FEDERAL AND STATE HEALTH LAW YEAR IN REVIEW

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I. UNITED STATES SUPREME COURT


On June 16, 2016, the United States Supreme Court decided the “Escobar” case upholding the implied false certification theory of liability under the False Claims Act. In the unanimous decision, the Court resolved a Circuit Court split by adopting the “implied false certification” theory of FCA liability, though with some limitation. The implied certification theory holds that when a Defendant submits a claim for payment to the government, it impliedly certifies compliance with various statutory, regulatory, and contractual requirements that would otherwise apply. Thus noncompliance with one of those requirements would render the claim “false” and provide the basis for FCA liability. The Supreme Court held that implied certification may be a viable basis for liability “at least where two conditions are satisfied”: (1) a claim makes specific representations about a good or service, and (2) the Defendants’ failure to disclose non-compliance with a material statutory, regulatory or contractual requirement makes those specific representations “misleading half-truths.” 136 S.Ct 1989, 2001. The Escobar decision introduces a new “materiality” standard for a misrepresentation to be actionable under the FCA.

Additionally, the Court held that FCA liability for failing to disclose violations of legal requirements does not turn upon whether those requirements were expressly designated as conditions of payment. Syllabus ¶2. “Whether a provision is labeled a condition of payment is relevant to but not dispositive of the materiality inquiry.” 136 S.Ct 1989, 2001.

Since the Escobar decision was handed down, Courts discussing the application of the new Escobar materiality standard include:


A copy of the Escobar Supreme Court opinion is available at https://www.supremecourt.gov/opinions/15pdf/15-7_a074.pdf


On May 16, 2016, the United States Supreme Court issued an unusual opinion in seven consolidated cases under the “Zubik” caption. The petitioners challenged a notice requirement under the Affordable Care Act regarding contraceptive coverage to their employees. Specifically, the petitioners claimed that submission of a form to their insurer or the Federal Government, stating that they objected on religious grounds to providing contraceptive coverage, violated their rights under the Religious Freedom Restoration Act of 1993. The Supreme Court expressed no view on the merits of the cases, but rather, remanded the consolidated cases back to their respective circuit courts in hopes of reaching a compromise between the parties, noting: “Given the gravity of the dispute and the substantial clarification and refinement in the positions of the parties, the parties on remand should be afforded an opportunity to arrive at an approach going forward that accommodates petitioners’ religious exercise while at the same time ensuring that women covered by petitioners’ health plans ‘receive full and equal health coverage, including contraceptive coverage.’” (slip op., at 4-5).
In light of the Supreme Court’s ruling, each case was remanded:


- *Little Sisters of the Poor Home for the Aged v. Burwell*, Case No. 13-1540 (10th Cir.).

- *Priests for Life v. Dep’t of Health & Human Servs.*, Case No. 13-5368 (D.C. Cir.).


- *S. Nazarene Univ. v. Burwell*, Case Nos. 14-6026, 14-6028 (10th Cir.).


A copy of the *Zubik* Supreme Court decision is available at https://www.supremecourt.gov/opinions/15pdf/14-1418_8758.pdf


On February 22, 2017, oral arguments were held before the United States Supreme Court in the “Kindred” case. There, the petitioners, Kindred Nursing Centers Limited Partnership, et al., seek review of a Kentucky Supreme Court decision that “refused to enforce two arbitration agreements entered into by attorneys-in-fact who had been given express authority to enter into “contracts” on behalf of their principals. The court held the this general authority to enter into contracts did not authorize arbitration agreements.” Rather, the Kentucky Supreme Court held that “explicit reference” to arbitration in the power-of-attorney document is required for this type of authority. The petitioners argue that this decision improperly “singles out” arbitration provisions and conflicts with the Federal Arbitration Act, which preempts state law rules that are “restricted to the field of arbitration and do not place arbitration contracts on equal footing with all other contracts.”
II. CMS RULES AND REGULATIONS

A. 60 day Overpayment Refund Rule (81 Fed. Reg. 7654)

On February 12, 2016, CMS issued the long-awaited regulations to implement the requirement that healthcare providers report and return Medicare overpayments within sixty days. The “60 day rule”, effective March 14, 2016, applies to Medicare Parts A and B and provides that the sixty day clock for reporting and repayment begins not when a provider notices a potential overpayment, but rather, when the provider identifies and quantifies the overpayment. “Identification” of an overpayment occurs when a provider “has, or should have through the exercise of reasonable diligence, determine that [it] has received an overpayment and quantify the amount of the overpayment.” Providers are expected to engage in reasonable diligence to identify an overpayment through proactive compliance and internal investigations. CMS specifies that these investigations should be completed within six months from the receipt of credible information of a potential overpayment. Overpayments must be reported and returned only if identified within six years of the date the overpayment was received.


B. Prohibition on Discrimination in Healthcare: Condition of Participation (81 Fed. Reg. 39447)

On June 16, 2016, CMS proposed a rule to amend the conditions of participation for hospitals and critical access hospitals to establish and implement a policy expressly prohibiting discrimination on the basis of race, color, religion, national origin, sex, sexual orientation, gender identity, age or disability.


C. The MACRA Final Rule (81 Fed. Reg. 77008)

On October 14, 2016, CMS published a final rule implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The new rule implements the legislative changes to the Medicare physician reimbursement system. In place of the legacy sustainable growth rate methodology which was the basis of the physician fee schedule payments for years, the final rule creates a two track payment system for qualifying physicians and midlevel providers that will shift these clinicians towards a quality based payment system.
Under the new rules, reimbursements are designed to encourage quality patient care and efficient utilization of resources. One payment track will be known as MIPS (Merit-based Incentive Payment System) and beginning in 2019 CMS will apply a positive or negative adjustment to physician reimbursement based on performance in four categories: (1) quality, (2) clinical practice improvement activities (3) advancing care information performance, and (4) cost performance.

The second payment track, AAPM (Advanced Alternative Payment Model) will reward eligible clinicians who participate in designated Medicare payment models which emphasize value of care rather than volume of care. Beginning in 2019, the eligible providers in the AAPM may qualify for a lump sum incentive payment and will be exempt from the MIPS payment adjustments.


D. CMS Revisions to the Long Term Care Requirements (81 Fed. Reg. 68688)

On September 29, 2016, CMS announced a Final Rule that serves as a comprehensive update to requirements for Long-Term Care (LTC) facilities. Upon announcement of the Final Rule, attention focused immediately on the ban on pre-dispute Arbitration Agreements in nursing home contracts (42 CFR § 483.70(n)). But the Final Rule is far more sweeping in scope: it reorganizes existing regulations from a structural standpoint, implements entirely new substantive regulations, and makes important revisions to existing requirements for LTC facilities.

New sections include:

- Comprehensive Person-Centered Care Planning (42 CFR § 483.21);
- Laboratory, Radiology, and Other Diagnostic Services (42 CFR § 483.50);
- Compliance and Ethics Program (42 CFR § 483.85); and
- Training Requirements (42 CFR § 483.95).

CMS indicated that this undertaking was long overdue, with the last comprehensive review and update taking place over 25 years ago. In its endeavor, CMS intended the Final Rule “to improve the quality of life, care, and services in LTC facilities, optimize resident safety, reflect
current professional standards, and improve the logical flow of the regulations.”

Given the breadth of the regulatory overhaul, CMS opted to implement the requirements in three phases, with Phase 1 effective November 28, 2016; Phase 2 to become effective November 28, 2017; and Phase 3 to become effective November 28, 2019.


E. Medicare Outpatient Observation Notice (MOON)

Beginning March 8, 2017, CMS requires compliance with the Medicare Outpatient Observation Notice (MOON). MOON is a standard written notice that hospitals and critical access hospitals must provide to Medicare beneficiaries receiving outpatient observation services for more than 24 hours. The notice explains the status of the individual as an outpatient and the implications of this status.


F. Proposed Rule to Stabilize Health Insurance Marketplaces (82 Fed. Reg. 10980)

On February 17, 2017, CMS announced a proposed rule that establishes new reforms to stabilize the individual and small group health insurance markets. The rule would “amend standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period for the individual market for the 2018 plan year; standards related to network adequacy and essential community providers for qualified health plans; and the rules around actuarial value requirements.” Public comments were accepted through March 7, 2017.

III. HEALTH CARE COMPLIANCE: OIG – FRAUD AND ABUSE – CMPs

A. Senate Finance Committee Explores Stark Reforms

In July 2016, the Senate Finance Committee held hearings to examine ways to improve and reform the Stark Law, and published a white paper suggesting changes to modernize the Stark Law to better serve the current healthcare industry. Referring to the Stark Law as a “minefield for the healthcare industry”, the Majority Staff Report considers potential reforms, even the possibility of complete repeal of the Stark Law. Suggested revisions include expanding the use of Stark Law waivers, simplifying existing definitions and exceptions, and reducing the penalties for technical violations.


B. Significant Stark Law Settlements Continue.

While the Stark Law remains on the books, the DOJ continues to enforce it and in 2016 DOJ announced significant settlements of Stark Law allegations involving the following health systems:

- $17M settlement with Lexington Medical Center, West Columbia, South Carolina
- $9.9M settlement with Memorial Health University Medical Center, Savannah, Georgia
- $3.3M settlement with Tri-City Medical Center, Oceanside, California

The Justice Department recovered $2.5 billion from false Claims Act cases involving the health care industry in Fiscal Year 2016. https://www.justice.gov/opa/pr/justice-department-recovers-over-47-billion-false-claims-act-cases-fiscal-year-2016

C. Inflation Adjustment of the Civil Monetary Penalties

On September 6, 2016 HHS issued an interim final rule providing for a “catch up” inflation adjustment of the CMP amounts authorized under the Social Security Act. (81 FR 61537). The Interim Final Rule (IFR) establishes new section 45 CFR Part 102, which lists the new CMP
amounts and ranges as adjusted by the IFR for affected regulations. This inflationary adjustment was required by the 2015 amendments to the Federal Civil Penalties Inflation Adjustment Act (FCPIAA) to improve the effectiveness of CMPs and to maintain their deterrent effect. The adjusted CMPs apply to violations which occur on or after November 2, 2015 and to CMPs assessed after August 1, 2016.

Additional detail on the new CMP amounts can be accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Civil-Monetary-Penalties-Annual-Adjustments.html

D. The “Yates memo” in Practice: Increasing Individual Liability for Corporate Wrongdoing

On September 9, 2015 former Deputy Attorney General Sally Q. Yates issued the so-called “Yates memo” announcing DOJ policy to place increased focus on prosecuting individual employees along with corporations for corporate wrongdoing. The memo states that “in coming months and years, when companies enter into high-dollar resolutions with the Justice Department, you’ll see a higher percentage of those cases accompanied by criminal or civil actions against the responsible individuals.” The new policy was evident in three healthcare industry settlements announced in 2016:

- September 19, 2016: DOJ announced a $30M settlement with North American Healthcare, Inc. and two executives (the Chairman of the Board and Senior Vice President of Reimbursement Analysis) in connection with allegations that the company provided medically unnecessary rehabilitation services after two executives.

- September 27, 2016: the former CEO of Tuomey Healthcare Systems, Inc. agreed to a $1M payment and a four year exclusion from participation in Federal healthcare programs in connection with the alleged Stark Law violations at the Tuomey Hospital.

- October 24, 2016: Lifecare Centers of America, Inc. and its owner agreed to a $145M settlement in connection with allegations that the company provided medically unnecessary rehabilitation services.

On December 7, 2016, the OIG published a final rule addressing safe harbors under the anti-kickback statute for certain payment practices and business arrangements, including: (1) cost-sharing waivers; (2) certain remuneration between federally qualified health centers and Medicare Advantage organizations; and (3) free/discounted local transportation to federal health program beneficiaries. OIG also clarified its interpretations of “low risk of harm” and “promotes access to care” in relation to the statutory exception under the Civil Monetary Penalty statute. The final rule is effective as of January 6, 2017.


On October 30, 2015, CMS announced the final 2016 Medicare Physician Fee Schedule, effective January 1, 2016, which contains changes to the Stark Law. Notably, two new exceptions to the Stark Law were added, regarding: (1) assistance to compensate non-physician practitioners; and (2) time-share arrangements. Through the 2016 Fee Schedule, CMS clarified aspects of exceptions to the Stark Law, including: the form of written arrangements; memorialization of the one-year requirement; remedying signature requirements; indefinite hold over of arrangements for office space, equipment rental, and personal services; and exclusions from the definition of “remuneration.”


G. **Office of Inspector General**

In 2016 (and 2017 to date) the OIG has appeared before Congress to provide updates and to testify on a range of health care fraud investigations, program integrity initiatives, and to review operations and enrollment in the ACA. For a full list of Congressional appearances and transcripts, see Appendix 1.

In 2016 the OIG issued 13 new Advisory Opinions on anti-kickback concerns involving proposed arrangements, and announced the modification or termination of five previous opinions. One Advisory Opinion has issued in 2017 to date. A Table of Advisory Opinion activity appears at Appendix 2.
IV. ANTITRUST

A. The Government Successfully Challenged Mergers of Major Health Insurance Companies

In 2015, Anthem, Inc. announced its proposed acquisition of Cigna, and Aetna, Inc. planned an acquisition of Humana, Inc. In July 2016 the DOJ and several states brought separate actions to challenge the mergers under the Clayton Act. United States Attorney General Loretta Lynch said: “If allowed to proceed, these mergers would fundamentally reshape the health insurance industry” and restrict competition in key markets. Challenges were heard on an expedited basis before the D.C. District Court.

On 01/23/2017, following a Bench trial, the District Court enjoined the Aetna-Humana merger concluding the proposed merger would substantially lessen competition in the market for individual Medicare Advantage plans and in the public exchange market. United States v. Aetna, Inc., --- F.Supp.3d ---, 2017 WL 325189.

One month later, on 02/21/2017, following a Bench trial, the District Court enjoined the Anthem-Cigna merger, concluding that the merger may substantially lessen competition in the market for the sale of medical health insurance to national accounts customers (defined as employers with more than 5000 employees) in the fourteen states where Anthem operates as the Blue Cross Blue Shield licensee, in the market for the sale of health insurance to “large group” employers of more than 100 employees in the Richmond Virginia market. United States v. Anthem, Inc. --- F.Supp.3d ---, 2017 WL 685563.

B. In 2016 the Federal Trade Commission challenged hospital mergers in 3 jurisdictions

The government sought to block the proposed hospital mergers of: (i) Penn State Hershey Medical Center and PinnacleHealth System in Harrisburg, Pennsylvania; (ii) Advocate Health Care Network and NorthShore University HealthSystem in the Chicago, Illinois area; and (iii) St. Mary’s Medical Center and Cabell Huntington Hospital in Huntington, West Virginia.

The FTC was initially unsuccessful, at the District Court level, in its challenge to the Harrisburg, Pennsylvania and Chicago, Illinois hospital mergers. Federal Trade Commission v. Penn State Hershey Medical, 185 F.Supp.3d 552 (M.D. Penn. 2016); Federal Trade Commission v. Advocate Health Care, Slip Copy, 2016 WL 3387163 (N.D. Ill. 2016). The FTC challenged both proposed mergers under Section 7 of the Clayton Act, and was ultimately successful in appealing to the Third and
Seventh Circuits, respectively. *Federal Trade Commission v. Penn State Hershey Medical Center*, 838 F.3d 327 (2016); *Federal Trade Commission v. Advocate Health Care Network*, 841 F.3d 460 (2016). Both Appellate Courts articulated a rule that the “hypothetical monopolist test” should be used when seeking to define the relevant geographic market that would be affected by a potential merger. Following the Appellate Court rulings, the Harrisburg Hospitals abandoned their merger plans while the Chicago hospitals’ case was remanded to the District Court for further proceedings with the merger remaining enjoined pending the district court’s reconsideration of the preliminary injunction motion.

Meanwhile, the FTC withdrew its administrative complaint challenging the proposed merger of two Huntington, West Virginia hospitals because the West Virginia legislature passed a Certificate of Public Advantage (COPA) law granting antitrust immunity to protect the hospitals’ “cooperative agreement” under the state action doctrine. Under the COPA law, the West Virginia Health Care Authority now holds exclusive power to approve or reject merger agreements between healthcare providers. *In the Matter of Cabell Huntington Hospital, Inc.* Docket No. 9366 (July 6, 2016).

V. HIPAA

A. Enforcement, Resolution Agreements and CMPs

In 2016 the Office of Civil Rights entered into 13 Resolution Agreements and CMPs with fines totaling more than $23.5M. In August 2016 OCR announced the largest single entity settlement to date: $5.5M with Advocate Health Care Network, a large non-profit health system based in Chicago. In June 2016 OCR also entered the first settlement with a business associate, Catholic Health Care Services of the Archdiocese of Philadelphia (CHSC) following the theft of a CHSC iPhone that was not password protected though it contained the PHI of hundreds of nursing home residents. Information on all OCR enforcement actions can be found at [https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/](https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/).

B. Phase 2 Audits Begin

OCR began the second phase of its audit program in 2016. On July 11, 2016, 167 covered entities received notification letters that they were being audited. In fall 2016, 48 business associates were selected for audit. [http://www.healthprivacyforum.com/sites/healthprivacyforum/files/privacy_and_security_forum_hipaa_audit_and_enforcement.pdf](http://www.healthprivacyforum.com/sites/healthprivacyforum/files/privacy_and_security_forum_hipaa_audit_and_enforcement.pdf)
OCR will conduct the audits as desk audits with a potential for some onsite activity. The audits are designed to check for compliance with HIPAA’s Privacy Rule (individual right to access and notice of privacy practices), Security Rule (risk analysis and risk management), and/or Breach Notification Rule (content and timing of breach notices). The audits are intended to enhance industry awareness of HIPAA compliance obligations. Depending on the outcome of the audits, some enforcement action may follow. A completion date for the Phase 2 audit program has not yet been announced.

Guidance and information about the Phase 2 Audit Program is available: https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/

C. Guidance Documents

In 2016 OCR issued three guidance documents to help covered entities, business associates and individuals know, understand, and comply with HIPAA obligations.

- February 2016: *Individuals’ right to access their PHI.* The guidance document is intended to provide information and clarification to facilitate individuals’ access to their own PHI. This guidance sets limits on what covered entities can charge for copies of medical records.

- July 2016: *Fact Sheet on Ransomware.* OCR recommends strategies for healthcare entities to prepare for potential ransomware intrusions including a recommendation that entities backup their data regularly and segregate their data within the entities’ network so that it will be more difficult for an attacker to prevent the entity from being able to access the entities’ own information. So that in the event of a ransomware attack, an entity will still be able to access and function with its own information.

- October 2016: *Guidance on HIPAA & Cloud Computing.* This guidance document clarifies that covered entities are permitted to use cloud service providers to store EPHI and that oversee storage of EPHI is also permitted. The guidance also clarifies that cloud service providers that store EPHI are business associates and covered entities and cloud service providers must have a Business Associate Agreement in place prior to transferring the EPHI.

In August 2016, the Centers for Disease Control and Prevention (CDC) released a “Healthcare Organization and Hospital Discussion Guide for
Cybersecurity.” The activity-based discussion guide is intended to aid health care organizations identify issues that may arise when responding to a cyber breach or attack, and to proactively develop strategies to address the identified issues.


VI. **AFFORDABLE CARE ACT §1557**

On May 18, 2016 the Office of Civil Rights published a Final Rule implementing Section 1557 of the Affordable Care Act to prohibit discrimination based on sex, gender, gender identity and sex stereotyping in health programs and activities that receive Federal financial assistance. 81 FR 31375. The Final Rule took effect on July 18, 2016. The final rule includes significant enforcement provisions. HHS may suspend or refuse to continue Federal funding to any organization that does not address complaints of noncompliance with the new rules banning sex discrimination in healthcare. Moreover, individuals who believe their rights have been violated may file individual or class action suits in Federal Court.

On December 31, 2016, the United States District Court for the Northern District of Texas enjoined enforcement, on a national basis, of the §1557 regulations which prohibited discrimination on the basis of gender identification and termination of pregnancy. Accordingly, the OCR may not enforce those provisions while the injunction remains in place. *Franciscan Alliance, Inc. v Burwell*, Case No. 7:16-cv-00108-O.

VII. **FEDERAL LEGISLATION**

On December 13, 2016 President Obama signed the 21st Century Cures Act into law. Pub.L. 114-255. The 21st Century Cures Act is composed of 19 pieces of legislation and among its provisions, will: expedite FDA approval for new medicines and devices while maintaining standards for safety and efficacy; increase medical research funding to support the NIH, help advance the “precision medicine initiative”, fund the “cancer moonshot” research initiatives, and the BRAIN research programs designed to focus research on Alzheimer’s and traumatic brain injuries. The act also provides extensive mental health reforms and encourages the FDA to develop clearer guidelines for clinical trial design.

On March 2, 2017, the “Preserving Employee Wellness Programs Act” (H.R. 1313) was introduced in the House of Representatives. This legislation seeks to clarify rules relating to nondiscriminatory workplace
wellness programs. Notably the Bill exempt workplace wellness programs from to prohibition on collecting genetic information in connection with health insurance, and limitations under GINA on collecting genetic information of employees or their family members. A copy of the proposed Bill is available at https://www.congress.gov/115/bills/hr1313/BILLS-115hr1313ih.pdf.

VIII. OHIO SUPREME COURT CASES DECIDED IN 2016


The Court rejected Simpkins’s argument that the General Assembly acted unreasonably and arbitrarily when it distinguished between catastrophic physical and catastrophic nonphysical injuries. And while the Fifth District’s opinion provided some language that seemed to leave open that a carve-out might meet with constitutional success when nonphysical injuries approach catastrophic proportions, no such facts exist in this case that required the lead opinion to resolve that issue. A copy of the full court decision is available at https://www.supremecourt.ohio.gov/rod/docs/pdf/0/2016/2016-Ohio-8118.pdf.


Plaintiff sought certain documents in discovery that the Clinic claimed were protected by the attorney-client privilege or work-product doctrine. The trial court ultimately ordered the Clinic to produce an incident report and the Clinic appealed. The Eighth District dismissed the appeal for lack of a final appealable order, premising its decision on the Supreme Court’s 2015 decision in Smith v. Chen, 142 Ohio St.3d 41, 2015-Ohio-1480.

The Ohio Supreme Court plurality limited Smith v. Chen to its facts, claimed counsel in that case did not make a R.C. 2505.02(B)(4)(b) showing (no adequate remedy following final judgment), and created a broad rule of law that an order requiring the production of information protected by the attorney-client privilege cannot be remedied by appeal following final judgment and therefore satisfies R.C. 2505.02(B)(4)(b). But “other discovery protections that do not involve common law, constitutional, or statutory guarantees of confidentiality, such as the work-product doctrine, may require a showing under R.C.
2505.02(B)(4)(b) beyond the mere statement that the matter is privileged.”
A copy of the full court decision is available at
https://www.supremecourt.ohio.gov/rod/docs/pdf/0/2016/2016-
Ohio8000.pdf.

Ohio’s four year Medical Malpractice Statute of Repose, R.C. 2305.113
(c) is a true Statute of Repose that applies to both vested and non-vested
claims. Therefore any medical malpractice action must be filed within
four years of the occurrence of the act or omission alleged to have
caus ed a Plaintiff’s injury. This decision did not address, and thus does
not disturb, R.C. 2305.113(D)(2) which explicitly extends the statute of
repose for Plaintiffs bringing a medical malpractice action under certain
circumstances, for instance, when the injury involves a foreign object.
The Court rejected the Plaintiff’s assertion that filing then voluntarily
dismissing the case nevertheless constitutes “commencing” suit so as to
suspend the statute of repose. The Court reiterated that once a Complaint
has been dismissed without prejudice, legally, that action is deemed to
never have existed. Accordingly, Plaintiff’s medical malpractice was not
“commenced” until he filed the second state court Complaint which was
more than four years after the prostatectomy surgery in January 2008
that gave rise to Plaintiff’s claim. Accordingly, R.C. 2305.113(C) is held
to be constitutional both when it extinguishes a vested and a non-vested
cause of action.
A copy of the full court decision is available at
http://www.supremecourt.ohio.gov/rod/docs/pdf/0/2016/2016-Ohio-
7432.pdf.

(decided Aug. 30, 2016).
Ohio’s Good Samaritan Statute, R.C. 2305.23, applies to any person who
administers emergency care or treatment at the scene of an emergency
including but not limited to healthcare professionals. This case arose
when Reese attempted to move a tractor-trailer that had pinned Carter’s
leg between the trailer and a loading dock. Carter told Reese to pull the
tractor-trailer forward in order to free his leg, but when Reese attempted
to do so, the truck rolled backward, resulting in serious injury to Carter.
The Court’s opinion includes a nationwide review of Good Samaritan
statutes. The Court also held that the phrase “administering emergency
care” is not limited to medical attention, but more broadly includes other
forms of assistance for the safety and wellbeing of another when the
result of an unforeseen combination of circumstances calls for immediate action. Accordingly, R.C. 2305.23 applies to Reese and he is not liable in civil damages to Carter.


E. **Griffith v. Aultman Hosp., 146 Ohio St.3d 196, 54 N.E.3d 1196 (decided Mar. 23, 2016).**

The term “medical record” in R.C. 3701.74(B) does not include all patient data but includes only that data that a healthcare provider has decided to keep or preserve in the process of treatment. The Court found the Fifth District erred when it previously found that the medical record consisted only of information maintained by the medical-record department. The key was construing the term “maintained” used in R.C. 3701.74(A)(8) defining “medical record.” Because that term is not defined by the statute, the majority applied its ordinary meaning, which “conveys that the healthcare provider has made a decision to keep or preserve the data.” That meaning does not limit the medical record to a particular location nor does the statutory definition state that the medical record is confined to a specific physical location. Instead, the focus is on whether the provider decided to keep the data generated in the course of providing medical care. In response to the Griffith decision, various members of the healthcare community are working together to draft and propose legislation that would clarify the definition of medical records.


F. **Whetstone v. Binner, 146 Ohio St.3d 395, 2016-Ohio-1006, 57 N.E.3d 1111 (decided Mar. 15, 2016).**

Punitive damages can be awarded against the estate of a deceased tortfeasor. The majority distinguished its decision on the basis that the tortfeasor was alive in this case at the time judgment on liability was entered. It therefore held that in cases where liability has already been determined while the tortfeasor was alive, punitive damages are available to a plaintiff. Even so, the tortfeasor’s death is relevant to the extent that the trier of fact may consider that the deceased tortfeasor is not available to testify at a hearing on punitive damages and that any award of punitive damages would be against the estate.

A copy of the full court decision is available at https://www.supremecourt.ohio.gov/rod/docs/pdf/0/2016/2016-Ohio-1006.pdf.

The Court found that a hearing examiner for the Board of Nursing has discretion to limit or quash subpoenas requested during disciplinary proceedings. In reaching this decision, it noted that R.C. Chapter 119 does not mention the power of an agency to quash or limit subpoenas, but that it is nonetheless an inferred power that “flows from the authority to issue them in an adjudicative hearing.” It reasoned that “[a]gencies must have at least some minimal authority to control those hearings” because [s]trict and technical rules of criminal or civil judicial hearings do not apply to their proceedings.”


The request for records from the Cuyahoga County Board of Health seeking documentation of the homes in Cuyahoga County where a minor child was found to have elevated blood levels, submitted as a public records request under R.C. 149.43 was properly denied because the release of the records is prohibited by R.C. 3701.17(B) which prohibits the release of “protected health information.” The Court distinguished *State ex rel Cincinnati Enquirer vs. Daniels*, 108 Ohio State 3d 518, 2006-Ohio-1215 in which the Court concluded that lead contamination notices issued by a city health department were not prohibited from disclosure under HIPAA because in that case, the information sought did not contain personally identifiable protected health information about elevated lead levels in identifiable children. Unlike the *Cincinnati Enquirer* case, the public records request in *Lipson O’Shea* “is inextricably linked to “protected health information.” Because the information requested identifies, or can be used to identify, specific individuals.

IX. OHIO SUPREME COURT CASES PENDING DECISION


Appeal accepted: March 15, 2017 (Case No. 2016-1348)

Appellant: State of Ohio Department of Health

Oral Argument: Not scheduled

Issues Accepted for Review:

(1) Ohio's administrative rule, O.A.C. 3701-83-19(E), validly requires ambulatory surgical clinics to have written transfer agreements with hospitals in cases of "medical complications, emergency situations, and for other needs." The Director acted in accordance with that law when finding that an agreement with a non-local hospital is not adequate for "emergency situations."

(2) A challenged law can only be found to be an "undue burden" on abortion rights if a plaintiff makes a factual and legal showing of such a burden, and a court cannot sua sponte find such a burden when the issue is not raised. Ohio's transfer-agreement requirement is a valid health-and-safety regulation that applies to all outpatient surgical clinics, and it is not an undue burden.

(3) Ohio law does not unconstitutionally delegate authority in requiring all ambulatory surgical facilities to have written transfer agreements with local hospitals in case of emergencies or other needs, as the ultimate decision remains with the Ohio Department of Health.

(4) The General Assembly did not violate the one-subject clause by using the budget bill to streamline the rules for a state agency to grant ambulatory-surgical-facility licenses.

B. Preterm-Cleveland, Inc. v. Kasich, Case No. 15-103103, 68 N.E.3d 314, 2016-Ohio-4859 (Ohio Ct. App., 8th Dist).

Appeal accepted: February 22, 2017 (Case No. 2016-1252)

Appellant: State of Ohio

Oral Argument: Not scheduled
Issue Accepted for Review:

The Ohio Constitution requires plaintiffs to establish standing for each claim, so a plaintiff challenging several provisions in a bill on one-subject grounds must prove standing for each provision. To do so, a plaintiff must identify an injury that is both concrete and particularized and actual and imminent. A plaintiff therefore lacks standing to challenge laws that may never harm it, that it may satisfy merely by sending a document, or that apply only to different persons.


Appeal accepted: July 27, 2016 (Case No. 2016-0636)

Appellants: Anthony and Tammy Rush

Oral Argument: Scheduled for May 3, 2017

Issue Accepted for Review:

In any tort action, the employee does not need to be joined in order to establish *respondeat superior* liability so long as the employer has been properly served.

X. *Jones v. MetroHealth Medical Center, et al., Court of Appeals, Eighth Appellate District, Case No. 102916 (on appeal from Case No. CV-11-757131)*.

*Jones* is on appeal from a birth injury/medical malpractice case tried in Cuyahoga County in which a jury awarded plaintiffs (mother and son) a combination of past and future economic damages, and non-economic damages in the amount of $14.5 million against MetroHealth Medical Center and a physician. In post-trial proceedings the trial court ordered statutory offsets of collateral sources for political subdivisions, pursuant to R.C. 2744.05(B)(1) and imposed damage caps on non-economic damages as required by R.C. 2744.05(C)(1). The application of the offsets and caps reduced the award to $3.451 million. The Plaintiffs appealed.

On July 7, 2016, in a 3-0 decision, the Eighth District affirmed that R.C. 2744.05 is constitutional in all respects, and that the procedure used by the trial court to conduct a post-trial hearing to determine MetroHealth’s right to a statutory offset and the amount of that offer was proper. Further, the Court affirmed that MetroHealth Medical Center is a political subdivision for purposes of R.C. 2744.05, and need not offer evidence of that status during trial. Finding the damage cap provision for political subdivisions to be constitutional, the Appellate Court
affirmed the application of the cap on non-economic damages (R.C. 2744.05(C)(1)), and then considered the offsets for collateral benefits, also available to political subdivisions (R.C. 2744.05(B)(1)). In considering the offsets for future economic damages, the court properly considered the availability of medical insurance under the Affordable Care Act to cover the child’s medical needs until his 20th birthday, and the availability of Medicare to cover all future medical expenses from point in time forward. The Appellate Court did reverse the Trial Court with respect to the award for the loss of future income, and remanded with instructions that an additional $1.7 million be added back.

In sum, the Appellate Court affirmed in large part, reversed on lost wages, and remanded with instructions to enter judgment for $5.151 million, which consists of $3.451 million (as entered by the trial court) plus $1.7 million in lost wages—the amount the trial court found was the minimum amount of lost wages the evidence supported. The conditional cross-appeal—only addressed because the court modified the trial court’s judgment—was rejected in all respects, including the argument about paying in installments under R.C. 2744.06.

The case remains before the Court of Appeals pending decision on Plaintiff’s Motion for Partial Reconsideration and Reconsideration en Banc.

XI. OHIO LEGISLATIVE UPDATE

A. Enacted Legislation

Throughout 2015 and 2016, the 131st General Assembly enacted numerous pieces of legislation germane to the Ohio health care industry. Major pieces of legislation include:

- **S.B. 319 (eff. Apr. 6, 2017)** – In an effort to strengthen Ohio law on drug abuse, Gov. John Kasich signed S.B. 319 on January 4, 2017. The Bill aims to increase: access to Naloxone; oversight authority of the Ohio Board of Pharmacy; limitations on opiate prescriptions; and access to methadone clinics.

- **S.B. 127 (eff. Mar. 14, 2017)** – After vetoing the “Heartbeat Bill” on abortion, Gov. Kasich instead signed S.B. 127 on December 13, 2016 which prohibits abortions after a fetus is 20 weeks or more post-fertilization.

• **Sub. H.B. 523 (eff. Sept. 8, 2016)** – “The Ohio Medical Marijuana Control Program,” signed by Gov. Kasich on June 8, 2016. The Bill legalizes the use of marijuana for patients with a qualifying medical conditions and a supporting note from their doctor. Under the Bill, the Ohio Medical Marijuana Advisory Committee was formed in the fall of 2016 and is composed of 14 members appointed by Gov. Kasich and state legislators. The Advisory Committee will work in conjunction with the Ohio Department of Commerce, Ohio Board of Pharmacy, and Ohio Board of Medicine regarding their respective rules and regulations. The Ohio Board of Medicine issued a Statement on the affirmative defense available under the Medical Marijuana Control Program, available at [http://med.ohio.gov/AffirmativeDefense.aspx](http://med.ohio.gov/AffirmativeDefense.aspx).

For a complete summary of health care related legislation enacted by the 131st General Assembly, please consult Appendix 3.

**B. Proposed Legislation**

The 132nd General Assembly convened on January 3, 2017 and is actively proposing new legislation. A summary of health care related legislation as proposed is located in Appendix 4.

**C. Temporary Restraining Order Issued on Ohio Price Transparency Law.**

In June 2015, Amended Substitute House Bill 52 was signed into law that included a requirement for providers to provide patients with a written cost estimate before delivering non-emergency products, services, or procedures (R.C. § 5162.80). This “price transparency law” was scheduled to take effect on January 1, 2017. However, in December 2016, a court in Williams County, Ohio issued a 30-day temporary restraining order on the price transparency law, preventing it from taking effect as slated. A motion for a preliminary injunction is currently pending before Common Pleas Judge J.T. Stelzer, and is scheduled for a hearing on August 14, 2017. In the meantime, the court has ordered that there “shall be no implementation or enforcement of R.C. 5162.80 or
other form of execution of same while plaintiffs’ motion for preliminary injunction is under consideration by the court."


XII. OHIO LICENSING BOARD UPDATES

A. Medical Board

1. Changes to Ohio Administrative Code Rules

Throughout 2016, the Ohio State Medical Board adopted the following rules for incorporation into the Ohio Administrative Code:

<table>
<thead>
<tr>
<th>OAC Rule</th>
<th>Topic</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4730-1-08</td>
<td>Physician assistant delegation of medical tasks and administration of drugs.</td>
<td>July 31, 2016</td>
</tr>
<tr>
<td>4731-8-05</td>
<td>Confidentiality statutes</td>
<td>July 31, 2016</td>
</tr>
<tr>
<td>4731-13</td>
<td>Medical Board Hearing Rules</td>
<td>July 31, 2016</td>
</tr>
<tr>
<td>4731-12</td>
<td>Application, examination for certificate to practice massage therapy</td>
<td>Nov. 30, 2016</td>
</tr>
<tr>
<td>4731-1-16</td>
<td>Massage therapy curriculum requirements</td>
<td>Nov. 30, 2016</td>
</tr>
<tr>
<td>4731-17-02</td>
<td>Exposure-prone invasive procedures-Universal precautions</td>
<td>Nov. 30, 2016</td>
</tr>
<tr>
<td>4731-17-07</td>
<td>Exposure-prone invasive procedures – Violations</td>
<td>Nov. 30, 2016</td>
</tr>
</tbody>
</table>
2. Proposed Rules


3. Medical Board Annual Report

On August 1, 2016, the State Medical Board of Ohio published its Annual Report which highlights information from fiscal year 2016. The Report includes updates on the following topics: fiscal report; licensure activities; investigations, compliance, enforcement and hearings; quality intervention program; public records; and educational outreach activities. A complete copy of the 2016 Annual Report is available at: [http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/Publications/Annual-Reports/2016-Annual-Report.pdf](http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/Publications/Annual-Reports/2016-Annual-Report.pdf).
B. Board of Nursing

1. Changes to Ohio Administrative Code Rules

As a result of the Ohio Board of Nursing’s five year rule review, several revisions were made to the governing administrative rules. These rules, effective February 1, 2016, are contained within Ohio Administrative Code (OAC) Chapter 4723, and noteworthy changes are captured in the following table.

<table>
<thead>
<tr>
<th>OAC Rule</th>
<th>Topic/Summary</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4723-7-10</td>
<td><strong>Volunteer’s Certificate</strong>&lt;br&gt;Adopts requirements for obtaining a Volunteer’s Certificate. When working in this capacity, must display identification showing “Volunteer’s Certificate” status and note same in nursing documentation (“V.C.” abbreviation is acceptable for documentation). A certificate holder that has been inactive or lapsed for at least 5 years, is subject to a criminal records check (O.R.C. 4723.24).</td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td>4723-8-04</td>
<td><strong>Standard Care Arrangements</strong>&lt;br&gt;For APRNs with prescriptive authority, quality assurance provision in standard care arrangement shall address prescribing opioids to minors and obtaining/reviewing OARRS reports. Standard care arrangements must be reviewed every 2 years, and retained for a minimum of 3 years.</td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td>4723-8-05</td>
<td><strong>Quality Assurance Standards</strong>&lt;br&gt;APRNs to verify the licensure of a collaborating physician for a standard care arrangement every 2 years, and can be obtained online from the Ohio e-license center.</td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td>4723-9-02</td>
<td><strong>Requirements for a Course of Study in Advanced Pharmacology</strong>&lt;br&gt;Instruction specific to schedule II controlled substances shall include instruction in fiscal and ethical implications. Schedule II controlled substances instruction can be integrated with other areas ((A)(2)(a)-(c)).</td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td>4723-9-07</td>
<td><strong>Certificate to Prescribe Renewal</strong>&lt;br&gt;Certificate holders inactive for 3 or more years must complete advanced pharmacology course. This requirement does not apply to practitioners who have held prescriptive authority in another jurisdiction (or as a U.S. government employee) in at least 1 of the last 3 years.</td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td>4723-9-08</td>
<td><strong>Safety Standards for Personally Furnishing Drugs and Therapeutic Devices</strong>&lt;br&gt;Specifies requirements for when a clinical nurse specialist, certified nurse mid-wife, or certified nurse practitioner (with a current, valid certificate to prescribe) can personally furnish a drug or therapeutic device to a patient.</td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td>OAC Rule</td>
<td>Topic/Summary</td>
<td>Effective Date</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>4723-9-09</td>
<td><strong>Standards of Prescribing for Nurses with a Certificate to Prescribe</strong></td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td></td>
<td>Additions regarding Naloxone and opioid analgesics to minors.</td>
<td></td>
</tr>
<tr>
<td>4723-9-10</td>
<td><strong>Formulary</strong></td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td></td>
<td>The Committee on Prescriptive Governance (CPG) shall review the formulary at least twice per year. Delineates certain requirements to prescribe drugs approved by the FDA but not yet reviewed/approved by the CPG.</td>
<td></td>
</tr>
<tr>
<td>4723-9-12</td>
<td><strong>Standards and Procedures for Review of OARRS</strong></td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td></td>
<td>Under certain circumstances, APRN prescribers use OARRS information when prescribing controlled substances. Also incorporates “red flags” pertaining to patients mandating review of an OARRS report.</td>
<td></td>
</tr>
<tr>
<td>4723-16-12</td>
<td><strong>Request to Address the Board Regarding a Hearing</strong></td>
<td>Feb. 1, 2016</td>
</tr>
<tr>
<td></td>
<td>Each representative of record who addresses the board is allotted no more than seven minutes in which to do so. Time for rebuttal, if requested, will be deducted from allotted time.</td>
<td></td>
</tr>
</tbody>
</table>


### 2. New and Updated Interpretive Guidelines

Also in 2016, the Ohio Board of Nursing published new Interpretive Guidelines and revised existing Guidelines. Two new Interpretive Guidelines were approved by the Board on March 16, 2016: (1) Guidelines for Registered Nurse Role in the Care of Patients Undergoing Exercise Cardiac Stress Testing, available at [http://www.nursing.ohio.gov/PDFS/Practice/IGs/IG%20Cardiac%20Sress%20Testing.pdf](http://www.nursing.ohio.gov/PDFS/Practice/IGs/IG%20Cardiac%20Sress%20Testing.pdf); and (2) Guidelines for Registered Nurse’s Role in the Care of Patients Receiving Intravitreal Injectable Medications, available at [http://www.nursing.ohio.gov/PDFS/Practice/IGs/IG%20Intravitreal%20Injections.pdf](http://www.nursing.ohio.gov/PDFS/Practice/IGs/IG%20Intravitreal%20Injections.pdf).

The following four Interpretive Guidelines were revised by the Board in 2016:


3. Nursing Board Annual Report

The Ohio Board of Nursing published its Annual Report which highlights information from fiscal year 2016. The Report includes updates on the following topics: the Board’s contributions to statewide initiatives; licensure and certification; nursing education; compliance, discipline and monitoring; continuing education; and regulatory issues and requirements. A complete copy of the 2016 Annual Report is available at: http://www.nursing.ohio.gov/PDFS/AnnualReport/AnnualReport2016.pdf.

C. Board of Pharmacy

1. New Legislation


R.C. 4729.281, as amended, permits a pharmacist to dispense medication, other than a Schedule II controlled substance, without a written or oral prescription if certain conditions are met.

On March 23, 2016, Sub. H.B. 124 took effect, authorizing Ohio physicians, advanced practice registered nurses, and physician assistants to prescribe or personally furnish a drug for a sexual partner
of a patient diagnosed with chlamydia, gonorrhea, or trichomoniasis without examining the sexual partner.

On September 8, 2016, **Sub. H.B. 523**, took effect, legalizing medical marijuana in Ohio, took effect. The Pharmacy Board is responsible for implementing rules on the registration of medical marijuana patients and the licensure of medical marijuana dispensaries.

**S.B. 319**, signed into law in January 2017, will take effect April 6, 2017. It is aimed at fighting opiate addiction and will make changes to the practice of pharmacy in Ohio including: mandating the registration and licensure of pharmacy technicians; requiring licensure of certain office-based opioid treatment clinics; expanding access to Naloxone to allow facilities that regularly interact with high-risk individuals to have onsite access to Naloxone, such as homeless shelters, halfway houses, schools and treatment centers.

Sole proprietors, including medical doctors, dentists, veterinarians and other health care professionals in private practice, who formally distributed controlled substances to their patients without oversight will now be subject to licensure by the Board of Pharmacy to provide safeguards to prevent theft or misuse of highly addictive dangerous drug substances.

The new law makes changes to out patient prescriptions for opioid analgesics, prohibiting the selling or dispensing of an opioid analgesic pursuant to a prescription if more than 14 days have elapsed since the prescription was issued. The new law also prohibits dispensing or selling more than a 90 day supply of an opioid analgesic drug regardless of whether the prescription was issued for a greater amount.

2. Guidance

The State Board of Pharmacy has issued guidance documents on the following topics:

- Dispensing of emergency refill of medication without a prescription (updated 5/6/2016) [https://pharmacy.ohio.gov/Documents/Pubs/Special/DangerousDrugs/Dispensing%20of%20Emergency%20Refill%20of%20Medication%20without%20Prescription.pdf](https://pharmacy.ohio.gov/Documents/Pubs/Special/DangerousDrugs/Dispensing%20of%20Emergency%20Refill%20of%20Medication%20without%20Prescription.pdf)
- Pharmacist consult agreements with physicians (updated 8/9/2016) [https://pharmacy.ohio.gov/Documents/Pubs/Special/Consult/Pharmacist%20Consult%20Agreement%20with%20Physicians.pdf](https://pharmacy.ohio.gov/Documents/Pubs/Special/Consult/Pharmacist%20Consult%20Agreement%20with%20Physicians.pdf)
• Storage of records outside of the pharmacy department (8/19/2016)

Effective August 15, 2016, designated areas outside of the pharmacy department may be used for storage of dangerous drugs, DEA controlled substance order forms, exempt narcotics, hypodermics, poisons, and records relating to the distribution of dangerous drugs, and other items or products that require the personal supervision or sale by a pharmacist, provided certain security requirements are met including use of physical barriers, suitable locks, and/or electronic barriers. Access to the storage area is strictly limited. Pharmacies have until February 1, 2017 to insure their record storage complies with the new security requirements.


• Reporting Gabapentin products to OARRS (effective 12/1/2016)
https://pharmacy.ohio.gov/Documents/Pubs/Special/OARRS/Reporting%20Gabapentin%20Products%20to%20OARRS%20–%20Effective%2012-1-2016.pdf

• Multiple guidance documents relating to drug compounding (affecting prescribers and pharmacists):

  • Compounding in Ohio (updated 2/2/2017)
https://pharmacy.ohio.gov/Documents/Pubs/Special/Compounding/Compounding%20in%20Ohio.pdf

  • Hazardous drug compounding by prescribers

  • Terminal distributor requirements for prescribers possessing compounded drugs or engaging in drug compounding
https://pharmacy.ohio.gov/Documents/Pubs/Special/Compounding/Terminal%20Distributor%20Requirements%20for%20Prescribers%20Possessing%20Compounded%20Drugs%20or%20Engaging%20in%20Drug%20Compounding.pdf
• New requirements for opioid prescriptions – effective 4/6/2017
https://pharmacy.ohio.gov/Documents/Pubs/Special/ControlledSubstances/New%20Requirements%20for%20Opioid%20Prescriptions%20-%20Effective%204.6.2017.pdf

3. Updates to the Ohio Automated Rx Reporting System

On February 1, 2016, OAC 4729-5-20 was updated to include new requirements on when a pharmacist is required to review patient information in OARRS.

Effective December 1, 2016, all products containing Gabapentin dispensed, personally furnished, or sold at wholesale, must be reported to OARRS. Reporting entities include all pharmacies within the state and licensed as a terminal distributor of dangerous drugs that dispense Gabapentin to outpatients; all prescribers, except veterinarians, located within the state that personally furnish Gabapentin to outpatients, including samples; and all pharmacies licensed as a terminal distributor of dangerous drugs that sell Gabapentin at wholesale. This requirement is the result of increased reports of the abuse of Gabapentin.

The OARRS system is being upgraded and on April 25, 2017, OARRS 2.0 goes live. In preparation for the transition, OARRS users must create new data upload accounts. Effective March 15, 2017 OARRS 1.0 will no longer accept dispensing uploads. All dispensing data must be submitted to an interim clearing house where it will then be tested and then transferred into the OARRS 2.0 system.

4. Board of Pharmacy Annual Report

The State of Ohio Board of Pharmacy published its Annual Report for Fiscal Year 2016. A central theme of the Board’s activities in Fiscal Year 2016 was its ongoing commitment to combatting Ohio’s drug overdose epidemic. The Board implemented a number of strategies to address this public health crisis. The Annual Report also provides updates for the Board’s different departments. For full report: https://pharmacy.ohio.gov/Documents/Pubs/Reports/AnnualReports/FY%202016%20Annual%20Report.pdf
XIII. OHIO DEPARTMENT OF HEALTH UPDATE

A. Final Ohio Administrative Code Rules

Throughout 2016, the ODH posted final rules to chapters of the Ohio Administrative Code that implicate the health care community, including the following:

<table>
<thead>
<tr>
<th>OAC Chapter</th>
<th>Description</th>
<th>Date Posted</th>
</tr>
</thead>
<tbody>
<tr>
<td>3701-3</td>
<td>Infectious Disease Prevention and Control</td>
<td>Oct. 5, 2016</td>
</tr>
<tr>
<td>3701-17</td>
<td>Nursing Homes and Residential Care Facilities</td>
<td>Sept. 2, 2016</td>
</tr>
<tr>
<td>3701-55</td>
<td>Genetic, Endocrine, or Metabolic Screening of Newborn Infants</td>
<td>July 5, 2016</td>
</tr>
<tr>
<td>3701-63</td>
<td>Appeal for Revocation of Certification of Long Term Care Communities</td>
<td>Nov. 16, 2016</td>
</tr>
<tr>
<td>3701-64</td>
<td>Long Term Care Facilities; Investigation of Resident Abuse, Neglect, or Misappropriation of Property</td>
<td>Apr. 13, 2016</td>
</tr>
<tr>
<td>3701-83</td>
<td>Health Care Facilities Licensure</td>
<td>June 27, 2016</td>
</tr>
<tr>
<td>3701-84</td>
<td>Health Care Services (HCS) Standards</td>
<td>Aug. 22, 2016</td>
</tr>
</tbody>
</table>

B. Ohio Department of Health Five-Year Rule Reviews

The Ohio Department of Health is in the midst of conducting its five-year rule review on Ohio Administrative Code Chapter 3701-84 regarding Health Care Service Standards. The proposed rules include changes to regulations over the following services: transplants; adult and pediatric cardiac catheterization; adult open-heart surgery; pediatric intensive care; linear accelerator, cobalt, or gamma knife; and pediatric cardiovascular surgery. Public comments to the draft rules were accepted through November 19, 2016. A copy of ODH’s memorandum summarizing the draft amendments is available at http://www.odh.ohio.gov//media/ODH/ASSETS/Files/rules/drafts/3701-84/MEMO-3701-84.pdf?la=en.
The Ohio Department of Health is also conducting its five-year review on Ohio Administrative Code Rules 3701-7-01 through 3701-7-17 regarding Licensing of Maternity Units, Newborn Care Nurseries and Maternity Homes. The rules are currently under their second posting for public comment through April 6, 2017. For copy of ODH’s memorandum summarizing the draft amendments see: https://www.odh.ohio.gov//media/ODH/ASSETS/Files/rules/drafts/3701-7/3701-7-memo-3rd.pdf?la=en.

C. Ohio Department of Health Annual Report

The Ohio Department of Health published its Annual Report which highlights information from fiscal year 2016. The Report includes updates on the following topics: aligning public health to help improve health outcomes; key public health initiatives and accomplishments; and financial management and stewardship. A complete copy of the 2016 Annual Report is available at: https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/health-resources/reports/ODH-SFY-2016-Annual-Report.pdf?la=en.
APPENDIX 1—OIG TESTIMONY BEFORE CONGRESS 2016-2017

2016

09-28-2016

09-14-2016
Testimony of Gloria Jarmon, Deputy Inspector General for Audit Services, Office of Inspector General, U.S. Department of Health and Human Services before the House Committee on Energy and Commerce: Subcommittee on Oversight and Investigations and Subcommittee on Health: "The Affordable Care Act on Shaky Ground: Outlook and Oversight"

05-24-2016

03-17-2016

02-24-2016
Testimony of Ann Maxwell, Assistant Inspector General, Office of Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services before the Senate Special Committee on Aging

02-10-2016
Testimony of John Hagg, Director of Medicaid Audits, Office of Audit Services, Office of Inspector General, U.S. Department of Health and Human Services before the House Committee on Energy and Commerce Subcommittee on Health
2017

03-09-2017


01-31-2017

Testimony of Vicki L. Robinson, Senior Counselor for Policy, Office of Inspector General, U.S. Department of Health and Human Services: House Committee on Oversight and Government Reform: Subcommittee on Health Care, Benefits, and Administrative Rules: "Fraud, Waste, and Abuse Under the Affordable Care Act"

01-31-2017

APPENDIX 2—OIG ADVISORY OPINIONS 2016-2017

2016

01-25-2016
Advisory Opinion 16-01 regarding the use of a "preferred hospital" network as part of Medicare Supplemental Health Insurance ("Medigap") policies, whereby [names redacted] (the "Requestors") would indirectly contract with hospitals for discounts on the otherwise-applicable Medicare inpatient deductibles for their policyholders and, in turn, would provide a premium credit of $100 to policyholders who use a network hospital for an inpatient stay.

03-01-2016
Advisory Opinion 16-02 regarding a state academic medical center that in certain circumstances offers pregnant women: (1) transportation aid to and from the campus hospital for delivery; and (2) short-term lodging near the campus hospital.

03-18-2016
Advisory Opinion 16-03 regarding the use of a "preferred hospital" network as part of Medicare Supplemental Health Insurance ("Medigap") policies.

04-19-2016
Advisory Opinion 16-04 regarding the use of a "preferred hospital" network as part of Medicare Supplemental Health Insurance ("Medigap") policies, whereby three insurance companies would indirectly contract with hospitals for discounts on the otherwise-applicable Medicare inpatient deductibles for their policyholders and, in turn, would provide a premium credit of $100 to policyholders who use a network hospital for an inpatient stay.

05-03-2016
Advisory Opinion 16-05 regarding the use of a “preferred hospital” network as part of Medicare Supplemental Health Insurance (“Medigap”) policies, whereby [name redacted] would indirectly contract with hospitals for discounts on the otherwise-applicable Medicare inpatient deductibles for its policyholders and, in turn, would provide a premium credit of $100 to policyholders who use a network hospital for an inpatient stay.

05-09-2016
Advisory Opinion 16-06 regarding your proposal for an entity to purchase the remaining five percent ownership interest in a group purchasing organization.

06-27-2016
Advisory Opinion 16-07 regarding a savings card program under which individuals who have prescription drug coverage under Medicare Part D receive discounts on a drug that is statutorily excluded from coverage.
Advisory Opinion 16-08 regarding an arrangement in which a hospice would make a supplemental payment to the nursing facilities in which the hospice's dually eligible patients reside when the nursing facilities—instead of the hospice—receive payment for their patients' room and board expenses.

Advisory Opinion 16-09 regarding a proposal to install a computerized point-of-care vaccine storage and dispensing system in physicians' offices for the physicians' use.

Advisory Opinion 16-10 regarding a local health care district's proposal to cooperate with another district to jointly fund the cost of a transportation coordinator to educate patients about local transportation options and subsidize certain forms of transportation for patients with financial need.

Advisory Opinion 16-11 regarding the use of a "preferred hospital" network as part of Medicare Supplemental Health Insurance ("Medigap") policies, whereby an insurance company would indirectly contract with hospitals for discounts on the otherwise-applicable Medicare inpatient deductibles for its policyholders and, in turn, would provide a premium credit of $100 to policyholders who use a network hospital for an inpatient stay.

Advisory Opinion 16-12 regarding a laboratory's proposal to provide services consisting of the labeling of test tubes and specimen collection containers at no cost to dialysis facilities.

Advisory Opinion 16-13 regarding: (i) a proposal to waive cost-sharing obligations incurred by individuals for health care services required for participation in a government-funded clinical research study (the "Proposed Arrangement"); and (ii) the payment of a stipend to study participants for the time and effort required to participate in study visits.

Modification of Advisory Opinion 10-12 modifies Advisory Opinion 10-12, which concerned a nonprofit, tax-exempt, charitable corporation's proposal to provide financially needy patients with grants to defray their cost-sharing obligations, to reflect guidance issued on May 21, 2014 in the Supplemental Special Advisory Bulletin regarding Independent Charity Patient Assistance Programs.
Modification of OIG Advisory Opinion 10-07 modifies OIG Advisory Opinion 10-07 which concerned a nonprofit, tax-exempt, charitable organization's proposal to provide assistance with cost-sharing obligations to financially needy individuals, including Medicare and Medicaid beneficiaries, diagnosed with certain specified diseases, and its first modification at Modification of OIG Advisory Opinion 10-07 to reflect guidance issued on May 21, 2014 in the Supplemental Special Advisory Bulletin regarding Independent Charity Patient Assistance Programs.

Termination of OIG Advisory Opinion No. 06-09 terminates OIG Advisory Opinion No. 06-09, which concerned a nonprofit, tax-exempt, charitable organization's proposals to subsidize Medicare Part D premium and cost-sharing obligations owed by financially needy patients with end-stage renal disease and chronic kidney disease.

Terminated Advisory Opinion No. 10-06 concerning a patient assistance program that assists underinsured patients with their prescription drug co-payment obligations Terminated Advisory Opinion No. 08-17 concerning a nonprofit, tax-exempt, charitable organization's arrangement to provide financial assistance to cover cost-sharing obligations associated with outpatient drug treatment owed by financially needy Medicare or Medicaid patients with a certain disease

Modification of Advisory Opinion 04-15 modifies Advisory Opinion 04-15 grants provided by a nonprofit, charitable organization to financially-needy patients suffering from specific chronic or life-threatening diseases to defray the costs of prescription drug therapies, and its first modification at Modification of Advisory Opinion 04-15, to reflect guidance issued on May 21 in the Supplemental Special Advisory Bulletin regarding Independent Charity Patient Assistance Programs.

Advisory Opinion 17-01 (regarding a hospital system's proposal to provide free or reduced-cost lodging and meals to certain financially needy patients)

Modification of Advisory Opinion 02-1 (modifies Advisory Opinion 02-1, which concerned a non-profit, tax-exempt, charitable organization's providing cost-sharing and premium assistance to financially needy patients diagnosed with specific chronic illnesses and rare disorders, to reflect guidance issued on May 21, 2014 in the Supplemental Special Advisory Bulletin regarding Independent Charity Patient Assistance Programs.)

Source: https://oig.hhs.gov/compliance/advisory-opinions/
## APPENDIX 3—OHIO LEGISLATIVE UPDATE 2016

*Health Care Legislation Enacted By The 131st General Assembly (2015-2016)*

<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Topic/Summary</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub. S.B. 332</td>
<td><strong>Infant Mortality Recommendations and Injection of Prescription Drugs</strong></td>
<td>Apr. 6, 2017</td>
</tr>
<tr>
<td>Sub. H.B. 451</td>
<td><strong>Prohibition on Certain Persons From Making Life-Support Decisions</strong></td>
<td>Apr. 6, 2017</td>
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<tr>
<td></td>
<td>Forfeiture of individual’s statutory authority to decide whether or not to withhold or withdraw life-sustaining treatment for a relative if the individual is the subject of a temporary protection order or civil protection order and the relative is the alleged victim, or if the individual and the relative are married and the parties to a divorce, dissolution, legal separation, or annulment proceeding, to provide that an attorney in fact under a durable power of attorney for health care is competent to make decisions pertaining to life-sustaining treatment, nutrition, or hydration, only if the attorney in fact is not subject to a temporary protection order or civil protection order in which the principal is the alleged victim. Complete enacted bill available at: <a href="https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-HB-451">https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-HB-451</a></td>
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<tr>
<td>S.B. 319</td>
<td><strong>Drugs, Pharmacies, Addition and Mental Health Services</strong></td>
<td>Apr. 6, 2017</td>
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<tr>
<td></td>
<td>To revise certain laws regarding the regulation of drugs, the practice of pharmacy, the procedures used by pharmacy benefit managers, and the provision of addition and mental health services. Complete enacted bill available at: <a href="https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-SB-319">https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-SB-319</a></td>
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<td>Bill No.</td>
<td>Topic/Summary</td>
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<tr>
<td>Sub. H.B.</td>
<td>Simultaneous Refills of Certain Prescriptions</td>
<td>Apr. 6, 2017</td>
</tr>
<tr>
<td>285</td>
<td>Authorizes pharmacists to convert prescriptions authorizing refills under certain circumstances.</td>
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<tr>
<td></td>
<td>Complete enacted bill available at:</td>
<td></td>
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<tr>
<td>Sub. H.B.</td>
<td>Scope of Practice for Chiropractors</td>
<td>Apr. 6, 2017</td>
</tr>
<tr>
<td>276</td>
<td>To authorize chiropractors to engage in certain activities involving nutrition-related items and therapies, nonprescription drugs, and medical goods and devices.</td>
<td></td>
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<td></td>
<td>Complete enacted bill available at:</td>
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<tr>
<td>Sub. H.B.</td>
<td>Treatment of Terminally Ill Patients with Unapproved Drugs</td>
<td>Apr. 6, 2017</td>
</tr>
<tr>
<td>290</td>
<td>To permit a patient with a terminal condition to be treated with a drug, product, or device that is not approved by the United States Food and Drug Administration, modify the laws governing the appointment of a county home superintendent or administrator, and permit health care professionals to earn continuing education credit by providing volunteer health care services to indigent and uninsured persons.</td>
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<td>Complete enacted bill available at:</td>
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<tr>
<td>Sub. H.B.</td>
<td>Advanced Practice Registered Nurses</td>
<td>Apr. 6, 2017</td>
</tr>
<tr>
<td>216</td>
<td>To revise the laws governing advanced practice registered nurses and the Board of Nursing, to authorize podiatrists to order and supervise hyperbaric oxygen therapy, and to require state agencies to assess the prevalence of diabetes and engage in other related activities.</td>
<td></td>
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<td>Complete enacted bill available at:</td>
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<tr>
<td>Sub. H.B.</td>
<td>Medicaid School Program Referrals</td>
<td>Mar. 21, 2017</td>
</tr>
<tr>
<td>89</td>
<td>To authorize certain Medicaid providers to make referrals for certain services under the Medicaid School Program.</td>
<td></td>
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<tr>
<td></td>
<td>Complete enacted bill available at:</td>
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<tr>
<td>Bill No.</td>
<td>Topic/Summary</td>
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<tr>
<td>S.B. 311</td>
<td><strong>Influenza Vaccine Information Sheet</strong>&lt;br&gt;Requiring the Ohio Department of Health to prepare an influenza vaccine information sheet pertaining to adults 60 years and older.  &lt;br&gt;&lt;br&gt;Complete enacted bill available at: <a href="https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-SB-311">https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-SB-311</a></td>
<td>Mar. 21, 2017</td>
</tr>
<tr>
<td>Sub. S.B. 127</td>
<td><strong>Prohibition on Abortion</strong>&lt;br&gt;Prohibits the performance of an abortion on a pregnant woman when the probable post-fertilization age of the unborn child is twenty (20) weeks or greater.&lt;br&gt;&lt;br&gt;Complete enacted bill available at: <a href="https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-SB-127">https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-SB-127</a></td>
<td>Mar. 14, 2017</td>
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<tr>
<td>Sub. H.B. 505</td>
<td><strong>Biological Products and Substitution by Pharmacists</strong>&lt;br&gt;To regulate biological products and the substitution of interchangeable biological products, to revise certain deadlines related to prior authorization requirements, to establish an exemption from the laws governing health insuring corporations, to delay the expiration of certain supervision agreements between physicians and physician assistants, and to declare an emergency.&lt;br&gt;&lt;br&gt;Complete enacted bill available at: <a href="https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-HB-505">https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-HB-505</a></td>
<td>Dec. 19, 2016</td>
</tr>
<tr>
<td>Sub. H.B. 158</td>
<td><strong>Correction for “Mental Retardation” Terminology</strong>&lt;br&gt;To replace provisions containing the term “mental retardation” and its derivatives with corresponding provisions containing the term “intellectual disability” and its derivatives and to specify that an intellectual disability is a form of developmental disability.&lt;br&gt;&lt;br&gt;Complete enacted bill available at: <a href="https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-HB-158">https://www.legislature.ohio.gov/legislation/legislation-documents?id=GA131-HB-158</a></td>
<td>Oct. 12, 2016</td>
</tr>
<tr>
<td>Bill No.</td>
<td>Topic/Summary</td>
<td>Effective Date</td>
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</table>
| Am. Sub. H.B. 483 | **Developmental Disabilities Programs**
To modify programs administered by the Department of Developmental Disabilities, to modify certain laws pertaining to tax levies for developmental disabilities, to modify certain laws regarding ABLE savings accounts and Ohio's disability savings account program, to designate October as "Disability History and Awareness Month," to require acceptance of certain certificate of need applications regarding relocation of long-term care facility beds, to remove behavioral health services from inclusion as direct care costs of nursing facilities, to delay certain laws regarding community behavioral health services, and to make an appropriation.  
*Complete enacted bill available at:*
| H.B. 230       | **Chemical Dependency Counseling and Prevention Services**
Regarding the practices of chemical dependency counseling and prevention services.  
*Complete enacted bill available at:*
| Sub. H.B. 113  | **Public Schools – Required to Provide CPR and AED Instruction and Staff Training**
To require public schools to provide students with instruction in cardiopulmonary resuscitation and the use of an automated external defibrillator, to require training for certain school employees in the use of an automated external defibrillator, to revise the law regarding the Joint Education Oversight Committee, high school equivalency tests, and the awarding of certificates of high school equivalence, and to make other revisions regarding the operation of primary and secondary schools.  
*Complete enacted bill available at:*
| Sub. S.B. 129  | **Insurers – Prior Authorization Requirements**
To amend the law related to the prior authorization requirements of insurers and to delay the effective date of certain laws regarding community mental health and addiction services.  
*Complete enacted bill available at:*
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<tr>
<th>Bill No.</th>
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<tr>
<td>Sub. H.B. 240</td>
<td><strong>Revisions to Laws Regarding Coroners; Qualifications to Hold Office</strong>&lt;br&gt;To define the legal residence of a dead person for purposes of the body's disposal; to recognize that coroners include medical examiners; to change the qualifications for holding office as a coroner of a charter county; to require, under certain conditions, and to authorize, under other conditions, supplemental compensation for coroners who are forensic pathologists; to revise how the office of coroner is filled when a vacancy cannot be filled by election or appointment; to specify the disposition of a firearm when a person meets death under certain circumstances; to specify who pays for the autopsy of an inmate of a state correctional facility; and to make other changes to the coroners' law.&lt;br&gt;&lt;i&gt;Complete enacted bill available at: ftp://sosftp.sos.state.oh.us/free/publications/SessionLaws/131/131-HB-240.pdf&lt;/i&gt;</td>
<td>Aug. 31, 2016</td>
</tr>
<tr>
<td>Sub. H.B. 116</td>
<td><strong>Partial Prescription Refills to Synchronize Multiple Prescriptions for Patients</strong>&lt;br&gt;Regarding insurance and Medicaid coverage of medication synchronization, professional discipline for actions involving dangerous drugs, consult agreements between pharmacists and physicians, pharmacists dispensing or selling drugs without a prescription, prescriptive authority of physician assistants, and acceptance of a certificate of need application for a new nursing home.&lt;br&gt;&lt;i&gt;Complete enacted bill available at: ftp://sosftp.sos.state.oh.us/free/publications/SessionLaws/131/131-HB-116.pdf&lt;/i&gt;</td>
<td>Aug. 31, 2016</td>
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<tr>
<td>Bill No.</td>
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<tr>
<td>Sub. H.B. 294</td>
<td><strong>Department of Health to Ensure State and Certain Federal Funds are not Used for Elective Abortions</strong>&lt;br&gt;To require the Department of Health to ensure that state funds and certain federal funds are not used either to perform or promote nontherapeutic abortions, or to contract or affiliate with any entity that performs or promotes nontherapeutic abortions; to provide for health departments and WIC clinics to determine presumptive eligibility for pregnant women and children; and to allocate existing funding within the Ohio Department of Health's budget to the Ohio Association of Community Health Centers for safe sleep, birth spacing, and smoking cessation initiatives. Complete enacted bill available at: <a href="">ftp://sosftp.sos.state.oh.us/free/publications/SessionLaws/131/131-HB-294.pdf</a></td>
<td>May 23, 2016</td>
</tr>
<tr>
<td>Am. S.B. 10</td>
<td><strong>Medical Assistance Recipients – Identification of Those Eligible for Military-Related Health Care Benefits</strong>&lt;br&gt;To establish a process for identifying individuals who are medical assistance recipients that may be eligible to receive federal military-related health care benefits and to extend eligibility for the enhanced homestead exemption for disabled veterans to include veterans who receive a total disability rating for compensation based on individual unemployability due to a service-connected disability. Complete enacted bill available at: <a href="">ftp://sosftp.sos.state.oh.us/free/publications/SessionLaws/131/131-SB-010.pdf</a></td>
<td>Mar. 23, 2016</td>
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<tr>
<td>Bill No.</td>
<td>Topic/Summary</td>
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<tr>
<td>Am. Sub. H.B. 188</td>
<td><strong>Practice of Pharmacy Under Consult Agreements, Authority of Pharmacists to Dispense or Sell Drugs, Renewal of Nursing Licenses</strong>&lt;br&gt;Regarding the practice of pharmacy under consult agreements, the authority of pharmacists to dispense or sell drugs without a prescription, the authority of pharmacists to prescribe drugs based on remote examination of patients, and the procedures for renewal of nursing licenses.  &lt;br&gt;&lt;br&gt;<em>Complete enacted bill available at:</em> <a href="">ftp://sosftp.sos.state.oh.us/free/publications/SessionLaws/131/131-HB-188.pdf</a></td>
<td>Mar. 23, 2016</td>
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</tbody>
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# APPENDIX 4—OHIO LEGISLATIVE UPDATE 2017

*Health Care Legislation Proposed by the 132nd General Assembly (2017-2018)*

<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Topic</th>
<th>Date Introduced</th>
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<tbody>
<tr>
<td>Bill No.</td>
<td>Topic</td>
<td>Date Introduced</td>
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<tr>
<td>H.B. 101</td>
<td>To improve access to epinephrine.</td>
<td>Feb. 28, 2017</td>
</tr>
<tr>
<td></td>
<td><em>Legislation text as introduced available at:</em></td>
<td></td>
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<tr>
<td>H.B. 79</td>
<td>Provide for firearms training for tactical medical professionals.</td>
<td>Feb. 22, 2017</td>
</tr>
<tr>
<td></td>
<td><em>Legislation text as introduced available at:</em></td>
<td></td>
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<tr>
<td>H.B. 85</td>
<td>To enter into the Health Care Compact.</td>
<td>Feb. 22, 2017</td>
</tr>
<tr>
<td></td>
<td><em>Legislation text as introduced available at:</em></td>
<td></td>
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<tr>
<td>H.B. 72, S.B. 56</td>
<td>To adopt requirements for step therapy protocols implemented by health plan issuers and the Department of Medicaid.</td>
<td>Feb. 21, 2017, Feb. 14, 2017</td>
</tr>
<tr>
<td></td>
<td><em>Legislation text as introduced available at:</em></td>
<td></td>
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<tr>
<td>H.B. 73</td>
<td>To prohibit sales of dextromethorphan without a prescription to persons under the age 18.</td>
<td>Feb. 21, 2017</td>
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<tr>
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<td><em>Legislation text as introduced available at:</em></td>
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<tr>
<td>S.B. 55</td>
<td>To establish minimum direct-care nurse to patient ratios in hospitals; to specify rights of nurses working in hospitals; to prohibit retaliatory actions by hospitals against nurses.</td>
<td>Feb. 14, 2017</td>
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<tr>
<td></td>
<td><em>Legislation text as introduced available at:</em></td>
<td></td>
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<tr>
<td>H.B. 49</td>
<td>To create the FY 2018-2019 operating budget (authorization and conditions for the operation of state programs).</td>
<td>Feb. 8, 2017</td>
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<tr>
<td></td>
<td><em>Legislation text as introduced available at:</em></td>
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<tr>
<td>Bill No.</td>
<td>Topic</td>
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| H.B. 7  | To addresses medical claims and provider immunities.  
  *Legislation text as introduced available at:*
| S.B. 16 | To require certain health professionals to complete instruction in cultural competency.  
  *Legislation text as introduced available at:*
| S.B. 28 | To address final disposition of fetal remains from surgical abortions.  
  *Legislation text as introduced available at:*