HB 1427-FN-A - AS INTRODUCED

2024 SESSION

24-2256
09/08

HOUSE BILL ***1427-FN-A***

AN ACT establishing the regulation and licensure of deputy physicians.

SPONSORS: Rep. Cole, Hills. 26; Rep. Infantine, Hills. 16; Rep. Packard, Rock. 16

COMMITTEE: Executive Departments and Administration

ANALYSIS

This bill:

I. Establishes the regulation and licensure of deputy physicians;

II. Regulates their practice through deputy physician collaborative practice arrangements; and

III. Establishes a grant program in the department of health and human services to provide matching funds for primary care clinics in medically underserved areas utilizing deputy physicians.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

24-2256
09/08

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Four

AN ACT establishing the regulation and licensure of deputy physicians.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; Deputy Physicians. Amend RSA by inserting after chapter 328-J the following new chapter:

CHAPTER 328-K

DEPUTY PHYSICIANS

328-K:1 Definitions. In this chapter:

I. "Board" means the board of medicine established in RSA 329.

II. "Department" means the department of health and human services.

III. "Deputy physician" means a person who fulfills the requirements for physician licensure established by RSA 329:12 except for RSA 329:12, I(d)(5) and RSA 329:12 I, (d)(6), and:

(a) Has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination; and

(b) Has proficiency in the English language.

IV. "Deputy physician collaborative practice arrangement" means an agreement between a physician licensed under RSA 329 and a deputy physician that meets the requirements of RSA 328-K:16.

V. "Medical school graduate" means any person who has graduated from a medical college or osteopathic medical college described in RSA 329:12, I(d)(4).

VI. "Medically underserved area" means an area designated by the department as a designated Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA), or a Governor-Designated and Secretary-Certified (GDSC) shortage area.

VII. "Primary care" means physician services in family practice, general practice, internal medicine, pediatrics, and obstetrics. It shall also include gynecology if paired with obstetrics.

328-K:2 License Required.

I. No person shall practice as or hold himself or herself out to be a deputy physician or use any letters designating himself or herself as a deputy physician unless the person is licensed in accordance with this chapter.

II. The board shall license each applicant who satisfies the requirements under RSA 328-K:3. Upon payment of a license fee, the board shall issue to such person a license, which shall be prima facie evidence of the right to practice as a deputy physician. A licensed deputy physician may use the letters "D.P." in connection with his or her name to denote licensure under this chapter.

III. Except as provided in RSA 328-K:15, persons licensed under this chapter shall be authorized to receive reimbursement from the Centers for Medicare and Medicaid Services (CMS) and other insurers as if they were licensed under RSA 329.

328-K:3 Conditions for Licensure.

I. To apply for licensure by the board as a deputy physician, an applicant shall file a written application on forms provided by the board and pay an application fee. The applicant to be licensed shall:

(a) Fulfill the requirements for physician licensure established by RSA 329:12 except for RSA 329:12, I(d)(5) and RSA 329:12, I(d)(6);

(b) Have successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination or the equivalent of such steps of any other board-approved medical licensing examination;

(c) Have proficiency in the English language; and

(d) Submit a complete set of fingerprints and a notarized criminal history record release form pursuant to RSA 328-K:4.

II. Circumstances that exist which would be grounds for disciplinary action under RSA 328-K:7 may be grounds for denial of a license.

328-K:4 Criminal History Record Checks.

I. Every applicant for initial permanent licensure or reinstatement shall submit to the board a notarized criminal history record release form, as provided by the New Hampshire division of state police, which authorizes the release of his or her criminal history record, if any, to the board.

II. The applicant shall submit with the release form a complete set of fingerprints taken by a qualified law enforcement agency or an authorized employee of the department of safety. In the event that the first set of fingerprints is invalid due to insufficient pattern, a second set of fingerprints shall be necessary in order to complete the criminal history records check. If, after 2 attempts, a set of fingerprints is invalid due to insufficient pattern, the board may, in lieu of the criminal history records check, accept police clearances from every city, town, or county where the person has lived during the past 5 years.

III. The board shall submit the criminal history records release form and fingerprint form to the division of state police which shall conduct a criminal history records check through its records and through the Federal Bureau of Investigation. Upon completion of the records check, the division of state police shall release copies of the criminal history records to the board.

IV. The board shall review the criminal record information prior to making a licensing decision and shall maintain the confidentiality of all criminal history records received pursuant to this section.

V. The applicant shall bear the cost of a criminal history record check.

328-K:5 Renewal of Licenses. Every person licensed to practice under this chapter shall apply to the board for annual renewal of license on forms provided by the board and shall pay a renewal fee as established by the board. A license issued under this chapter shall not expire until the board has taken final action upon the application for renewal.

328-K:6 Failure to Renew; Lapse.

I. Any licensee who fails to apply for renewal under RSA 328-K:5 shall pay double the renewal fee, provided the licensee applies and pays the renewal fee no later than 90 days after the expiration date. Any licensee who fails to apply for renewal of his or her license within the 90-day period after expiration, shall have his or her license lapse. A lapsed license shall be reinstated only upon payment of a reinstatement fee as established by the board, and upon showing evidence of professional competence as the board may reasonably require.

II. If a license expires or lapses as a result of a licensee being ordered to active duty with the armed services, the licensee shall have 90 days from the date of discharge or release from the armed service to apply for renewal and all late fees shall be waived.

328-K:7 Grounds for Discipline. The board, after hearing, may take action against any person licensed under this chapter upon finding that the licensee:

I. Has knowingly provided false information on any application for professional licensure, whether by making any affirmative statement which was false at the time it was made or by failing to disclose any fact material to the application.

II. Is a habitual user of drugs or intoxicants or is afflicted with a physical disability, insanity, psychiatric disorder, or other disease deemed dangerous to the public health.

III. Has displayed a pattern of behavior which is incompatible with the basic knowledge and competence expected of persons in the practice of his or her profession.

IV. Has engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent in practicing his or her profession or in performing activities ancillary to the practice of his or her profession or any particular aspect or specialty thereof, or has intentionally injured a patient while practicing his or her profession or performing such ancillary activities.

V. Has undertaken to practice independent of the referral or prescription, direction, or supervision of a physician licensed under RSA 329.

VI. Has failed to provide adequate safeguards with regard to aseptic techniques or radiation techniques.

VII. Has included in advertising any statement of a character tending to deceive or mislead the public or any statement claiming professional superiority.

VIII. Has advertised the use of any drug or medicine of an unknown formula or any system of anesthetic that is unnamed, misnamed, misrepresented, or not in reality used.

IX. Has willfully or repeatedly violated any provision of this chapter or any substantive rule of the board.

X. Has been convicted of a felony under the laws of the United States or any state.

XI. Has failed to maintain adequate medical record documentation on diagnostic and therapeutic treatment provided or has unreasonably delayed medical record transfer, or violated RSA 332-I.

328-K:8 Disciplinary Action. The board, upon making an affirmative finding under RSA 328-K:7, may take disciplinary action in any one or more of the following ways:

I. Administer a public or private reprimand.

II. Revoke, suspend, limit, or otherwise restrict a license.

III. Require the deputy physician to submit to the care, counseling, or treatment of a physician, counseling service, health care facility, professional assistance program, or any combination thereof which is acceptable to the board.

IV. Place the deputy physician on probation.

V. Require the deputy physician to participate in a program of continuing education in the area or areas in which he or she has been found deficient.

VI. Assess administrative fines in amounts established by the board which shall not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the violation continues, whichever is greater.

328-K:9 Appeals. Disciplinary action taken by the board under RSA 328-K:8 may be appealed to the supreme court under RSA 541.

328-K:10 Rulemaking.

I. Unless the board elects to follow RSA 328-K:10, III, the board shall adopt rules under RSA 541-A relative to:

(a) The scope of practice for a licensed deputy physician.

(b) Form and content of the application for licensure.

(c) Application procedures.

(d) Conduct of hearings under RSA 328-K:7.

(e) Standards for deputy physician education and training.

(f) Supervision of deputy physicians.

(g) Notification of changes in employment.

(h) Definition of supervision.

(i) Manner of recordkeeping under RSA 328-K:11.

(j) Except as provided in paragraph II, any other matter which is consistent with the legislative intent of this chapter and which is necessary to the administration of this chapter.

II. Unless the board elects to follow paragraph III, the board, in consultation with the New Hampshire pharmacy board, shall adopt rules under RSA 541-A relative to the prescriptions to be issued by a deputy physician.

III. The board may elect to make all rules applicable to physician assistants under RSA 328-D:10 apply to deputy physicians under this chapter.

328-K:11 Recordkeeping. The board shall keep a record of its proceedings under this chapter and a register of all persons licensed under it. The register shall list the name, last known business address, and last known residence address of each living licensee, and the date and number of the license of each licensed deputy physician. The board shall maintain and publish a list of licensed deputy physicians once a year.

328-K:12 Physician Liability. This chapter shall not be construed to relieve the responsible physician of professional or legal responsibility for the care and treatment of his or her patients.

328-K:13 Penalty.

I. Any person who, not being licensed or otherwise authorized according to the law of this state, shall advertise oneself or hold oneself out as a deputy physician, or any person who does such act after receiving notice that such person's license has been revoked, shall be guilty of a misdemeanor.

II. Any person who shall practice or attempt to practice as a deputy physician in this state without a license shall be guilty of a class A misdemeanor if a natural person or guilty of a felony if any other person.

328-K:14 Limitation on Action. A person, licensed or authorized to practice as a deputy physician under this chapter or under the laws of any other state, who, in good faith, renders emergency care at the scene of an emergency, shall not be liable for any civil damages as a result of acts or omissions by such person in rendering such emergency care, or as a result of any act or failure to act to provide or arrange for further medical treatment or care, as long as such person receives no direct compensation for the care from or on behalf of the person cared for.

328-K:15 Rural Health Clinics. When working in a rural health clinic under the federal Rural Health Clinic Services Act of 1977, Public Law 95-210, as amended:

I. A deputy physician shall be considered a physician assistant for purposes of regulations of the Centers for Medicare and Medicaid Services (CMS); and

II. No supervision requirements in addition to the minimum federal law shall be required.

328-K:16 Deputy Physician Collaborative Practice Arrangements.

I. A physician may enter into collaborative practice arrangements with deputy physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative practice arrangements, which shall be in writing, may delegate to a deputy physician the authority to administer or dispense drugs and provide treatment as long as the delivery of such health care services is within the scope of practice of the deputy physician and is consistent with that deputy physician's skill, training, and competence and the skill and training of the collaborating physician.

Collaborative practice arrangements shall provide for deputy physicians to practice in medically underserved areas pursuant to funding under RSA 126-A:18-c.

II. The written collaborative practice arrangement shall contain at least the following provisions:

(a) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the deputy physician;

(b) A list of all other offices or locations besides those listed in subparagraph (a) where the collaborating physician authorized the deputy physician to prescribe;

(c) A requirement that there shall be posted at every office where the deputy physician is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by a deputy physician and have the right to see the collaborating physician;

(d) All specialty or board certifications of the collaborating physician and all certifications of the deputy physician;

(e) The manner of collaboration between the collaborating physician and the deputy physician, including how the collaborating physician and the deputy physician shall:

(1) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;

(2) Maintain geographic proximity; except, the collaborative practice arrangement may allow for geographic proximity to be waived for a maximum of 28 days per calendar year for rural health clinics under RSA 328-K:15, as long as the collaborative practice arrangement includes alternative plans as required in subparagraph (3). Such exception to geographic proximity shall apply only to independent rural health clinics, provider-based rural health clinics if the provider is a critical access hospital as provided in 42 U.S.C. section 1395i-4, and provider-based rural health clinics if the main location of the hospital sponsor is greater than 50 miles from the clinic. The collaborating physician shall maintain documentation related to such requirement and present it to the board of medicine when requested; and

(3) Provide coverage during absence, incapacity, infirmity, or emergency by the collaborating physician;

(f) A description of the deputy physician's controlled substance prescriptive authority in collaboration with the physician, including a list of the controlled substances the physician authorizes the deputy physician to prescribe and documentation that it is consistent with each professional's education, knowledge, skill, and competence;

(g) A list of all other written practice agreements of the collaborating physician and the deputy physician;

(h) The duration of the written practice agreement between the collaborating physician and the deputy physician; and

(i) A description of the time and manner of the collaborating physician's review of the deputy physician's delivery of health care services. The description shall include provisions that the deputy physician shall submit a minimum of 10 percent of the charts documenting the deputy physician's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every 14 days.

III. The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every 14 days a minimum of 20 percent of the charts in which the deputy physician prescribes controlled substances. The charts reviewed under this paragraph may be counted in the number of charts required to be reviewed under subparagraph II(i).

IV. The board under RSA 541-A shall adopt rules regulating the use of collaborative practice arrangements for deputy physicians. Such rules shall specify:

(a) Geographic areas to be covered;

(b) The methods of treatment that may be covered by collaborative practice arrangements;

(c) In conjunction with the commissioner of the department of health and human services, or designee and deans of medical schools and primary care residency program directors in the state, or adjacent states, the development and implementation of educational methods and programs undertaken during the collaborative practice service which shall facilitate the advancement of the deputy physician's medical knowledge and capabilities, and which may lead to credit toward a future residency program for programs that deem such documented educational achievements acceptable; as well as a means to certify completion of such a program, to be used according to RSA 329:12, III;

(d) Within 5 years of the effective date of this chapter, in conjunction with the commissioner or designee, the adoption of an existing test equivalent to Part 3 of the United States Medical Licensing Examination, or the development and implementation of such a test, which shall be used as an alternative path for licensure under RSA 329:12, III; and

(e) The requirements for review of services provided under collaborative practice arrangements, including delegating authority to prescribe controlled substances. Any rules relating to dispensing or distribution of medications or devices or controlled substances by prescription or prescription drug orders under this section shall be subject to the approval of the state board of pharmacy. The board shall adopt rules applicable to deputy physicians that shall be consistent with guidelines for federally funded clinics.

V. The board shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to a deputy physician provided the provisions of this section and the rules adopted thereunder are satisfied.

VI. Within 30 days of any change and on each renewal, the board shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each deputy physician with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that arrangements are carried out for compliance under this chapter.

VII. A collaborating physician shall not enter into a collaborative practice arrangement with more than 3 full-time equivalent deputy physicians. Such limitation shall not apply to collaborative arrangements of hospital employees providing inpatient care service in hospitals or population-based public health services.

VIII. The collaborating physician shall determine and document the completion of at least a one-month period of time during which the deputy physician shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. Such limitation shall not apply to collaborative arrangements of providers of population-based public health services.

IX. An agreement made under this section may govern hospital medication orders under protocols and standing orders for the purpose of delivering inpatient or emergency care within a hospital if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

X. No contract or other agreement shall require a physician to act as a collaborating physician for a deputy physician against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular deputy physician. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any deputy physician, but such requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by a hospital's medical staff.

XI. No contract or other agreement shall require any deputy physician to serve as a collaborating deputy physician for any collaborating physician against the deputy physician's will. A deputy physician shall have the right to refuse to collaborate, without penalty, with a particular physician.

XII. All collaborating physicians and deputy physicians in collaborative practice arrangements shall wear identification badges while acting within the scope of their collaborative practice arrangement. The identification badges shall prominently display the licensure status of such collaborating physicians and deputy physicians.

XIII. A deputy physician may prescribe any controlled substance listed in Drug Enforcement Administration (DEA) schedule III, IV, or V and may have restricted authority in schedule II, when delegated the authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions for schedule II medications prescribed by a deputy physician are restricted to only those medications containing hydrocodone. Such authority shall be filed with the board. The collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug category that the deputy physician is permitted to prescribe. Any limitations shall be listed in the collaborative practice arrangement. Deputy physicians shall not prescribe controlled substances for themselves or members of their families. Schedule III controlled substances and schedule II hydrocodone prescriptions shall be limited use in an inpatient hospital setting or to a 5-day supply without refill. Deputy physicians who are authorized to prescribe controlled substances under this section shall register with the federal Drug Enforcement Administration and shall include the Drug Enforcement Administration registration number on prescriptions for controlled substances.

XIV. The collaborating physician shall be responsible to determine and document the completion of at least 124 hours in a 4-month period by the deputy physician during which the deputy physician shall practice with the collaborating physician on-site prior to prescribing controlled substances when the collaborating physician is not on-site. Such limitation shall not apply to deputy physicians of population-based public health services.

2 New Paragraph; Physicians; Alternative for Licensure. Amend RSA 329:12 by inserting after paragraph II the following new paragraph:

III. As an alternative to paragraph I, upon approval of the board applicants for licensure may:

(a) Fulfill all the requirements of RSA 329:12, I(a), (b), (c), and (1) through (4) of (d).

(b) Have been licensed in this state and practiced continuously under RSA 328-K for 5 or more consecutive years without any disciplinary action.

(c) Have successfully completed the educational component implemented pursuant to RSA 328-K:16, IV(c).

(d) Have passed Parts 1 and 2 of the United States Medical Licensing Examination or equivalent.

(e) Have passed the test adopted pursuant to RSA 328-K:16, IV(d).

3 New Paragraph; Physicians; Person Excepted. Amend RSA 329:21 by inserting after paragraph XV the following new paragraph:

XVI. To such deputy physicians as have been licensed under RSA 328-K while acting under the terms of that chapter.

4 Professionals Health Program; Deputy Physicians Added. Amend RSA 329:13-b to read as follows:

329:13-b Professionals' Health Program.

I. Any peer review committee may report relevant facts to the board relating to the acts of any physician***,*** [~~or~~] physician assistant***, or deputy physician*** in this state if it has knowledge relating to the physician***,*** [~~or~~] physician assistant***, or deputy physician*** which, in the opinion of the peer review committee, might provide grounds for disciplinary action as specified in RSA 329:17.

II. Any committee of a professional society comprised primarily of physicians, its staff, or any district or local intervenor participating in a program established to aid physicians impaired or potentially impaired by mental or physical illness including substance abuse or disruptive behavior may report in writing to the board the name of a physician whose ability to practice medicine safely is impaired or could reasonably be expected to become impaired if the condition is allowed to progress together with the pertinent information relating to the physician's impairment. The board may report to any committee of such professional society or the society's designated staff information which it may receive with regard to any physician who may be impaired by a mental or physical illness including substance abuse or disruptive behavior. In this chapter, "disruptive behavior" means any abusive conduct, including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care of patient safety could be compromised.

III. Notwithstanding the provisions of RSA 91-A, the records and proceedings of the board, compiled in conjunction with a peer review committee, shall be confidential and are not to be considered open records unless the affected physician so requests; provided, however, the board may disclose this confidential information only:

(a) In a disciplinary hearing before the board or in a subsequent trial or appeal of a board action or order;

(b) To the physician licensing or disciplinary authorities of other jurisdictions; or

(c) Pursuant to an order of a court of competent jurisdiction.

IV.(a) No employee or member of the board, peer review committee member, medical organization committee member, medical organization district or local intervenor furnishing in good faith information, data, reports, or records for the purpose of aiding the impaired physician***,*** [~~or~~] physician assistant***, or deputy physician*** shall by reason of furnishing such information be liable for damages to any person.

(b) No employee or member of the board or such committee, staff, or intervenor program shall be liable for damages to any person for any action taken or recommendations made by such board, committee, or staff unless the person is found to have acted recklessly or wantonly.

V.(a) The office of professional licensure and certification may contract with other organizations to operate the professionals' health program for physicians***,*** [~~and~~] physician assistants***, and deputy physicians*** who are impaired or potentially impaired because of mental or physical illness including substance abuse or disruptive behavior. This program shall be available to all physicians***,*** [~~and~~] physician assistants***, and deputy physicians*** licensed in this state, all physicians***,***

[~~and~~] physician assistants***, and deputy physicians*** seeking licensure in this state, and all resident physicians in training, and shall include, but shall not be limited to, education, intervention, ongoing care or treatment, and post-treatment monitoring.

(b) [Repealed.]

VI. Upon a determination by the board that a report submitted by a peer review committee or professional society committee is without merit, the report shall be expunged from the physician's**,** [~~or~~] physician assistant's***, or deputy physician's*** individual record in the board's office. A physician, [~~or~~] physician assistant, ***or deputy physician*** or authorized representative shall be entitled on request to examine the peer review or the organization committee report submitted to the board and to place into the record a statement of reasonable length of the physician's**,** [~~or~~] physician assistant's***, or deputy physician's*** view with respect to any information existing in the report.

VII. Rules governing the program shall be implemented through the office of professional licensure and certification pursuant to RSA 310.

5 New Section; Health and Human Services; Medically Underserved Areas. Amend RSA 126-A by inserting after section 18-b the following new section:

126-A:18-c Medically Underserved Areas.

I. The department shall establish and administer a program to increase the number of medical clinics in medically underserved areas as defined in RSA 328-K:1. A not-for-profit or nonprofit entity in this state that includes a medically underserved area may establish a medical clinic in the medically underserved area by contributing start-up money for the medical clinic and having such contribution matched wholly or partly by grant moneys from the medical clinics in medically underserved areas fund established in paragraph IV. An existing clinic which the not-for-profit or nonprofit entity has not been able to recruit a physician or APRN to provide needed primary care services despite reasonable effort for a period of one or more years shall also be considered an eligible clinic under this section. The department shall seek all available moneys from any source whatsoever, including but not limited to health care foundations, insurance companies, pharmaceutical companies, and hospitals to assist in funding the program. The legislature may appropriate general fund moneys or moneys raised under RSA 84-A for this fund.

II. A participating not-for-profit or nonprofit entity that includes a medically underserved area may provide start-up money for a medical clinic over a 2-year period. The department shall not provide more than $100,000 per clinic in a fiscal year unless the department makes a specific finding of need in the medically underserved area.

III. The department shall establish priorities so that the neediest medically underserved areas eligible for assistance under this section are prioritized.

IV. There is established a nonlapsing fund to be known as the medical clinics in medically underserved areas fund administered and expended by the commissioner of health and human services, or designee. The fund shall be expended for the purposes of paragraph I. The fund shall be

continually appropriated to the department of health and human services for the purposes of this section. The fund shall consist of:

(a) Revenue from appropriations or other moneys authorized from the general fund or from tax receipts under RSA 84-A.

(b) Funds from public or private sources, including, but not limited to gifts, grants, donations, rebates, and settlements received by the state specifically designated to be credited to the fund.

(c) Funds repaid per paragraph VI.

V. To be eligible to receive a matching grant from the department, a not-for-profit or nonprofit entity that includes a medically underserved area shall:

(a) Apply for the matching grant; and

(b) Provide evidence satisfactory to the department that it has entered into an agreement or combination of agreements with a collaborating physician or physicians for the collaborating physician or physicians and deputy physician or deputy physicians in accordance with a collaborative practice arrangement under RSA 328-K:16 to provide primary care in the medically underserved area for at least 2 years.

VI. The department shall adopt rules under RSA 541-A necessary for the implementation of this section, including rules addressing:

(a) Eligibility criteria for a medically underserved area and for existing clinics in a medically underserved area which have not been able to recruit physicians or APRNs;

(b) A requirement that a medical clinic utilize a deputy physician in a collaborative practice arrangement under RSA 328-K:16;

(c) Minimum and maximum contributions to the start-up money for a medical clinic to be matched with grant moneys from the state;

(d) Conditions under which grant moneys shall be repaid for failure to comply with the requirements for receipt of such grant moneys;

(e) Procedures for disbursement of grant moneys by the department;

(f) The form and manner in which start-up money shall be contributed; and

(g) Requirements for the not-for-profit or nonprofit entity to retain interest in any property, equipment, or durable goods for 7 years including, but not limited to, the criteria for a not-for-profit or nonprofit entity to be excused from such retention requirement.

7 New Paragraph; Application of Receipts. Amend RSA 6:12, I(b) by inserting after subparagraph (394) the following new subparagraph:

(395) The medical clinics in medically underserved areas fund established in RSA 126-A:18-c.

8 Effective Date. This act shall take effect July 1, 2024.

LBA
24-2256
12/4/23

HB 1427-FN-A- FISCAL NOTE
AS INTRODUCED

AN ACT relative to establishing the regulation and licensure of deputy physicians.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

Estimated State Impact - Increase / (Decrease)				
	FY 2024	**FY 2025**	**FY 2026**	**FY 2027**
Revenue	$0	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Revenue Fund(s)	Medical Clinics in Medically Underserved Areas Fund and the Office of Professional Licensure and Certification Fund			
Expenditures	$0	Indeterminable ($200,000 to $1,500,000)	Indeterminable ($200,000 to $1,500,000)	Indeterminable ($200,000 to $1,500,000)
Funding Source(s)	General Fund, Medical Clinics in Medically Underserved Areas Fund and Office of Professional Licensure and Certification Fund			
Appropriations	$0	$0	$0	$0
Funding Source(s)	None			

- Does this bill provide sufficient funding to cover estimated expenditures? [X] N/A
- Does this bill authorize new positions to implement this bill? [X] N/A

METHODOLOGY:

This bill establishes the regulation and licensure of deputy physicians under the Board of Medicine as well as regulates their practice through deputy physician collaborative practice arrangements; and establishes a grant program in the Department of Health and Human Services to provide matching funds for primary care clinics in medically under served areas utilizing deputy physicians.

The Office of Professional Licensure and Certification (OPLC) states this bill would provide an alternative path to licensure for deputy physician. The OPLC is unable to determine a fiscal impact as they are not able to estimate the number of applicants who would apply for this new license and what the cost of the new license would be. Additionally, any costs associated with the new license would be attributable to rules as the rules set the license fee amounts. This bill may duplicate existing rules for doctor licenses and not align with current laws regarding the Board of Medicine's authority, rules, fees, renewals, and penalties. This may require changes to align with RSA 310.

The Department of Health and Human Services (DHHS) states the bill instructs the DHHS to set up a program to boost the number of medical clinics in areas with limited healthcare access. It creates a non-lapsing fund called the Medical Clinics in Medically Underserved Areas Fund, aiming to gather money from the General Fund, public or private sources (like gifts, grants, donations, etc.), and settlements designated for the fund. The Department will establish rules for the program, allowing non-profit organizations to start clinics in underserved areas and receive up to $100,000 per fiscal year for two years for startup costs. If a clinic struggles to recruit medical professionals, it might also qualify for these funds. To finance the program, the Department is encouraged to seek contributions from healthcare foundations, insurance, pharmaceutical, and hospital entities, and the legislature can allocate general fund or RSA 84-A money for this fund.

The DHHS anticipates needing 1.5 full-time positions at the State Office of Rural Health: a full-time Administrator I (LG 27) responsible for program oversight, budgeting, grant writing, and managing defaults; and a part-time Program Specialist IV (LG 25) handling applications, documentation, payments, and tracking, working with finance staff. Estimated personnel costs are $112,000 for the Administrator I in FY 2025, $113,000 in FY 2026 and FY 2027, and $50,000 for the part-time Program Specialist IV in FY 2025, $48,000 in FY 2026, and $50,000 in FY 2027. The actual grant funds disbursed are uncertain due to unpredictable yearly clinic establishments, potentially ranging between $200,000 to $1.5 million in general funds for up to 15 estimated clinics costing around $100,000 each annually.

AGENCIES CONTACTED:

Office of Professional Licensure and Certification and Department of Health and Human Services