an administrative law judge.

(d) The administrative law judge to whom a case has been assigned shall convene the parties for a scheduling conference within fifteen (15) days of the date the petition for contested case is filed. At the scheduling conference, the parties shall state their respective positions on the mediation alternative described in this section. If the parties are unable to agree on a mediation alternative, then the scheduling order for the contested case adopted by the administrative law judge must establish a schedule that results in a hearing completed within one hundred eighty (180) days of the date on which the petition for contested case was received by the agency, with the initial order to be entered within sixty (60) days of the date the hearing is completed. Extensions of time

or variances from the scheduling order must be granted sparingly, and only because of unforeseen developments that would cause substantial prejudice to a party.

(e) As an alternative to the contested case process described in subsection (c), the parties may agree to mediation of the issues raised in the contested case. The mediator shall be designated by mutual agreement of the parties. The parties may designate a mediator who is not listed as a qualified Supreme Court Rule 31 mediator, but such mediator shall observe the standards of professional conduct set forth in Appendix A to Supreme Court Rule 31, to the extent applicable. The mediator's fee must be shared equally among the parties, except that the state is not required to contribute to payment of the mediator's fee. If mediation results in agreement of the parties, then the agreement must be memorialized in the order terminating the contested case. A mediation proceeding under this subsection (e) is not subject to the scheduling order requirements set forth in subsection (d).

(f) The general assembly declares the public policy of this state to be that certificate of need contested cases should be resolved through mediation, and the parties to such proceedings are encouraged to pursue this alternative.

(g) Judicial review of the agency's final order in a contested case is as provided by law.

(h) Costs of the contested case proceeding and appeals, including the administrative law judge's costs and deposition costs, such as expert witness fees and reasonable attorney's fees, must be assessed against the losing party in the contested case. If there is more than one (1) losing party, then the costs must be divided equally among the losing parties. Costs shall not be assessed against the agency.

(i) This section governs all contested cases relative to approval or denial decisions by the agency.

(j) If a person, who is not the applicant or the agency, seeks review of a decision in a contested case, then that person shall file an appeal fee equal to twenty-five percent (25%) of the examination fee for the application that was filed in the case.

68-11-1611. Review of progress — Revocation of certificate.

The agency shall, at least annually, review progress on a project covered by an issued certificate of need, and may require a showing by the holder of the certificate of substantial and timely progress to implement the project. If, in the opinion of the executive director, progress is lacking, then the executive director may present a petition for revocation of the certificate of need for the agency's consideration. The agency may revoke the certificate of need based upon a finding that the holder has not proceeded to implement the project in a timely manner.

68-11-1612. Enjoining violations — Jurisdiction.

(a) The agency, in addition to the powers and duties expressly granted by this part, is authorized and empowered to petition a circuit or chancery court having jurisdiction to enjoin a person who is performing any of the actions specified in this part without possessing a valid certificate of need.

(b) Jurisdiction is conferred upon the circuit and the chancery courts of this state to hear and determine such causes as chancery causes, and to exercise full and complete jurisdiction in such injunctive proceedings.

68-11-1613. Appropriation/expenditures impact statement.

The division of TennCare or its successor, by the fifteenth of each month, shall submit to the chairs of the finance, ways and means committees of the senate and the house of representatives and to the office of legislative budget analysis a statement reflecting the estimated impact on future state appropriations or expenditures of applications approved by the agency the preceding month.

68-11-1614. Independent review and verification of information submitted to agency.

(a) The commissioner of health shall provide the agency with aggregate data from the hospital discharge database and ambulatory surgical treatment center discharge database within seven (7) business days from the commissioner's receipt of a request. The information must include aggregate data by state, county, or zip code, as requested. The information must not include patient identifiers that would lead to a patient's identity, such as name or street address. Information received pursuant to this section must be available for public disclosure by the agency, as long as it does not contain patient identifiers.

(b) The commissioner of mental health and substance abuse services shall provide the agency with aggregate data about nonresidential substitution-based treatment centers for opiate addiction licensed in this state within seven (7) business days from the commissioner's receipt of a request. The information must include aggregate data about patient origin by state, county, or zip code, as requested, at licensee treatment centers in this state. The information must not include patient identifiers that would lead to a patient's identity, such as name or street address. Information received pursuant to this section must be available for public disclosure by the agency, as long as it does not contain patient identifiers.

(c) The commissioners of health, mental health and substance abuse services, and intellectual and developmental disabilities may submit written reports or statements and they may also send representatives to testify before the agency to inform the agency with respect to applications.

68-11-1615. Independent review and verification of information for joint annual report.

The commissioners of health, mental health and substance abuse services, and intellectual and developmental disabilities shall establish policies and procedures to ensure independent review and verification of information submitted by healthcare providers for inclusion in the joint annual report.

68-11-1616. Violations — Penalties.

(a) The agency has the power and authority, after notice and an opportunity for a hearing, to impose a civil monetary penalty against a person who performs, offers to perform, or holds such person out as performing an activity for which a certificate of need is required, without first obtaining a valid certificate of need.

(b) The executive director shall initiate a civil penalty proceeding by filing a petition with the agency. The proceeding must be conducted as a contested case hearing in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, part 3.

(c) The civil penalty is in an amount not less than one hundred dollars ($100) nor more than five hundred dollars ($500) per day of continued activity or operation. Once a civil penalty has been imposed, the violator has the burden of submitting verifiable evidence satisfactory to the agency that the violator has discontinued the activity for which the civil penalty was imposed. The penalty begins to accrue on the date the agency notified the violator of the violation or violations, and continues to accrue until such evidence of discontinuance is received at the agency office.

(d) An appeal of a final order imposing a civil penalty must be conducted in accordance with the Uniform Administrative Procedures Act.

(e) In determining whether to impose a civil penalty and the amount of the penalty, the agency may consider the following factors:

(1) The economic benefits gained from the activities in question. The agency does not have to show that the violator would not have been granted a certificate of need had one been sought;

(2) Whether the civil penalty and the amount of the penalty will be a substantial economic deterrent to the violator and others;

(3) The circumstances leading to the violation, and whether the violator had notice that the activity was in violation of the certificate of need laws or agency regulations;

(4) The financial resources of the violator, and the violator's ability to pay the penalty; and

(5) The failure to meet a quality standard applicable to the violator.

68-11-1617. Revocation of certificate of need — Grounds.

In addition to other grounds for revocation provided by other statutes, rule of law, or equity, the agency has the power to revoke a certificate of need whenever the following has occurred:

(1) The holder of a certificate of need has not made substantial and timely progress toward the completion of the project or acquisition of the equipment;

(2) The acquisition or project as described in the person's application has been changed or altered in a manner that significantly deviates from the acquisition or project approved by the agency when the certificate of need was granted;

(3) The decision to issue a certificate of need was based, in whole or in part, on information or data in the application which was false, incorrect, or misleading, whether intentional or not;

(4) The holder of the certificate of need has committed fraud in obtaining the certificate of need or has committed fraud upon the agency after the certificate of need was issued. For purposes of this section, "fraud" means a form of deceit, trickery, misrepresentation, or subterfuge, including, but not limited to, the following actions:

(A) Making a knowingly false statement, orally or in writing, in connection with a certificate of need application or project subject to the jurisdiction of the agency;

(B) Intentionally withholding or suppressing information that the person knows, or reasonably should know, is relevant to a certificate of need application or project subject to the jurisdiction of the agency; or

(C) Altering, forging, or otherwise modifying, with fraudulent intent, a document submitted to the agency in connection with a certificate of need application or project subject to the jurisdiction of the agency; or

(5) The violation of a condition placed upon a certificate of need by the agency, prior to licensure by the department of health or department of mental health and substance abuse services.

68-11-1618. Nontransferability of certificate of need.

(a) Except as provided in this section, the transfer of a certificate of need renders the certificate of need and all rights under it void. As used in this section, "transfer" means the sale, assignment, lease, conveyance, purchase, grant, donation, gift, or other direct or indirect transfer of any nature whatsoever of a certificate of need. However, this section does not prohibit the transfer of a certificate of need in the following circumstances:

(1) If the transfer has been approved by the agency after the agency determines that the new holder of the certificate of need would provide health care that meets appropriate quality standards, and that the transfer would not reduce access to consumers, particularly those in underserved communities; those who are uninsured or underinsured; women and racial and ethnic minorities; TennCare or medicaid recipients; and low-income groups; and

(2) If the certificate of need is transferred as part of the transfer of ownership of a licensed healthcare institution.

(b)

(1) With regard to a certificate of need for the establishment of a proposed new healthcare institution, a change of control of the entity prior to completion or licensing renders the certificate of need and all rights under it null and void. "Change of control" means:

(A) In the case of a partnership, the termination of interest of a general partner;

(B) In the case of a limited liability company or limited liability partnership, a change in the composition of members or partners to the extent that the management or membership control is different than that described in the certificate of need application; and

(C) In the case of a corporation, the termination of interest of a shareholder or shareholders controlling more than fifty percent (50%) of the outstanding voting stock of the corporation.

(2) Subdivision (b)(1) does not prohibit change of control as described in subdivision (b)(1), if the agency determines, upon petition of the prospective owner or owners of the entity, that the prospective owner or owners demonstrate that they meet the criteria of economic feasibility, contribution of orderly development, and the considerations of § 68-11-1605.

(c) A certificate of need, and the rights under the certificate of need, are null and void if it is the subject of a development contract or agreement to sell or lease the facility that was not fully disclosed in the application.

68-11-1619. Application for medicare skilled nursing facility (SNF) beds.

(a) During each fiscal year after June 30, 2016, until June 30, 2021, the agency shall not issue certificates of need for new nursing home beds, including the conversion

of hospital beds to nursing home beds or swing beds, other than one hundred twenty-five (125) beds per fiscal year, to be certified as medicare skilled nursing facility (SNF) beds as authorized in this section.

(b) The number of medicare SNF beds issued under this section shall not exceed thirty (30) for each applicant. The applicant shall specify in the application the skilled services to be provided and how the applicant intends to provide the skilled services. In reviewing applications, the agency shall consider the application without regard as to whether the applicant currently has medicare SNF beds. If the pool of one hundred twenty-five (125) medicare SNF beds created by this section is not depleted prior to June 30 of the fiscal year, then the beds remaining in the pool must be considered to be available to applicants who apply before June 30 of each fiscal year, even though review may occur after June 30 of that year.

68-11-1620. Account for disposition of fees — Budget.

(a) Fees and civil penalties authorized by this part must be paid by the health services and development agency or the collecting agency to the state treasurer and deposited in the state general fund and credited to a separate account for the agency. Fees include, but are not limited to, fees for the application of certificates of need, subscriptions, project cost overruns, copying, and contested cases. Disbursements from that account may only be made for the purpose of defraying expenses incurred in the implementation and enforcement of this part by the agency. Funds remaining in the account at the end of a fiscal year do not revert to the general fund but remain available for expenditure in accordance with law.

(b) The agency shall prescribe fees by rule as authorized by this part. The fees must be in an amount that, in addition to the fees prescribed in subsection (c), provides for the cost of administering the implementation and enforcement of this part by the agency. The agency shall adjust the prescribed fees as necessary to provide that the

account is fiscally self-sufficient and that revenues from fees do not exceed necessary and required expenditures.

(c) The agency shall annually collect the following schedule of fees from healthcare providers, and the fees must be paid to the state treasurer and deposited in the state general fund and credited to the agency's separate account. The following schedule applies:

(1) Residential hospice ..... $100 per license;

(2) Nursing homes 1-50 beds ..... $500 per license;

(3) Nursing homes 51-100 beds ..... $1,500 per license;

(4) Nursing homes 101+ beds ..... $2,500 per license;

(5) Hospitals 1-100 beds ..... $2,000 per license;

(6) Hospitals 101-200 beds ..... $3,500 per license;

(7) Hospitals 201+ beds ..... $5,000 per license;

(8) Ambulatory surgical treatment centers ..... $2,000 per license;

(9) Outpatient diagnostic centers ..... $2,000 per license;

(10) Home care organizations authorized to provide home health services or hospice services ..... $500 per license;

(11) Birthing Centers..... $50 per license;

(12) Nonresidential substitution-based treatment centers for opiate addiction ..... $500 per license;

(13) Mental health residential treatment facilities..... $100 per license;

(14) Intellectual disability institutional habilitation facilities ..... $100 per license.

68-11-1621. Participation by local governing body in hearing for certificate of need application.

At a hearing conducted by the agency for a certificate of need application, if a local governing body requests to participate in the hearing, then the officials of the local

governing body may appear before the agency and express support or opposition to the granting of a certificate of need to the applicant. The testimony of such officials is informational and advisory to the agency, and the support of the local governing body is not a requirement for the granting of a certificate of need by the agency.

68-11-1622. State health planning division of the department of health.

(a) There is created the state health planning division of the department of health. It is the purpose of the planning division to create a state health plan that is evaluated and updated at least annually. The plan guides the state in the development of healthcare programs and policies and in the allocation of healthcare resources in this state.

(b) It is the policy of this state that:

(1) Every citizen should have reasonable access to emergency and primary care;

(2) The state's healthcare resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's healthcare industry;

(3) Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by healthcare providers; and

(4) The state should support the recruitment and retention of a sufficient and quality healthcare workforce.

(c) The planning division is administratively staffed by the department of health in a manner that the department deems necessary for the performance of the planning division's duties and responsibilities, which may include contracting for the services provided by the division through a private person or entity.

(d) The duties and responsibilities of the planning division include:

(1) To develop and adopt a state health plan, which must include, at a minimum, guidance regarding allocation of this state's healthcare resources;

(2) To submit the state health plan to the governor for approval and adoption;

(3) To hold public hearings as needed;

(4) To review and evaluate the plan at least annually;

(5) To respond to requests for comment and recommendations for healthcare policies and programs;

(6) To conduct an ongoing evaluation of this state's resources for accessibility, including, but not limited to, financial, geographic, cultural, and quality of care;

(7) To review the health status of Tennesseans as presented annually to the planning division by the department of health, the department of mental health and substance abuse services, and the department of intellectual and developmental disabilities;

(8) To review and comment on federal laws and regulations that influence the healthcare industry and the healthcare needs of Tennesseans;

(9) To involve and coordinate functions with state entities as necessary to ensure the coordination of state health policies and programs in this state;

(10) To prepare an annual report for the general assembly and recommend legislation for their consideration and study; and

(11) To establish a process for timely modification of the state health plan in response to changes in technology, reimbursement, and other developments that affect the delivery of health care.

68-11-1623. Replacement facility applications — Certificates of need for nursing home beds.

(a) A replacement facility application is an application that proposes to replace one (1) or more currently licensed nursing homes with one (1) single licensed nursing home.

(b) An application or portion of a replacement facility application that does not increase the number of licensed beds over the number of beds in the existing facility or facilities being replaced must be reviewed by the department and considered by the agency pursuant to the criteria in § 68-11-1609(b), and shall not be considered new nursing home beds. In reviewing the application, the agency shall give preference to projects that propose replacement facilities because of building or life safety standard issues. The criteria of § 68-11-1619 do not apply to replacement facility applications.

(c) If a replacement facility application seeks to increase the number of licensed beds over the number of beds in the existing facility or facilities being replaced, then that portion of the application that increases the number of beds must comply with § 68-11-1619, and is considered new nursing home beds. The remaining part of the application relative to the replacement of the facility or facilities must be reviewed by the department and considered under the criteria set out in subsection (b). In reviewing such an application, the agency shall give preference to projects that propose replacement facilities because of building or life safety standard issues.

(d) With regard to a certificate of need to replace a nursing home that has ceased operations, the original facility is not required to maintain its license after the certificate of need has been approved for the replacement facility.

68-11-1624. Delegation of authority to the department to issue new license to successor owner.

With regard to a healthcare facility that has been the subject of a change of control as defined by regulation, the board for licensing health care facilities in its discretion may delegate to the department the authority to issue a new license to the successor owner. The delegation of this authority is limited to circumstances where:

(1) The successor owner meets the qualifications for a license;

(2) The healthcare facility has no outstanding license or certification deficiencies; and

(3) The successor owner already owns or controls at least one (1) other healthcare facility in this state.

68-11-1625. Development of measures for assessing quality of entities receiving certificate of need — Failure to meet quality measures — Penalties.

(a) In consultation with the department of health, the department of mental health and substance abuse services, and the department of intellectual and developmental disabilities, and subject to § 68-11-1609(h), the agency shall develop by rule measures for assessing quality for entities that, on or after July 1, 2016, receive a certificate of need under this part. In developing quality measures, the agency may seek the advice of stakeholders with respect to certificates of need for specific institutions or services.

(b) If the agency determines that an entity has failed to meet the quality measures developed under this section, then the agency shall refer that finding to the board for licensing health care facilities or the department of mental health and substance abuse services, whichever is appropriate, for appropriate action on the license of the entity under part 2 of this chapter.

(c) If the agency determines that an entity has failed to meet a quality measure imposed as a condition for a certificate of need by the agency, then the agency may impose penalties pursuant to § 68-11-1616 or revoke a certificate of need pursuant to § 68-11-1617.

68-11-1626. Relocation of nursing home beds.

(a)

(1) An existing licensed and operating nursing home may relocate sixty-two (62) or fewer of its licensed beds to a new, separately licensed nursing home if the following conditions are satisfied:

(A) The proposed location for the partial relocation of beds is within the same county as the original facility;

(B) Both the original licensed facility and the new separately licensed facility will be licensed to nonprofit corporations, and are affiliated through common ownership or management;

(C) The original facility is located on a campus of not more than five (5) acres;

(D) The original facility is not less than forty (40) years old and is licensed for not less than two hundred (200) nor more than two hundred twenty-five (225) nursing home beds by the department of health; and

(E) A certificate of need application for the relocation of the beds is filed with and approved by the health services and development agency pursuant to this part.

(2) Subdivision (a)(1) does not affect a certificate of need application filed before July 1, 2019.

(b) Beds relocated to a new location must initially have the same medicaid certification status that the original, existing nursing home relocating its beds maintains when the certificate of need is granted allowing the movement of beds.

(c) A certificate of need application for the partial relocation of nursing home beds provided for in this section that seeks to increase the number of licensed beds above the licensed bed capacity of the existing nursing home must be reviewed by the department and considered by the health services and development agency pursuant to § 68-11-1609(b), and is not considered an application for new nursing home beds under the criteria in § 68-11-1619.

(d) Notwithstanding subsection (c), if an application for a certificate of need for the partial relocation of nursing home beds provided for in this section seeks to increase the number of licensed beds above the licensed bed capacity of the existing nursing home, then that portion of the application that increases the number of beds must comply with § 68-11-1619, and is considered an application for new nursing home beds.

The remaining part of the application relative to the qualified divided relocation must be reviewed by the department and considered by the health services and development agency pursuant to § 68-11-1609(b), and is not considered an application for new nursing home beds.

68-11-1627. Renewal of license for closed hospitals in rural or distressed counties.

(a) Notwithstanding this part, a certificate of need is not required for the establishment of a hospital licensed under this title if:

(1) The hospital was previously licensed under this title or another hospital was previously licensed under this title at the proposed location;

(2) The hospital is located in a county:

(A) Designated by the department of economic and community development as a tier 2, tier 3, or tier 4 enhancement county pursuant to § 67-4-2109; or

(B) With a population less than forty-nine thousand (49,000), according to the 2010 federal census or a subsequent census;

(3) The last date of operations at the hospital, the hospital site service area, or proposed hospital site service area was no more than fifteen (15) years prior to the date on which the party seeking to establish the hospital submits information to the department pursuant to subsection (b); and

(4) The party seeking to establish the hospital applies for a certificate of need from the agency within twelve (12) months of the date on which the party submits information to the department pursuant to subsection (b).

(b)

(1) Notwithstanding this part, the department may renew a license for a hospital meeting the criteria in subdivisions (a)(1)-(3) upon application by the party seeking to establish the hospital and finding that the hospital will operate in

a manner that is substantially similar to the manner authorized under the previous hospital's license at the time of the previous hospital's closure.

(2) The department shall review and make a determination on an application submitted pursuant to subdivision (b)(1) and notify the applicant in writing of the determination within sixty (60) days of the date the applicant submits a completed application to the department. If the department determination is to deny the application, then the department must also provide to the applicant a written explanation detailing the reasons for the denial.

SECTION 2. Tennessee Code Annotated, Section 4-29-242(a)(28), is amended by deleting the subdivision.

SECTION 3. Tennessee Code Annotated, Section 4-29-244(a)(1), is amended by deleting the subdivision.

SECTION 4. Tennessee Code Annotated, Section 4-29-245(a), is amended by adding the following as new subdivisions:

( ) Board for licensing health care facilities, created by § 68-11-203;

( ) Health services and development agency, created by § 68-11-1604;

SECTION 5. The headings to sections in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 6. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #2

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 1281 **House Bill No. 948***

by deleting § 68-11-1607(j) in SECTION 1 and substituting:

(j)

(1) Notwithstanding subdivision (a)(2)(A) or (a)(4), a nursing home may increase its total number of licensed beds by the lesser of ten (10) beds or ten percent (10%) of its licensed capacity no more frequently than one (1) time every three (3) years without obtaining a certificate of need. The nursing home shall provide written notice of the increase in beds to the agency on forms provided by the agency prior to the request for licensing by the board for licensing health care facilities.

(2) For new nursing homes, the ten-bed or ten-percent increase cannot be requested until one (1) year after the date all of the new beds were initially licensed.

(3) When determining projected county nursing home bed need for certificate of need applications, all notices filed with the agency pursuant to subdivision (j)(1), with written confirmation from the board for licensing health care facilities that a request and application for license has been received and a review has been scheduled, must be considered with the total of licensed nursing home beds, plus the number of beds from approved certificates of need, but yet unlicensed.

House Health Subcommittee Am. #1

Amendment No._____

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Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 484 **House Bill No. 582***

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 63-1-164(f), is amended by designating the existing language as subdivision (1) and adding the following as a new subdivision:

(2) The commissioner shall include as part of the report required by subdivision (f)(1) an analysis of the impact of the COVID-19 pandemic on the following:

(A) The lawful, prescribed usage of opioids in this state;

(B) The unlawful diversion of opioids in this state;

(C) The ability of the department to collect data to determine the impacts and effects of the restrictions and limitations established by this section; and

(D) Whether the impacts and effects that were sought to be achieved through the implementation of the restrictions and limitations of this section are achievable by July 1, 2023.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 702* **House Bill No. 1284**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 63-5-111(a), is amended by deleting subdivision (2) and substituting:

(2) The examination may be written or oral, or both; shall include subjects as may be designated by the board; and may also include practical tests, working operations, and demonstrations, within the discretion of the board. An examination may be conducted on a live human patient or a non-patient-based model may be used.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 221* **House Bill No. 370**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 1, Part 2, is amended by adding the following as a new section:

Within five (5) business days of quarantine and disease communication tracking procedures being implemented in response to a state of emergency declared under § 58-2-107 due to a disease outbreak, epidemic, or pandemic, and weekly thereafter until the state of emergency is no longer effective, each county health department shall publish on the department of health website the following information as obtained from each county health department and obtained from communicable disease reporting:

(1) Total tests administered for the disease outbreak, epidemic, or pandemic;

(2) Total positive tests;

(3) Types of tests used;

(4) Number of cases of the disease outbreak, epidemic, or pandemic detected with each type of test;

(5) Number of asymptomatic cases; and

(6) Number of symptomatic cases.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it, and applies to a state of emergency declared or extended on or after that date.

House Health Subcommittee Am. #1

Amendment No._____

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Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 665* **House Bill No. 920**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 63-17-201(8), is amended by deleting the subdivision and substituting:

(8) "Practice of dispensing and fitting hearing instruments" includes:

(A) The evaluation or measurement of the powers or range of human hearing by means of an audiometer for the consequent selection or adaptation for sale of hearing instruments intended to compensate for hearing loss, and the appropriate instructions, consultations, suggestions, recommendations, or opinions related to this practice;

(B) Making an impression of the ear, or an ear mold; and

(C) Cerumen management in the course of examining ears by a person who holds a certification of completion of a cerumen management course, as described in § 63-17-224; and

SECTION 2. Tennessee Code Annotated, Section 63-17-201, is amended by adding the following as new subdivisions:

( ) "Cerumen" means a wax like secretion from glands in the external auditory canal;

( ) "Otolaryngologist" means a physician specialist dedicated to the care of patients with disorders of the ears, nose, throat and related structures of the head and neck, commonly referred to as ENTs;

SECTION 3. Tennessee Code Annotated, Title 63, Chapter 17, Part 2, is amended by adding the following as a new section:

63-17-223. Cerumen management.

A licensed hearing instrument specialist shall comply with the following cerumen management principles:

(1) The indications for cerumen management for a licensed hearing instrument specialist include:

(A) Enabling audiometric testing;

(B) Making ear impressions;

(C) Fitting hearing protection or prosthetic devices; and

(D) Monitoring continuous use of hearing aids;

(2) The licensed hearing instrument specialist shall refer a patient who exhibits any of the following contraindications to cerumen removal for medical consultation or medical intervention to an otolaryngologist or a licensed physician:

(A) An age less than twelve (12) years of age;

(B) A perforated tympanic membrane;

(C) History of pain, active drainage, or bleeding from the ear;

(D) Evidence of congenital or traumatic deformity of the ear;

(E) Ear surgery within the last six (6) months;

(F) Tympanostomy tubes, such that irrigation should not be used;

(G) A bleeding disorder;

(H) Actual or suspected foreign body in the ear;

(I) Stenosis or bony exostosis of the ear canal;

(J) Cerumen impaction that totally occludes the ear canal;

(K) Cerumen located medial to the cartilaginous external auditory canal; or

(L) A tympanic membrane that the licensee is unable to see;

(3) In performing cerumen removal, a licensed hearing instrument specialist shall only remove cerumen lateral to the external auditory canal using the following instruments:

(A) Cerumen loop;

(B) Cerumenolytic liquid;

(C) Irrigation, for patients with intact tympanic membranes and a closed mastoid cavity, no tympanostomy tubes, no recent ear surgery, and no recent dizziness; or

(D) Suction used lateral to the bony canal, only for patients with no recent surgery, intact tympanic membranes and no clear otorrhea;

(4) If the patient, while undergoing cerumen management that did not present contraindications, complains of significant pain, exhibits uncontrolled bleeding or a laceration of the external auditory canal, or notices the acute onset of dizziness or vertigo or sudden hearing loss, then the licensed hearing instrument specialist shall immediately stop the procedure and refer the patient to an otolaryngologist or a licensed physician;

(5) The licensed hearing instrument specialist shall maintain the following proper infection control practices:

(A) Universal health precautions;

(B) Decontamination;

(C) Cleaning, disinfection, and sterilization of multiple use equipment; and

(D) Universal precautions for prevention of the transmission of human immunodeficiency virus (HIV), hepatitis B virus, and other bloodborne pathogens, as defined by occupational safety and health standards promulgated pursuant to 29 CFR 1910;

(6) The licensed hearing instrument specialist who performs cerumen management shall maintain a case history for every patient and informed consent signed by the patient as part of the patient's records;

(7) The licensed hearing instrument specialist shall carry appropriate professional liability insurance before performing cerumen removal; and

(8) The licensed hearing instrument specialist is prohibited from requiring patients to sign any form that eliminates liability if patient is harmed.

SECTION 4. Tennessee Code Annotated, Title 63, Chapter 17, Part 2, is amended by adding the following as a new section:

63-17-224. Cerumen management course.

(a) A licensed hearing instrument specialist who engages in cerumen management under § 63-17-223, must have completed a cerumen management course approved by the International Hearing Society, the American Academy of Otolaryngology-Head and Neck Surgery, or another organization approved by the board. The course must:

(1) Be overseen by a physician, preferably an otolaryngologist;

(2) Consist of at least six (6) hours of a participant practicing removing cerumen from an ear canal model using a variety of safe techniques; and

(3) Result in a certificate of completion and attestation of competence signed by the overseeing physician.

(b) The board is authorized to promulgate rules to effectuate the requirements of the course outlined in this section only after consultation with the board of medical examiners established at § 63-6-101. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 5. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 6. For rule promulgation purposes, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect July 1, 2021, the public welfare requiring it, and applies to a licensed hearing instrument specialist engaging in cerumen management on or after that date.

House Health Subcommittee Am. #1

Amendment No._____

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Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 1392 **House Bill No. 577***

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 49-6-1304(b)(4), is amended by deleting the subdivision and substituting:

(4) Distribute contraception on school property; provided, however, that medically accurate information about contraception and condoms that is consistent with public policy may be provided so long as the information is:

(A) Presented in a manner consistent with this part and that clearly informs students that while such methods may reduce the risk of acquiring sexually transmitted diseases or becoming pregnant, only abstinence removes all risk;

(B) Reviewed and approved by the local board of education or charter school governing body, prior to the information being used by the LEA or public charter school in a family life curriculum, to ensure that it is:

(i) Medically accurate;

(ii) Age appropriate;

(iii) In compliance with this part; and

(iv) Aligned to academic standards in this state; and

(C) Provided, upon request, to a parent of a student attending a school in the LEA or charter school, to allow the parent to review the information and to opt the parent's student out of receiving the information as part of a family life curriculum, without penalty.

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SECTION 2. This act takes effect July 1, 2021, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
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Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 858 **House Bill No. 575***

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Section 68-2-601, is amended by deleting subdivisions (f)(2) and (f)(3) and substituting:

(2) Advise the county mayor on the enforcement of such rules and regulations as may be prescribed by the commissioner essential to the control of preventable diseases and the promotion and maintenance of the general health of the county;

(3) Advise the county mayor on the adoption of rules and regulations as may be necessary or appropriate to protect the general health and safety of the citizens of the county; and

SECTION 2. Tennessee Code Annotated, Section 68-2-603(a)(2), is amended by deleting the language "and the county board of health".

SECTION 3. Tennessee Code Annotated, Section 68-2-603(b), is amended by deleting the subsection and substituting:

(b) It is the county health director's duty to enforce the regulations of the state department of health.

SECTION 4. Tennessee Code Annotated, Section 68-2-609, is amended by adding the following as a new subdivision:

(4) Rules and regulations as are necessary or appropriate to protect the general health and safety of the county.

SECTION 5. Tennessee Code Annotated, Section 68-1-201, is amended by adding the following as a new subsection (c):

(c) As used in this part, "quarantine" means the limitation of a person's freedom of movement, isolation of a person, or preventing or restricting access to premises upon which the person or the cause or source of a disease may be found, for a period of time as may be necessary to confirm or establish a diagnosis, to determine the cause or source of a disease, or to prevent the spread of a disease.

SECTION 6. Tennessee Code Annotated, Title 68, Chapter 5, Part 1, is amended by adding the following as a new section:

(a) A state or local governmental official, entity, department, or agency shall not require, or mandate that a private business require, proof of vaccination against COVID-19 as a condition of entering upon the premises of the business or utilizing services provided by the business.

(b) As used in this section:

(1) "Private business" means a person, proprietor, partnership, corporation, or other non-governmental entity, whether for profit or not for profit, engaged in business, commerce, or an activity in this state; and

(2) "Proof of vaccination" means physical documentation or digital storage of protected health information related to an individual's immunization or vaccination against COVID-19.

SECTION 7. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

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Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 126* **House Bill No. 1027**

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 63, Chapter 1, Part 1, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Healthcare prescriber" means an individual licensed under this title and authorized to prescribe medications;

(2) "Minor" means a person who is less than eighteen (18) years of age; and

(3) "Prepubertal minor" means a minor in Tanner stage 1 development.

(b) Standard medical practice does not involve prescribing hormone treatment for gender dysphoric or gender incongruent prepubertal minors. Except as provided in subsection (c), a healthcare prescriber shall not prescribe a course of treatment that involves hormone treatment for gender dysphoric or gender incongruent prepubertal minors.

(c) A healthcare prescriber may prescribe a course of treatment that involves hormone treatments for prepubertal minors for diagnoses of growth deficiencies or other diagnoses unrelated to gender dysphoria or gender incongruency.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED	
Date	_____
Time	_____
Clerk	_____
Comm. Amdt.	_____

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Signature of Sponsor

AMEND Senate Bill No. 212* **House Bill No. 1045**

by deleting all language following the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 63, Chapter 1, Part 1, is amended by adding the following new section:

(a) Notwithstanding any law, if the licensing authority of a healthcare prescriber learns that the healthcare prescriber is the subject of an indictment for a federal or state criminal offense that involves a controlled substance violation or sexual offense, then the chair of the licensing authority or administrative staff of the licensing authority designated by the chair shall immediately restrict the license of the healthcare prescriber by removing the prescriber's authorization to prescribe controlled substances in this state until the case against the healthcare prescriber reaches final disposition. The chair of the licensing authority or administrative staff of the licensing authority designated by the chair shall immediately send written notice of the license restriction to the healthcare prescriber. Upon receipt of sufficient proof, the chair of the licensing authority or administrative staff of the licensing authority designated by the chair shall remove the license restriction if:

(1) The healthcare prescriber is acquitted by a verdict of the jury upon the merits; or

(2) The prosecution is dismissed, or a nolle prosequi is entered by the prosecuting authority.

(b) Notwithstanding any law, if the licensing authority of a healthcare prescriber learns that the healthcare prescriber is convicted of a federal or state criminal offense

that involves a controlled substance violation or sexual offense, then the chair of the licensing authority or administrative staff of the licensing authority designated by the chair shall automatically and immediately, without further action by the licensing authority, revoke the license of the healthcare prescriber. The chair of the licensing authority or administrative staff of the licensing authority designated by the chair shall immediately send written notice of the license revocation to the healthcare prescriber. If the conviction on which the revocation is based is subsequently overturned or reversed, then the chair of the licensing authority or administrative staff of the licensing authority designated by the chair shall:

(1) Grant the prescriber a new license if the prescriber otherwise satisfies the qualifications for licensure under this title and the criminal charges against the prescriber involving a controlled substance violation or sexual offense have reached final disposition; or

(2) Grant the prescriber a new license subject to the restriction described in subsection (a) if the prescriber otherwise satisfies the qualifications for licensure under this title, but the criminal charges against the prescriber involving a controlled substance violation or sexual offense have not reached final disposition.

(c)

(1) Failure by a person licensed under and required by chapter 7 or 19 of this title to collaborate with a physician for any act within the person's licensed scope of practice constitutes a threat to the public health, safety, and welfare and imperatively requires emergency action by the person's licensing authority.

(2) Notwithstanding any law, if the licensing authority of a person licensed under and required by chapter 7 or 19 of this title to collaborate with a physician for any act within the person's licensed scope of practice learns that the person has failed to comply with the collaboration requirement, then the chair

of the licensing authority, or the chair's designee, shall direct the administrative staff to automatically and immediately, without further action of the licensing authority, suspend the license of the person until the licensing authority receives sufficient proof that the person is in compliance with the collaboration requirements of this title.

SECTION 2. Tennessee Code Annotated, Title 63, Chapter 7, Part 1, is amended by adding the following new section:

(a)

(1) Failure by a person licensed under and required by this chapter to collaborate with a physician for any act within the person's licensed scope of practice constitutes a threat to the public health, safety, and welfare and imperatively requires emergency action by the board.

(2) Notwithstanding any law, if the board learns that a person licensed under this chapter and subject to a requirement to collaborate with a physician for any act within the person's licensed scope of practice has failed to comply with the collaboration requirement, then the board chair, or the chair's designee, shall direct the administrative staff to automatically and immediately, without further action by the board, suspend the person's license until the board receives sufficient proof that the person is in compliance with the collaboration requirements of this chapter.

(3) The licensure sanction authorized by this subsection (a) is supplementary to, and does not limit, the authority of the board to take other disciplinary action against a licensee the board determines to be in violation of this chapter.

(b) If a healthcare prescriber licensed under this chapter is the subject of a disciplinary action by the board for conduct related to improper prescribing or diversion of a controlled substance, but retains an active license with prescribing authority

following the disciplinary action, then the healthcare prescriber shall not prescribe a controlled substance in this state unless the healthcare prescriber is working in collaboration with a physician who is physically present at the same practice site and licensed to prescribe controlled substances in this state. The board shall determine the period of time that a healthcare prescriber is subject to the on-site supervision requirement of this subsection (b), which must not be less than two (2) years.

SECTION 3. Tennessee Code Annotated, Title 63, Chapter 19, Part 1, is amended by adding the following new section:

(a)

(1) Failure by a person licensed under and required by this chapter to collaborate with a physician for any act within the person's licensed scope of practice constitutes a threat to the public health, safety, and welfare and imperatively requires emergency action by the board.

(2) Notwithstanding any law, if the board learns that a person licensed under this chapter and subject to a requirement to collaborate with a physician for any act within the person's licensed scope of practice has failed to comply with the collaboration requirement, then the board chair shall direct the administrative staff to automatically and immediately, without further action by the board, suspend the person's license until the board receives sufficient proof that the person is in compliance with the collaboration requirements of this chapter.

(3) The licensure sanction authorized by this subsection (a) is supplementary to, and does not limit, the authority of the board to take other disciplinary action against a licensee the board determines to be in violation of this chapter.

(b) If a healthcare prescriber licensed under this chapter is the subject of a disciplinary action by the board for conduct related to improper prescribing or diversion of a controlled substance, but retains an active license with prescribing authority

following the disciplinary action, then the healthcare prescriber shall not prescribe a controlled substance in this state unless the healthcare prescriber is working in collaboration with a physician who is physically present at the same practice site and licensed to prescribe controlled substances in this state. The board shall determine the period of time that a healthcare prescriber is subject to the on-site supervision requirement of this subsection (b), which must not be less than two (2) years.

SECTION 4. Tennessee Code Annotated, Section 4-5-322(h)(5), is amended by deleting the subdivision and substituting the following:

(5)

(A)

(i) Except as provided in subdivision (h)(5)(B), unsupported by evidence that is both substantial and material in the light of the entire record;

(ii) In determining the substantiality of evidence, the court shall take into account whatever in the record fairly detracts from its weight, but the court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact;

(B)

(i) Unsupported by a preponderance of the evidence in light of the entire record, if the administrative findings, inferences, conclusions, or decisions were made by a board, council, committee, agency, or regulatory program created pursuant to chapters 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31 of title 63;

(ii) In determining whether the administrative findings, inferences, conclusions, or decisions are supported by a preponderance of the evidence, the court shall take into account whatever in the record fairly

detracts from its weight, but the court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact.

SECTION 5. Tennessee Code Annotated, Section 68-11-218, is amended by deleting the section and substituting the following:

(a) The chief administrative official of each hospital or other facility shall report to the respective licensing board, committee, council, or agency the following:

(1) Any disciplinary action taken concerning any person licensed under title 63 or this title, when the action is related to professional ethics, professional incompetence, negligence, moral turpitude, or drug or alcohol abuse; and

(2) Any information that the chief administrative official reasonably believes indicates that a person licensed under title 63 or this title has been referred to or participated in a professional assistance program on two (2) or more separate occasions because the person:

(A) Inappropriately prescribed an opioid;

(B) Diverted an opioid;

(C) Engaged in sexual activity with a patient; or

(D) Has a mental or physical impairment that prevents the person from safely practicing the licensed profession.

(b)

(1) A report to a licensing board, committee, council, or agency made pursuant to subdivision (a)(1) must be in writing and must be made within sixty (60) days of the date of a disciplinary action described in subdivision (a)(1).

(2) A report to a licensing board, committee, council, or agency made pursuant to subdivision (a)(2) must be in writing, must be made on or before January 31 of each year, and must cover any referrals occurring during the previous calendar year.

(c) For purposes of this section, "disciplinary action" includes termination, suspension, reduction, or resignation of hospital privileges for any of the reasons listed in subsection (a).

(d) Notwithstanding § 63-1-150, § 63-6-228, or any other provision to the contrary, the hospital or facility shall make available to the respective licensing board, committee, council, or agency, for examination all records pertaining to a disciplinary action described in subdivision (a)(1).

(e) Any individual who, as a member of any committee, an employee, or a contractor of any hospital or facility, files a report pursuant to this section, is immune from liability to the extent provided in § 63-1-150.

SECTION 6. This act takes effect upon becoming a law, the public welfare requiring it, and applies to disciplinary actions taken or information first received on or after the effective date of this act.

House Health Subcommittee Am. #2

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

_____

Signature of Sponsor

AMEND Senate Bill No. 212* **House Bill No. 1045**

by deleting "to prescribe controlled substances" in subsection (a) in Section 1 and substituting instead "to prescribe Schedule II controlled substances".