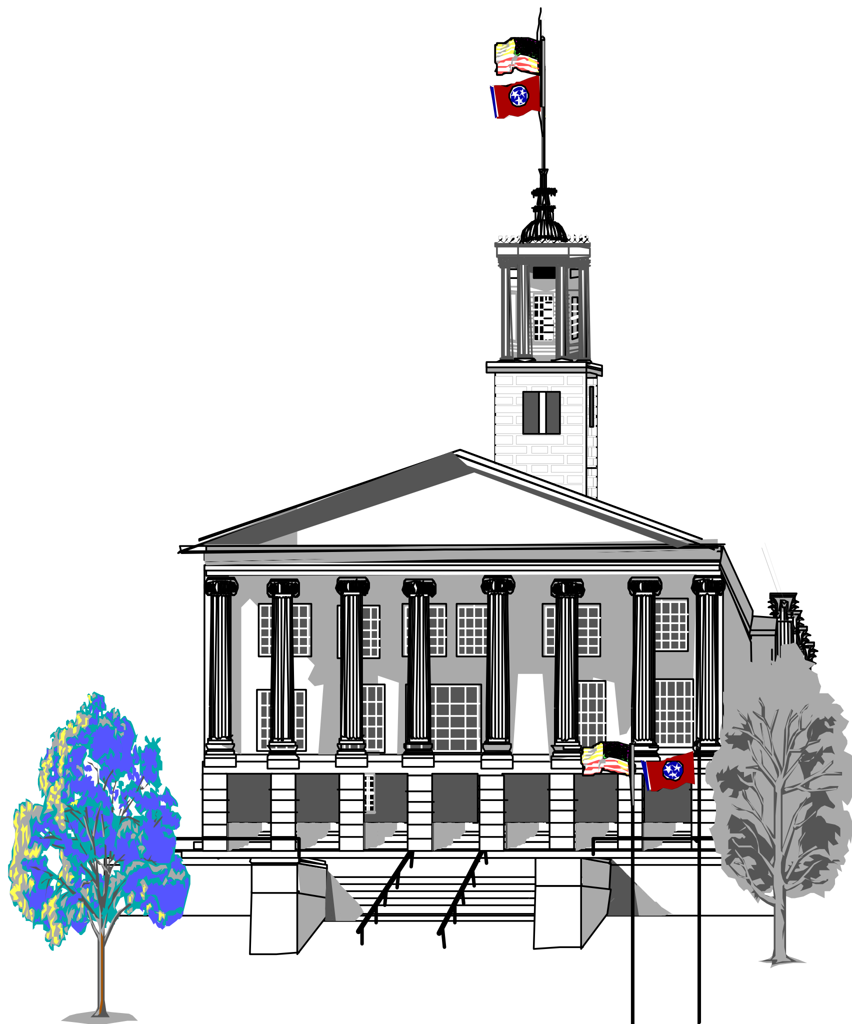
2009 LEGISLATIVE SUMMARY

TENNESSEE GENERAL ASSEMBLY



July 31, 2009

Dear THA Member:

The 2009 legislative session proved to be one full of changes. For the first time in 150 years, a Republican was elected as the Speaker of the House. In his first term, Speaker Kent Williams rearranged the House committee structure, which made it particularly difficult to predict the outcome of legislation at the committee level. Looming over the entire session was the drastically declining shortfall in state revenues. This made securing funding for TennCare and mental health services a session-long challenge for THA.

Despite this session's hurdles, THA was victorious in its top two priorities: preserving the certificate of need process and continuing full funding for TennCare.

- THA successfully extended the Health Services and Development Agency (HSDA) for four more years. The HSDA was scheduled to terminate on June 30, 2009 and go into a one-year wind down period.
- With the help of the federal stimulus dollars, THA was successful in securing full funding for TennCare for FY 2009/2010. Next year, all cuts are back on the table, but for now, the funding is intact.

THA staff thanks you for your active support and strong relationships that ensured success for our top legislative priorities.

Legislative wins are realized not only by passing bills, but also in stopping them. THA defeated numerous bills proposing reporting procedures and processes that, if implemented, would have cost hospitals significant amounts of money.

A detailed review of this year's legislation is provided below. It is important to remember that the Tennessee General Assembly is structured on a two-year cycle. Legislation that did not pass this year always can be resurrected next year.

If you have any questions, please contact us.

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BUDGET

Appropriations Bill for FY 2009-2010—Public Chapter 554 (Effective 7/1/2009)

Mental Health Statute Changes and HMO Tax—Public Chapter 53 (Effective 4/9/2009)

The General Assembly closed its 2009 session by passing a $29.6 billion budget for FY 2009/2010. Because of shortfalls in state revenues, over one billion state dollars had to be cut from the current budget, leaving funding for TennCare and mental health services particularly vulnerable. The infusion of dollars from the federal economic stimulus package was critical to the state's ability to mitigate the devastating cuts that would have been required without it.

With the support of the leadership in the House and Senate, as well as other key legislators, THA was successful in limiting the impact of cuts on hospitals in several key areas, including:

- Continued funding of the $100 million for essential access hospital payments (EAH);
- Continued funding of the current TennCare provider rates;
- Continued funding of the $25 million charity pool to be utilized for safety net and federal disproportionate share hospital (DSH) funding; and
- Continued funding of the $5 million for critical access hospitals (CAHs).

Other restorations to the original administration budget proposal include:

- Additional dollars for the community portion of the mental health safety net in the amount of $10 million, plus an additional $5 million for community-based grants; and
- Dollars to continue making payments for inpatient psychiatric services for uninsured committed patients in upper east Tennessee.

It became clear during budget negotiations that legislators were very concerned that revenues in the coming year would continue to fall below projections and additional cuts would be necessary. As part of the final agreement, the governor was given broad authority to implement additional reductions of $55 million if projections are not met. On behalf of THA, Lieutenant Governor Ron Ramsey received a commitment from the administration that EAH payments would be protected should additional reductions become necessary.

Because a large portion of funding for TennCare, as well as other critical services, was funded on a non-recurring basis, hospitals will be facing significant reductions once again in the FY 2010/2011 budget.

Suitable Accommodations

In addition to the bed reductions that will be occurring during this fiscal year at the regional mental health institutes (RMHIs), the Tennessee Department of Mental Health and Developmental Disabilities was successful in passing language making all admissions to the RMHIs subject to the availability of suitable accommodations. Under the provisions, transportation to an RMHI cannot occur without written verification that an appropriate bed is available.

Although concerns were raised by THA and other mental health providers, the department was able to convince legislators that the number of beds could not be reduced without this provision and would, therefore, require an additional appropriation of approximately $11 million. The department has drafted a policy outlining the referral process to be used until final rules are issued.

Trauma Funding

Language was passed that could allow the state to receive federal matching dollars for the trauma funds generated through the 2-cent tobacco tax. Tennessee is waiting on the Centers for Medicare and Medicaid Services (CMS) to make that determination.

CERTIFICATE OF NEED

Extension of the Health Services and Development Agency—Public Chapter 245 (Effective 5/20/2009)

License Transfer Approval/CON Threshold for Major Medical Equipment—Public Chapter 323 (Effective 7/1/2009)

With a tremendous grassroots campaign, THA successfully passed legislation to extend the life of the Health Services and Development Agency (HSDA) for four years and effectively continued the certificate of need (CON) process in Tennessee. The HSDA was scheduled to terminate on June 30, 2009, and go into a one-year wind down period. THA's number one priority this legislative session was preserving the CON process. Public Chapter 245 went into effect on May 20, 2009, and extends the HSDA to June 30, 2013 (four more years).

All bills containing sunset provisions (provisions in the law that terminate a portion of the law on a certain date) for state agencies are assigned to the Government Operations Committees. Rep. Susan Lynn (R-Lebanon) is the chair of the House Government Operations Committee and an outspoken CON opponent. THA successfully maneuvered around such obstacles by enlisting the help of legislative leadership. Lieutenant Governor Ron Ramsey and House Majority Leader Jason Mumpower helped greatly by applying the necessary pressure to ensure that the HSDA extension bill passed out of the Government Operations Committees. Their leadership, coupled with calls from THA members, solidified the successful passage of the bill.

Extending the HSDA for four years came with a price. As part of the agreement to extend the HSDA, THA supported an amendment to increase the threshold for purchasing major medical equipment without a CON from $1.5 million to $2 million. This amendment was added to a THA bill that allows the state Board for Licensing Health Care Facilities to delegate to Tennessee Department of Health staff the ability to approve the transfer of a facility license to a purchaser of the facility under certain circumstances. This legislation went into effect July 1, 2009, and is Public Chapter 323.

Conditions Placed on Certificates of Need—Public Chapter 327 (Effective 5/29/2009)

The Hospital Alliance of Tennessee (HAT) brought legislation this year to ensure that conditions placed on certificates of need will be recorded on subsequent licenses that are issued when the license is transferred to a new facility owner.

COMMERCIAL LAW

Protection of Social Security Numbers of Consumers—Public Chapter 269 (Effective 7/1/2009)

Legislation aimed at protecting consumers' identities passed this year and prohibits one's social security number from being printed on any card, identification or badge that the consumer must display or present in order to receive a benefit, good, service or other thing of value.

CRIMINAL LAW

Concealing Controlled Substances in Effort to Obtain More—Public Chapter 67 (Effective 7/1/2009)

The legislation was brought by the Tennessee Medical Association (TMA) this year in an effort to expand, beyond TennCare, the types of patients who must be reported for what is commonly referred to as "doctor shopping." This term refers to the practice of seeing various healthcare providers with the deceptive intent to obtain multiple prescriptions for a controlled substance. This new law does not place reporting requirements on hospitals though hospitals' accounting for disclosures policies should be reviewed with this new law in mind.

This legislation makes two major changes, one relative to the prescriber and the second relative to the "drug seeker." It requires any physician, dentist, optometrist, podiatrist, veterinarian, nurse authorized pursuant to TCA § 63-6-204 or § 63-9-113 or physician assistant who has good reason to believe a person illegally is seeking controlled substances to report this person to local law enforcement within three business days. Failure to make a report is a Class D felony. The law makes it a Class A misdemeanor for a person to deceive or fail to disclose to a healthcare provider that he/she has received a controlled substance or a prescription for a controlled substance within the previous 30 days.

During the upcoming legislative session, TMA plans to amend the law to reduce a doctor's penalty for failing to report. Such a stiff penalty for failure to report was unintended by TMA. In addition, TMA will clean up the requirement for reporting to prevent double reporting for TennCare patients. The law may be interpreted to require two different reporting procedures for TennCare patients in certain circumstances. THA will be supporting TMA in their efforts to fix this legislation. For more information, please review the bulletin THA released on this new law.

Forced Blood Draws—Public Chapter 324 (Effective 7/1/2009)

The legislature passed a bill mandating officers to have blood drawn if there is probable cause to believe an intoxicated driver has been involved in an accident resulting in injury or death. It is important to note this law does not place a mandate on hospitals to draw the blood.

THA met with the District Attorneys General Conference to discuss this legislation since there now will be more opportunities for blood draws that could present in emergency departments. THA was pleased to discover that Tennessee soon will begin training officers to take the blood themselves. In the meantime, the association is certain it can work with law enforcement to streamline the blood draw process. It is important to note that in situations where the hospitals are requested to take blood from combative persons, the hospitals are not required to and should not restrain anyone in order to take their blood. If restraint is required, the officer would need to restrain anyone in the emergency department and maintain control over that individual at all times.

Elderly and Disabled Adults Protection Act of 2009—SB 2297/HB 2284

The Bureau of TennCare introduced comprehensive legislation that would have required hospitals and other healthcare providers/entities licensed by the state to perform criminal background checks on all employees, contractors and volunteers who provide healthcare-related services or have direct contact with an individual receiving health care. As drafted, this bill required TBI fingerprinting, along with the background checks, mandatory re-checking every three years and re-checking when a worker's responsibilities change.

THA worked for weeks and amended the bill several times to closely reflect current hospital practices. Ultimately, the Bureau of TennCare could not live with the changes made by THA and other providers and the bill was stalled in committee. THA expects this bill to reappear next session and will keep members posted on any developments.

FAMILY LAW

Infants Voluntarily Delivered to Law Enforcement Offices—Public Chapter 257 (Effective 5/20/2009)

Legislation passed that expands the places where infants aged 72 hours or younger may be voluntarily delivered to include a fire department that is staffed 24 hours a day, a law enforcement facility that is staffed 24 hours a day and an emergency medical services facility.

HEALTH DATA REPORTING

Health Data Reporting Act of 2009—Public Chapter 318 (Effective 5/27/2009)

Legislation that limits the list of reportable adverse events that healthcare facilities are required to report to the Tennessee Department of Health was unanimously passed by the General Assembly this session. The Tennessee Department of Health brought this legislation to reduce its burden of having to perform in-depth hospital complaint surveys for events that are more effectively resolved through other measures.

Facilities now are required to report incidents of abuse, neglect and misappropriation within seven business days from discovery and file a corrective action report within 40 days of discovery. In addition, incidents that may result in the disruption in the delivery of healthcare

services, including employee strikes, external disasters impacting the facility or fires at the facility, must be reported.

All-Payer Data Reporting Bill—Public Chapter 611 (Effective 7/9/2009)

Legislation requiring payers to report claims data to the state passed after lengthy negotiations and numerous rewrites of the bill. At the recommendation of THA, physicians and payers, the Tennessee Department of Finance and Administration agreed to a number of modifications to the provisions in the original proposal. The bill grants the state's Health Information Committee, with representatives from all interested parties, including two members from hospitals, the authority over the development of the database and requires a two-thirds affirmative vote before the public release of any generated report on quality, effectiveness or cost of care. In addition, providers will be given 60 days prior to the public release of reports to review and comment on them. Stringent protections were included to ensure no patient-level data will be released. The bill lists 18 unique patient identifiers that cannot be included in the database.

Inspection of Medical Records by Department of Health—Public Chapter 188 (Effective 5/7/2009)

This legislation makes revisions to the law regarding providers' medical records and the Tennessee Department of Health and health-related boards' inspection of them. It removes the requirement that an independent reviewer must approve requests for medical records in the context of an open complaint investigation or pending survey.

HOME HEALTH

Qualifying for Hospice Care—Public Chapter 36 (Effective 4/8/2009)

This legislation clarifies that existing residents, as well as new admissions, qualify for hospice care in an assisted-care living facility. It also clarifies that hospice services are provided pursuant to a patient's hospice plan of care.

Providing of Home Health Care Services—Public Chapter 471 (Effective 7/1/2009)

Legislation passed that requires home healthcare services to follow the recipient into the community for purposes of outpatient medical appointments, educational functions and employment and religious services.

HOSPITAL DEBT COLLECTION

Establishes Certain Debt Collection Standards—SB 1755/HB 1585

THA worked hard to stop egregious legislation that would require hospitals to comply with debt collection practices and, therefore, be subjected to treble damages under the Consumer Protection Act. This legislation was brought by the Tennessee Health Care Campaign. It contained provisions that would prohibit the hospital from turning patients' bills over to collections for 180 days and barred the hospital from charging interest on patient debt. In addition, the legislation required hospitals to disclose to a consumer the costs incurred in

providing treatment, and required a hospital to post on its web site copies of the latest five joint annual reports. After weeks of negotiation, THA successfully convinced the sponsors not to pursue this legislation.

INSURANCE

24-Hour Admissions Notification—Public Chapter 333 (Effective 6/1/2009)

The General Assembly passed legislation proposed by THA clarifying last year's bill that prohibited payers from requiring hospitals to provide notification within 24 hours of weekend emergency inpatient admissions. The bill passed this session provides that hospitals cannot be required to make notifications within less than one business day for **any** inpatient admissions (emergency or no emergency), if the admission occurs or notification would occur, on a weekend or federal holiday.

Recoupment—Public Chapter 462 (Effective 10/1/2009)

Legislation was passed providing some limitations on the ability of insurance companies to recoup payments made to providers after a patient's eligibility has been confirmed. Under the bill as passed, if the patient is covered by another payer at the time of service, the second payer is responsible for payment if a covered service was provided and cannot deny the claim for lack of being timely filed. In addition, employers are required to notify payers within 60 days that an employee is no longer covered.

An amendment supported by THA, the Tennessee Medical Association (TMA) and payers was added to the bill that prohibits companies that are not associated with any insurer or third-party administrator from recouping provider payments on behalf of a self-insured business. Over the past several months, physicians and other providers have been receiving letters from Tennessee-based Health Research Insights (HRI) on behalf of two self-insured plans, alleging overpayments and improper billing with demands for either payment of the amount specified or submission of copies of medical records sufficient to justify the billings. The amendment ensures that a recoupment only can be made by a payer or an entity that has a contracted relationship with the payer.

Internal Reconsideration and Independent Review of Claims—Public Chapter 334 (Effective 10/1/2009)

Legislation that requires a health insurance entity to clearly identify material changes to the provider manual passed this year with the help of THA and other providers. Effective Oct. 1, 2009, material changes must be identified in bold or larger print and the new policy changes must be distributed in a separately categorized communication, such as a compact disc, online or direct mailing to the provider. This should help reduce the problems that providers experience with not being updated about policy changes.

By July 1, 2010, each health insurance entity shall maintain a web-based preadjudication tool that network providers can use prior to submitting claims. This law does not apply to state or federal insurance programs or hospital inpatient claims.

Exclusive Health Care Provider Agreement—HB 1681/SB 753

Private Act Metropolitan Hospital Authority—HB 1680/SB 752

Two bills brought on behalf of Community Health Systems (CHS) failed to pass the General Assembly. HB 1681/SB 753 would have prohibited exclusive provider agreements with hospitals for providing services to state employees covered by the state employees' health insurance. The second bill, HB1680/SB 752, would have placed private act metropolitan hospitals under antitrust provisions.

Preferred Provider Organization (PPO) Transparency Act—Public Chapter 466 (Effective 1/1/2010)

The commercial silent PPO legislation will go into effect Jan. 1, 2010, and should provide some transparency to this complicated subject. This law will require all entities who sell, rent or lease a PPO network (and that are not already licensed) to register with the Tennessee Department of Commerce and Insurance within 90 days. It limits to whom a contracting entity may rent, sell or lease a network. All entities with access to a provider contract must abide by all terms and conditions of the direct contract under which they are accessing a discount. This law gives the provider the ability to refuse a discount to any entity that does not comply with provisions of the law.

Under this law, contract entities also are required to maintain a website or toll-free telephone number that a provider can access to obtain a list of all third-party entities that the contracting entity has provided access to the provider's contract. The explanation of benefits must identify under which provider contract the payor claims the right to access the provider's healthcare services and contractual discounts. In addition, a toll-free number must be included for the provider to call for questions concerning the claim.

The commissioner of the Tennessee Department of Commerce and Insurance will oversee the enforcement of this act. Disregarding this law would be an unfair trade practice though the following are exempted from the act: ERISA plans and administrative services only (ASO) arrangements for non-ERISA self-funded entities, such as local governments and church plans.

LABOR UNIONS

Urges Congress to Enact Employee Free Choice Act—HJR 50

THA opposed and defeated a resolution that could have sent the wrong message to congress, if passed. Rep. Barbara Cooper (D-Memphis) introduced a resolution that urged congress to pass the "card check" legislation. THA and the business community made it clear to the House Employee Affairs Subcommittee that the association opposed the federal "card check" legislation, which would create a process whereby union organizers can represent employees simply by presenting a majority of union authorization cards to the employer and force negotiating parties into binding arbitration.

MEDICAL EXAMS/RECORDS

Forensic Medical Examinations for Domestic Abuse Victims—SB 86/HB 317

THA convinced sponsors to defer legislation that would circumvent current requirements under the State Criminal Injuries Compensation Fund by prohibiting hospitals from billing a patient who is a victim of domestic assault, aggravated assault or a sexually-oriented crime for a forensic medical examination. The hospital would be required to instead seek reimbursement directly from the fund even if the victim had insurance or was eligible under another program, such as TennCare or Medicare. It would have required hospitals to make an immediate determination as to whether one of the specified crimes was committed.

Release of Medical Test Results of Child to Parent—SB 2089/HB 1762

After hours of debate, Rep. Tony Shipley's (R-Kingsport) bill that would require doctors and hospitals treating minor children to release the results of medical tests and procedures performed on a child to the child's parents upon written request did not pass. Current law states that hospitals shall furnish a copy of a patient's medical record to the patient or the patient's authorized representative within 30 days of receiving a written request. Hospitals already interpret "authorized representative" to mean parent in these cases. The amendment adds the language "parent or legal guardian of a patient who is an unemancipated minor" as those entitled to receive records. An amendment to the bill includes a reference to the Health Insurance Portability and Accountability Act (HIPAA), which allows the hospital to refuse to release such records if there is a reasonable belief that the child has been abused by a parent or legal guardian and the hospital decides it is not in the best interest of the child to release the records.

THA worked hard to ensure that bill was amended to reflect current practices at hospitals. The bill was controversial due to its potential impact on the practice of medicine, especially as it relates to reproductive medical treatment for female teenagers. Shipley plans to bring this bill, as amended, again next year.

Newborns Toxicology Test Bill—SB 2095/HB 2136

Legislation that originally required physicians to administer a toxicology test to a newborn suspected of suffering from neonatal abstinence syndrome and prohibited the discharge of an infant who is suffering from withdrawal prior to treatment was rewritten by the sponsor at the request of Vanderbilt Medical Center, the Tennessee Department of Health and THA.

As passed by the House, the bill simply requires providers who suspect: (1) a mother has used alcohol or a controlled substance for a non-medical purpose during the pregnancy; and (2) the infant is suffering from withdrawal to comply with the "clinical standard of care in deciding whether to administer a confirmatory test, what treatment is needed, and what medical follow up is indicated."

If the provider determines the infant is suffering from withdrawal, the Tennessee Department of Children's Services shall be notified. The department shall presume the child should remain with

the mother and shall not intervene in the absence of abuse or neglect beyond the mother's use of alcohol or drugs.

The bill is still pending in the Senate General Welfare Committee.

Release of Workers' Compensation Records—Public Chapter 486 (Effective 7/1/2009)

Public Chapter 486 makes changes to provisions of the law governing the medical records of persons being treated with work-related injuries. This new law requires hospitals to first obtain a signed Form C-31 before releasing records in a workers' compensation claim. THA shared concerns with the Tennessee Department of Labor and Workforce Development about the need to include dates of service on the form. The department is working to clarify this issue.

According to the new law, no medical provider will incur any liability as a result of providing medical information as described in subdivision (C) of the law, provided the applicable provisions of subdivision (C) are followed by the medical provider.

MEDICAL MALPRACTICE

Liability for Delivery of Services for a Nominal Charge—Public Chapter 581 (Effective 7/1/2009)

This legislation exempts a person licensed by the board of any of the professions of healing arts from liability for civil damages resulting from the delivery of health services for a nominal charge.

MENTAL HEALTH

Availability of Crisis Care Services—Public Chapter 404 (Effective 6/11/2009)

This legislation sets forth procedures to be followed by the Tennessee Department of Mental Health and Developmental Disabilities (DMHDD) should funding be made available to them. In such an event, the DMHDD shall coordinate with other departments and agencies to promote access to a continuum of appropriate services for persons in psychiatric emergencies, including a 24-hour, seven-day-a-week, toll-free telephone number, telephone and walk-in triage screening, assessment, intervention and follow-up; and access to crisis respite and crisis stabilization beds.

DMHDD must report to the Planning and Policy Council and Fiscal Review Committee identifying all means it intends to use to increase resources available in the event that appropriations are not sufficient to continue funding emergency psychiatric services for uninsured persons.

Transportation of Persons with a Mental Illness—Public Chapter 468 (Effective 7/1/2009)

This new law expands who may transport people with mental illness without a need for physical restraint or vehicular security. The sheriff may permit one or more persons, other than the sheriff or secondary transportation agent, to transport a person with mental illness, provided that person is willing and able to transport and can provide proof of current car insurance. The following

people are among those that can transport: friends, neighbors, other mental health professionals familiar with the person, relatives of the person or a member of the clergy. Under this law, the sheriff still must notify the hospital about the estimated time of arrival pursuant to TCA § 33-6-406(b) and must provide the name of the person(s) who actually will transport the person subject to admission to a hospital or treatment resource.

Behavioral Health Safety Net—Public Chapter 95 (Effective 7/1/2009)

This legislation defines “adult behavioral health services for the seriously and persistently mentally ill" to mean behavioral health services for individuals 19 years of age or older. It establishes that support for community-based providers of behavioral health services is for adults who are uninsured, lack financial resources to secure behavioral health care and whose income is at least 100 percent of the federal poverty level. In addition, this legislation clarifies legislative intent that the state Department of Mental Health and Developmental Disabilities should maintain the funding amount and extent of services of the behavioral health safety net of Tennessee. If the appropriations are not sufficient to maintain the funding amount, the department must provide a report to the Planning and Policy Council.

PHYSICIANS/HEALTH PROFESSIONALS

Corporate Practice/Non-Liability of Hospital for Non-Employee Physicians— SB 1583/HB 1717

This session, THA introduced legislation that would allow, but not mandate, hospitals to employ hospital-based physicians: radiologists, anesthesiologists, pathologists and emergency room physicians. Currently, hospitals are prohibited from employing these physician groups.

This legislation also includes a clear method for hospitals to give notice to patients that certain doctors are not employed by the hospital. This notice, when given, effectively would limit the hospital's liability for these independent contractors, absent any negligence by the hospital. The Tennessee Supreme Court recently held hospitals liable for non-employee, hospital-based physicians in the Boren and Dewald cases.

In order to pass the legislation next year, THA will need all members to make calls and visits to their legislators. This legislation will not pass without heavy member involvement.

On Call Physicians under One-Hour Time Constraint—SB 1552/HB 1895

The bill requiring a physician who agrees to serve as an "on call" physician to arrive within one hour of being called passed the Senate in an amended form. THA explained the potential negative impact this bill would have on physicians willing to take call and negotiated an amendment that deletes most provisions in the original bill and allows the chief of staff of a hospital medical staff to report physicians to the state Board of Medical Examiners who repeatedly violate a hospital's time policy regarding "on-call" coverage. This bill has not had any traction in the House.

Practice of Polysomnography—Public Chapter 421 (Effective 7/1/2009)

After session-long negotiations among players, compromise legislation on the practice of polysomnography passed without some of the more egregious provisions requiring physician direct supervision. The compromise legislation revises the present law definition of "practice of polysomnography" to mean the staging and scoring of sleep by continuous and simultaneous monitoring of the stages of sleep and wake through the use of an EEG, EOG or EMG in conjunction with the recording and monitoring of other physiological variables, and the assignment of values for duration, frequency and type of event to each stage of sleep in which the event occurred.

The new law also expands the credentialing avenues for respiratory therapists who provide polysomnography services. Previously, a respiratory therapist providing such services had to be credentialed by the Board of Registered Polysomnographic Technologists. Now, respiratory therapists who provide polysomnography services have three options: (1) become credentialed as a registered polysomnographic technologist by the Board of Polysomnographic Technologists; (2) become credentialed as a sleep disorders specialist by the National Board for Respiratory Care; or (3) undergo a mechanism to document competency in polysomnography as independently approved by the Tennessee Board of Respiratory Care.

On the third option, the Tennessee Board of Respiratory Care will consult with the Tennessee Board of Medical Examiners to develop the mechanism. The consultation must be documented, along with any comments by the Board of Medical Examiners regarding the mechanism. That documentation must be filed with the chairs of the House Health and Human Resources Committee and Senate General Welfare, Health and Human Resources Committee.

Certified Medication Technicians—Public Chapter 403 (Effective 7/1/2009)

Under this law, nursing homes and assisted care living facilities (ACLFs) are allowed to utilize trained and certified medication aides to administer routine oral and topical medications under the supervision of a licensed nurse.

A medication aide can administer medications under this new law if that aide meets the following requirements: (1) was a CNA in a facility for at least a year; (2) completed a 75-hour course given at a higher education institution that includes 50 hours of classroom instruction and 25 hours of clinical time; and (3) passed a standardized exam. The medication aide certification program will be administered by the Tennessee Board of Nursing (BON).

The law specifies that the medication aide cannot administer controlled substances, medications delivered by aerosol/nebulizer, chemotherapeutic agents, rectal and vaginal medication, or medications administered as drops to the eye, ear or nose. In addition, the medication aide cannot give medication through injections, intravenously or in feeding tubes.

The BON will promulgate rules to implement the program by Feb. 1, 2010.

RURAL HOSPITALS

Urges Passage of Medicare Rural Health Access Improvement Act of 2009—HJR 690

THA brought a resolution that the General Assembly passed this year, which urges congress to enact the Medicare Rural Health Access Improvement Act of 2009 (S. 318 of the 111th U.S. Congress). If passed, this federal legislation temporarily would eliminate the 12 percent cap on Medicare disproportionate share hospital (DSH) payments for rural and small urban hospitals and effectively equalize payments for all DSH hospitals.

TRANSPORTATION VEHICLES

Helmet Bill—HB 1511/SB 1506

The controversial bill that would allow motorcyclists age 21 and older to ride without helmets failed in the House Public Safety Subcommittee this year. The bill never received the proper motion to permit a committee vote. THA worked hard with physicians and trauma centers to defeat this legislation.