WEST VIRGINIA HOSPITAL ASSOCIATION

2016 Legislative Summary

Compilation of Information and Resources

2016 REGULAR SESSION AT A GLANCE

ceobulletin

April 18, 2016

TO: Chief Executive Officers
WVHA Member Hospitals and Health Systems

FROM: Tony Gregory
Vice President, Legislative Affairs

SUBJECT: 2016 REGULAR SESSION AT A GLANCE

Members of the West Virginia Legislature closed Regular Session business and adjourned March 16, 2016, marking an end to what proved to be a very successful legislative session for the West Virginia Hospital Association (WVHA) and its member hospitals. The purpose of this communication is to "set the stage" for future communications that you'll be receiving in the next several weeks from various WVHA staff and the Legislative Team. These communications will be in the form of individual CEO Bulletins summarizing key bills passed by the Legislature during the 2016 Regular Session.

Our intent in these upcoming communications is to provide you and your pertinent management team, with a summary of relevant provisions to be aware of as these bills are being implemented or face upcoming effective dates. These summaries will not be exhaustive reviews, but rather highlights of the legislation passed. We advise that in some instances, you may need to consult with your counsel or internal management staff for additional guidance. However, please feel free to contact WVHA team members with any questions, concerns or comments.

Among the major accomplishments this session includes the passage of a number of bills that will prove beneficial to hospitals, including the following:

- SB 68 – **Elimination of Hospital Rate-Setting**. This bill repeals all of the provisions in WV Code relating to Hospital Rate Setting – *to be effective July 1, 2016*;

- HB 4365 – **CON Modernization**. This bill is intended to modernize, simplify and streamline the CON process – to be effective June 10, 2016 (*with corresponding emergency legislative rules to be implemented by the WV Health Care Authority by December 31, 2016*);

- HB 4209 – **(UPL)**. This bill continues the current Private Hospital Upper Payment Limit Program for an additional year to June 30, 2017. Beginning July 1, 2016, this legislation amends the current tax rate paid by eligible acute care hospitals under the Private UPL Program from the current .72 percent up to .74 percent; and

- HB 4520 – **Open Hospital Proceedings Act**. This bill clarifies that certain nonprofit-owned hospitals may have only one governing body – *to be effective June 6, 2016*.

Passing legislation however was only part of the successful session. Playing defense effectively to ensure that potentially harmful legislation or amendments did not become law was just as important. The WVHA Legislative Team played a key role in keeping several of those bills/amendments off the table. Chief among those were:

- SB 491 – Prohibiting the use of non-compete provisions in employment contracts between hospitals and physicians; and

- An amendment offered to **HB 4365** CON Modernization which would have exempted private office physician practices from CON.

The WVHA Legislative Team also intends to communicate key provisions of a number of relevant bills impacting hospitals. It's important to note that in many instances with these bills, the Team worked to ensure minimal negative impact from a financial, clinical and operational perspective. Strategies included offering amendments or drafting language to narrow the scope or time-frame of impact as well as ensuring hospital input or representation in the drafting of corresponding legislative rules or implementation of the legislation. Bills include:

- SB 602 – Relating to the **Patient Injury Compensation Fund**. The purpose of this bill is to close the Patient Injury Compensation Fund within the Medical Liability Practice Act (MPLA) and to satisfy the liability of the fund with minimal assessments on physicians, hospitals and trial attorneys who settle malpractice claims. *This bill goes into effect July 1, 2016*;

- SB 421 – **(DME Tax)** This bill terminates the Behavioral Health Severance and Business Privilege Tax currently paid by Behavioral Health providers. The change is being implemented in reaction to the Federal Office of Inspector General's (OIG) review of WV's Severance Tax on Behavioral Health providers. The OIG's review attempted to determine if it was a permissible health-care-related tax under Federal requirements. The OIG could not determine whether the tax was permissible; however, the State of WV elected to terminate the Severance Tax on Behavioral Health providers through legislation effective June 30, 2016. To generate a $14 million replacement revenue stream to Medicaid (lost by the removal of the tax on behavioral health services), the bill narrows the **durable medical goods** sales tax exemption to home users only as defined in the bill, but eliminates the exemption for healthcare providers including hospitals and nursing homes, for two years. Through advocacy and communication with key legislators and the Governor's Administration, the WVHA Legislative Team was able to secure the sunset date of July 1, 2018 on the new DME tax on healthcare providers. In discussions, WVHA was told that without a $14-15 million replacement via the temporary elimination of the tax exemption on DME, hospital provider cuts of $60 million were very likely. There are important provisions and definitions in the bill that we advise you to carefully review in order to properly comply with this new requirement. *This bill goes into effect July 1, 2016*;

- HB 4388 – Establishing criteria for hospitals to be designated as **comprehensive stroke centers**. The bill merely requires the DHHR to develop legislative rules regarding protocols, treatment and transport of patients identified as stroke patients. *This bill goes into effect on June 10, 2016 (with corresponding legislative rules to be developed by the DHHR to effectuate the changes contemplated in the bill)*; and

- SB 597– Relating to the Health Care Authority's review and approval of **cooperative agreements**between academic medical centers and other healthcare providers. The bill contains a number of important

definitions which help narrowly define the hospitals subject to the provisions of this bill. *This bill is effective upon passage*.

While the Regular Session is complete, it's important to note that the Legislature still has its work cut out in a special session to be called by the Governor to fill a $270 million hole in the upcoming State Fiscal Year (FY) 2017 Budget. Legislators left town in mid-March without passing a State Budget for next fiscal year and it's required by the WV Constitution that a budget be in place by July 1, 2016. The Legislature also will need to close a remaining projected deficit of about $146 million in the current FY 2016 Budget which ends June 30. Due to mid-year spending cuts and an infusion of funds from legislation that passed during the Regular Session, the current shortfall could have been worse. Still yet, it's being reported that additional measures such as executive orders and new legislation will be needed to close this remaining shortfall, although no details have emerged.

WVHA continues to closely follow the budget discussions as legislators have not yet determined how to plug the shortfalls in this and next year's budgets. This could include a number of scenarios drawn out by the Governor's administration including cuts in Public and Higher Education; the elimination of state agencies; and spending reductions of $150 million, to name a few options identified in the media. We're also following any developments around proposed provider cuts that may become part of the discussions.

If you have any questions regarding legislative issues/activity, please do not hesitate to contact me at the Association at (304) 353-9719 or tgregory@wvha.org. Thanks. Tony

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WVHA Review of the Certificate of Need Programmatic Changes
Prepared by WVHA Director of Legal Research and Policy Brandon Hatfield

House Bill 4365, to modernize, streamline and simplify the Certificate of Need (CON) Program, was approved by the Governor on March 25, 2016, following its bipartisan passage in both the House of Delegates and the Senate. The goal of this bill summary is to highlight a few of the substantive changes this legislation accomplishes. This document is not meant to serve as an exhaustive analysis of the new CON program and we advise that you review the legislation in its entirety. If you have any questions pertaining to the summary or issues not addressed in this Review, please feel free to contact myself at bhatfield@wvha.org or Tony Gregory at tgregory@wvha.org.

Implementation

The bill is effective 90 days from passage which brings the effective date to **June 10, 2016**. However, the Health Care Authority must propose emergency rules to implement certain provisions of the bill no later than **December 31, 2016**. Specifically, the rules to be developed relate to:

- Information a person shall provide when applying for a certificate of need;
- Information a person shall provide when applying for an exemption;
- The process for the issuance of grants and loans to financially vulnerable health care facilities located in underserved areas;
- The required information in a letter of intent;
- The process for an expedited certificate of need;
- Defining "medically underserved population." The authority may consider unusual local conditions that are a barrier to accessibility or availability of health services. The authority may consider, when making its determination of a medically underserved population, areas designated by the federal Secretary of Health and Human Services under Section 330(b)(3) of the Public Health Service Act, as amended, Title 42 U.S.C. §254;
- The process to review an approved certificate of need; and
- The process to review approved proposed health services for which the expenditure maximum is exceeded or is expected to be exceeded.

All of the authority's rules in effect and not in conflict with the provisions of this article shall remain in effect until they are amended or rescinded. WVHA staff is currently evaluating how best to provide input into the timely development of the emergency rules.

Definitional Changes §16-2D-2

House Bill 4365 substantially amended the definitions section to reflect the programmatic changes taking place throughout the article. Among these key changes is an amendment to the definition of expenditure minimum by increasing the threshold from the previous amount of $2,700,000 (with an annual increase based on DRI inflation) up to $5,000,000 (with an annual increase based on DRI inflation).

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Power and Duties of the Authority §16-2D-3

One key provision added to the powers and duties of the Authority is a requirement that the Authority review the state health plan, the certificate of need standards, and the cost effectiveness of the certificate of need program and make any amendments and modifications to each that it may deem necessary, no later than

September 1, 2017 and biennially thereafter. The Authority shall establish a standing advisory committee to advise and assist this review.

Proposed Health Services That Require a Certificate of Need §16-2D-8

This section was amended to remove some services that previously required a certificate of need prior to offering the service. One key service that was removed from the list of reviewable services is behavioral health services.

Exemptions from Certificate of Need which Require Approval from the Authority §16-2D-11

This section includes numerous new exemptions, as well as a new process for applying for an exemption. New key provisions as it relates to the exemption process include:

- A new application to be developed specifically for exemptions;
- A flat $1,000 application fee for all exemption applications;
- The Authority has 45 days to review the exemption request, and make its determination. If the Authority fails to render a decision within 45 days, the exemption is deemed approved;
- The Authority shall not hold an administrative hearing and an affected person may not file an objection; and
- If an exemption application is denied, the application can be refiled with the Authority or the decision may be appealed to the Office of Judges.

New exemptions have also been added to this section, including a number that are beneficial to WVHA member hospitals and health systems. A few of these exemptions include:

- Installing a CT scanner in a private office practice where at least 75% of the scans performed are to be on patients of the practice and the fair market value of the purchase and installation of the CT scanner is less than $250,000 (this number will increase annually based on DRI inflation);
- The replacement of major medical equipment with like equipment;
- Renovations within a hospital. The renovations may not expand the health care facility's current square footage, incur a substantial change to the health services, or a substantial change to the bed capacity;
- The construction, development, acquisition or other establishment by a licensed West Virginia hospital of an ambulatory health care facility in the county in which it is located and in a contiguous county within or outside this state;
- The donation of major medical equipment to replace like equipment for which a certificate of need has been issued and the replacement does not result in a substantial

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change to health services. This exemption does not include the donation of major medical equipment made to a health care facility by a related organization;
- A hospital converting the use of beds, except a hospital may not convert a bed to a skilled nursing bed and conversion of beds may not result in a substantial change to health services provided by the hospital;
- Providing behavioral health services; and
- The construction, development, acquisition or other establishment by a health care facility of a non-health related project.

Fees

Current law relating to the fees charged by the Health Care Authority can be found in its *Legislative Rule at 65-10*. The following provisions currently regulate the amount of fees charged to each application:

- No fee for a determination of reviewability
- Current fee structure:
    1. A fee of $350.00 per bed for any application which involves the addition of beds;
    2. A fee of $1,500 for an application with a capital expenditure less than the expenditure minimum; and
    3. A fee of one-tenth of one percent of the total capital expenditure for any application with a capital expenditure in excess of the expenditure minimum, with a maximum fee of $100,000.
- A fee of $1,000 shall be charged for the filing of any request for an exemption from CON review.

In comparison, below is the new fee structure that will go into effect upon implementation:

- Determination of reviewability is now $100;
- For services that are exempt and do not require application, no application fee will be charged;
- For services that are exempt and do require an application fee, the fee is $1,000;
- Projects up to $1,500,000, the fee is $1,500;
- Projects from $1,500,001 to $5,000,000, the fee is $5,000;
- Projects from $5,000,000 to $25,000,000, the fee is $25,000; and
- Projects from $25,000,001 and above, the fee is $35,000.

Certificate of Need Process

(Below is a "step by step" comparison of the current CON Process compared to new provisions contained in HB 4365.Please note that this Code Section is a rewrite and not all provisions have a "current vs. new" comparison.)

- **Current:** Prior to submitting an application for a CON, the applicant shall submit long-range plans with respect to the development of the proposal. **New:** No long range plan requirement.

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- **Current:** Submit letter of intent not less than 15 days prior to submitting an application. **New:** Letter of intent shall be submitted 10 days prior to submitting an application.

- **Current:** The authority shall make a determination of completeness within 15 days of receipt of the application. **New:** The authority shall make this determination within 10 days of receipt.

- **Current:** The authority shall provide timely notice to the applicant and all affected persons of the beginning of the review and to any person who has asked the authority to place the person's name on a mailing list maintained by the state agency. **New:** The authority has 5 days from the receipt of the letter of intent to provide notification to the public through a newspaper of general circulation in the area where the health service is being proposed and place a copy of the letter of intent on its website.

- **Current:** Affected person was required to be afforded "not less than 30 days" from written notification of the beginning of the review to request a public hearing on an application.

- **New:** Affected person has 30 days starting from the date the application is batched (if applicable, batching of application is permissive) to request an administrative hearing.

- **New:** Hearing order shall be approved by the authority within 15 days from the last day an affected person may request an administrative hearing.

- **New:** The authority shall render a decision within 45 days of the conclusion of the administrative hearing.

- **Current:** If an administrative hearing is not conducted, the authority may propose rules to provide for a file closing date. **New:** If an administrative hearing is not conducted, the authority shall provide a file closing date of 5 days after the date an affected party may no longer request an administrative hearing.

- **Current:** Authority shall adopt schedules for reviews which provide that no review may, to the extent practicable, take longer than ninety days from the date that notification is sent to the applicant to the date of the final decision of the authority. **New:** A review of an uncontested CON application shall be complete within 60 days from the date the application is batched. An uncontested application is deemed approved if the review is not completed within 60 days, unless an extension of up to 15 days is requested by the applicant.

Additional Programmatic changes to the CON Process

- Reconsideration hearings to the authority have been eliminated. An appeal will now go directly to the Office of Judges.

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- There is a new exemption process found at *§16-2D-11.* The authority has 45 days to review and exempt a request. The authority may not hold an administrative hearing to review the application. An affected person may not file an objection to the request for an exemption. If the authority does not approve or deny the application within 45 days, then the exemption is immediately approved.

April 19, 2016

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WVHA Summary Review of SB 602 – Patient Injury Compensation Fund (PICF)
Prepared by WVHA Director of Legal Research and Policy Brandon Hatfield

The PICF was created in 2004, with the purpose of providing fair and reasonable compensation to claimants in medical malpractice actions for any portion of economic damages awarded that are uncollectible as a result of limitations on economic damage awards for trauma care or as a result of the elimination of joint liability in the Medical Professional Liability Act ("MPLA"), W. Va. Code § 55-7B-1, et seq.

The PICF has a current balance below $1 million with multiple claims pending, each seeking the maximum award available of $1 million. The goal of this legislation is to close the fund to new claims, and create a funding mechanism to fund the current and projected future liability until the fund can be fully terminated.

In order to close the fund to new claims, Senate Bill 602 does the following:

- Closes down the PICF to all claims not filed before July 1, 2016; and
- Allows a plaintiff who, as a result of an injury suffered prior to or after July 1, 2016, suffers or has suffered economic damages in excess of the limit of liability to collect economic damages up to an addition $1 million. This provision does not increase the total amount available for recovery, it allows for the same amount of monetary recovery as before. It simply amends the source of the recovery.

Funding sources

As mentioned above, Senate Bill 602 also creates a funding mechanism to fully fund the remaining and project future liabilities of the PICF. These funding sources include:

- Transferring funds from an existing Medical Liability Fund to the PICF;
- An annual assessment on physicians licensed by both the Board of Medicine and the Board of Osteopathic Medicine. Beginning July 1, 2016 and through calendar year 2019, every new license and license renewal issued shall be assessed in the amount of $125. Some exemptions are provided under §29-12D-1a(a);
- An assessment on trauma centers. Beginning July 1, 2016 and ending June 30, 2020, an assessment of $25 shall be levied by the Board of Risk and Insurance Management (BRIM) on trauma centers for each trauma patient treated at a health care facility designated by the Office of Emergency Medical Services as a trauma center, as reported to the West Virginia Trauma Registry; and
- An assessment on claims filed under the Medical Professional Liability Act. Beginning July 1, 2016 through June 30, 2020, an assessment of one percent of the gross amount of any settlement of judgment in a qualifying claim shall be levied.

PLEASE NOTE: The bill as originally introduced contained two separate assessments imposed on hospitals to begin July 1, 2016; one in the amount of $100 per number of patient beds as reported to the Health Care Authority; and another in the amount of $50 on each patient treated at a trauma center. Legislative leaders strongly desired a shared responsibility in funding by providers and stakeholders impacted by the PICF (doctors, hospitals and the trial bar), so the WVHA Legislative Team worked to replace these two assessments with one less onerous and short-term funding source involving trauma patients reported to the WV Trauma Registry. This Registry is maintained by the state Bureau for Public Health – Office of Emergency Medical Services, and it's contemplated that a report be generated annually from which BRIM may base their assessment to the hospitals. It's important to note that the first annual assessment of $25 per trauma patient (as reported to the Registry) will not be collected until June

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30, 2017. The first assessment will be based on trauma patients reported from January 1, 2016 – December 31, 2016.

Finally, there also is a provision that provides for the early termination of assessments if the liability of the PICF is fully satisfied prior to the end date of the assessments detailed above. The BRIM shall submit a report to the legislative Joint Committee on Government and Finance each year beginning January 1, 2018, giving recommendations based on an actuarial analysis of the fund's liability. The recommendations shall include discontinuance of the assessments, closure of the fund, and transfer of the fund's liability.

April 20, 2016

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WVHA Review of HB 4520 – Open Hospital Proceedings Act
Prepared by WVHA Director of Legal Research and Policy Brandon Hatfield

Background

The West Virginia Open Hospital Proceedings Act (OHPA) was enacted in 1982 and amended in 1999. The Act requires all meetings of the "governing body" of a non-profit hospital to be open to the public, and imposes various other requirements with regard to such meetings *(for example, the meetings must be noticed, and meeting minutes must be prepared within a reasonable time following the meeting).*

For many years, hospitals around West Virginia operated in the belief that the term "governing body" meant the board of trustees or other body with legal authority over and responsibility for the operations and direction of the hospital. This belief was based on the definition of "governing body" found in the Act, which reads as follows:

> *"Governing body' means the board of directors or other group of persons having the authority to make decisions for or recommendation on policy or administration to a hospital owned or operated by a nonprofit co1poration, nonprofit association or local governmental unit, the membership of which governing body consists of two or more members."*

Issue

Litigation arose earlier in the 2000s in which a plaintiff asserted that a Medical Staff Executive Committee at a hospital was a "governing body" within the meaning of the Act. Consistent with the understanding of hospitals around the state, the trial judge ruled that under the Act a hospital could have only one governing body, and that the Medical Staff Executive Committee was not the governing body of the hospital within the meaning of the Act.

On appeal, the West Virginia Supreme Court of Appeals reversed the trial court. The Supreme Court ruled that the Act should be given a flexible and functional interpretation and application, and that more than one group at a hospital could meet the definition of "governing body" and therefore be subject to the provisions of the Act. Under the 2007 Supreme Court decision, it was unclear which of the many operating committees at hospitals are or may be subject to the provisions of the Act.

Summary of Legislation

HB4520 was passed by the Legislature during the 2016 Regular Session, and was signed into law by the Governor March 23, 2016, and goes into effect June 6, 2016. The bill amends two sections of the Open Hospital Proceedings article.

First, the definition of “governing body” and “meeting” were amended to add clarity and specificity to these two definitions.

Under current law, “governing body” is defined as “the board of directors or other group of persons having the authority to make decisions for or recommendations on policy or administration to a hospital owned or operated by a nonprofit corporation, nonprofit association or local governmental unit, the membership of which governing body consists of two or more members.” HB4520 amends this definition by first specifying the single governing body for a hospital owned or operated by a nonprofit corporation, a county hospital, and then all other hospitals. This definition was also amended to add a provision specifying exactly what *is not* to be considered the governing body of any hospital described in the definition.

The definition of “meeting” was amended to state that the convening of any group other than the governing body is not to be considered a meeting within the meaning of this definition unless the “group is vested with independent decision-making authority and exercises the independent decision-making authority at any convening.”

The second section amended by HB4520 relates to exceptions to the Open Hospital Proceedings requirements. Current law provides that the governing body of a hospital may hold an executive session, but that no official action shall be made in such executive session. This has been amended to state that no official action may be made in the executive session, except as is necessary. Four exceptions are detailed in the bill, including:

- To protect the confidentiality of protected health information as defined by the Health 7 Insurance Portability and Accountability Act of 1996;
- To preserve the privilege and confidentiality of peer review information as provided in 9 article three-c, chapter thirty of this code;
- To approve confidential legal settlements or otherwise act in connection with matters 11 described in subdivision (5), subsection (b) of this section; or
- To end an executive session and readmit the public to a meeting.

Lastly, the bill allows for an executive session to be held to conduct privileged attorney-client communications or to consider the work product of the hospital's attorney or the hospital administration, including materials prepared by an attorney or others in anticipation of litigation, litigation strategies and reports, confidential legal settlements and discussions, negotiations and alternative dispute resolution proceedings conducted in pursuit of a legal settlement.

The WVHA believes HB 4520 provides all parties with needed clarity as to what committees at a non-profit hospital are covered by the Act.

April 27, 2016

WEST VIRGINIA HEALTH CARE AUTHORITY – RATE REVIEW ELIMINATION

ceobulletin

May 03, 2016

TO: Chief Executive Officers
WVHA Member Hospitals and Health Systems

FROM: Carol Haugen
Vice President, Financial Policy

SUBJECT: WEST VIRGINIA HEALTH CARE AUTHORITY – RATE REVIEW ELIMINATION

As noted in an earlier CEO Bulletin (dated April 19), one of the major successes from the 2016 Legislative session was Senate Bill 68 which eliminated hospital rate review. Hospital rates no longer require review and approval by the Authority as was the case from 1984 to 2015 under several methodologies of review. Effective July 1, 2016 West Virginia State law codifying hospital rate review is eliminated. In the interim, the Authority has instructed hospitals NOT to file rate applications for hospital year ends of June 30.

Rate review encompassed the following statutory functions, which are now eliminated:
• Review and approval of commercial provider contracts;
• Quarterly hospital compliance rate evaluation; and
• Annual non-governmental rate review and decision.

The Authority continues the functions of:
• Financial Disclosure;
• Certificate of Need; and
• Health Planning.

WVHA encourages members to maintain compliance with the remaining Authority duties and to become familiar with the 2016 amended Certificate of Need law. The Financial Disclosure duty is changing to include disclosure of the top twenty-five (25) outpatient services; however, the Authority must publish rules to implement the provision which is expected to occur within the next year.

Member hospital questions or concerns can be directed to me at (304) 353-9721 or by email at chaugen@wvha.org.

CH/kw

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WVHA Review of *Health Care Bills of Interest* passed during the 2016 Regular Session

Prepared by WVHA Director of Legal Research and Policy Brandon Hatfield

Below please find a Summary Review of health care bills passed by the Legislature this year that may impact you from a financial, clinical regulatory and operational perspective. This inventory of bills was prepared by the WVHA Legislative Team and is not intended to be an exhaustive review but rather a summary of the key highlights. We recommend that you and your legal or senior management team carefully review the legislation prior to implementation and the noted effect dates.

APRNs

HB 4334: Clarifying the requirements for a license to practice as an advanced practice registered nurse and expanding prescriptive authority

The purpose of this bill is to modify the prescriptive authority of an advanced practice registered nurse (APRN). An APRN may now prescribe a 30 day supply pf schedule 3 drugs with no refill. The bill requires certain collaboration, however after an APRN participates in a collaborative practice for 3 years he or she may prescribe without a collaborative agreement. The bill also expands the signature authority of an APRN. Finally, the bill creates an advisory council consisting of MDs, DOs, APRNs, a Pharmacist, and others to perform a number of duties detailed in the bill. **Effective: June 10, 2016**

Health Care Authority / Cooperative Agreements

SB597: Relating generally to Health Care Authority

The purpose of this bill is to create a process by which the Health Care Authority can review and approve cooperative agreements between academic medical centers and other healthcare providers. The bill defines "cooperative agreement" as "an agreement between a qualified hospital which is a member of an academic medical center and one or more other hospitals or other health care providers. The agreement shall provide for the sharing, allocation, consolidation by merger or other combination of assets, or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic, or laboratory facilities or procedures or other services traditionally offered by hospitals or other health care providers. The bill details the process an entity must follow when applying for approval of a cooperative agreement. In addition, the bill specifies certain requirements that must be adhered to if the cooperative agreement involves a combination of hospitals through merger, consolidation or acquisition. **Effective: From Passage March 12, 2016**

Hospital Stroke Center Designation

HB4388: Relating to stroke centers
The purpose of this bill is to provide a mechanism for a hospital to be recognized and certified as a comprehensive stroke center, a primary stroke center or an acute stroke ready hospital. The bill also grants relevant rule making authority to the Secretary of DHHR. To assist in the developing of these rule, the bill mandates that the Secretary consult with an advisory committee made up of representatives of the department, an association with the primary purpose of promoting better heart health, a registered emergency medical technician, hospitals located in rural areas of the state and hospitals located in urban areas of this state. **Effective: June 10, 2016**

Insurance

HB 4040: Regulating step therapy protocols in health benefit plans
The purpose of this bill is to put in place a procedure for exemption from a prescription drug step therapy plan. The bill requires the procedure to be easily accessible on a health plan's website. There are certain conditions to granting an exemption. **Effective: June 10, 2016**

HB4146: Providing insurance cover abuse-deterrent opioid analgesic drugs
The purpose of this bill is to provide insurance coverage for abuse-deterrent opioid analgesic drugs. Beginning January 1, 2017, coverage shall be provided for at least one abuse-deterrent opioid analgesic drug product for each active opioid analgesic ingredient. The bill creates four new sections and key terms are defined. **Effective: June 10, 2016**

HB 4655: Prohibiting insurers, vision care plan or vision care discount plans from requiring vision care providers to provide discounts on non-covered services or materials
The purpose of this bill is to prohibit an insurer from seeking or requiring an eye care provider to provide services or materials at a fee limited or set by the insurer, unless they are reimbursed as covered services or covered materials under the contract. Reimbursements paid by the insurer must be reasonable and clearly listed on a fee schedule that is made available before signing of the contract. The bill also allows a person or entity adversely affected by a violation of this section, or the Commissioner, to seek an injunction against the insurer. The person or entity may recover monetary damages of no more than $1,000 for each instance found to be in violation of this section, plus attorney's fees and costs. **Effective: June 10, 2016**

HB 4659: Authorizing local health departments to bill health insurance plans for services
The purpose of this bill is to authorize local health departments to bill a payor at the maximum allowable rate and that the fees are not subject to the approval of the Commissioner of the Bureau for Public Health. **Effective: June 10, 2016**

SB404: Removing prohibition on billing persons for testing for HIV and sexually transmitted diseases
The purpose of this bill is to permit all health care providers, the bureau, or a local health department that routinely bills insurance companies or other third-party providers to bill for

HIV-related testing and treatment. It also provides that no person may be refused a test at a local health department due to a lack of insurance or due to a request to remain anonymous. The subsection relating to mandatory testing has also been rewritten for clarity and moved to a separate new section. **Effective: June 10, 2016**

Medicaid

SB 384: Requiring Bureau for Medical Services seek federal waiver for 30-day waiting period for tubal ligation

This bill directs the Secretary of the Department of Health and Human Resources (DHHR) to seek a waiver within the Medicaid program to allow for a tubal ligation procedure without first having to request a thirty day preapproval, which is the current federal requirements. **Effective: June 8, 2016**

Medical Care

SB 10: Creating Unborn Child Protection from Dismemberment Abortion Act

The purpose of this bill is to ban the "dismemberment abortion" procedure. The bill also contains narrow exceptions and criminal penalties for violation of the ban. **Effective: May, 29 2016**

SB416 Allowing terminally ill patients access to investigational products

The purpose of this bill is to allow a manufacturer of an investigational drug, biological product or device to make its product available to an eligible patient. The bill also precludes any action against a health care provider's license or Medicare certification based solely on the health care provider's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product or device as long as the recommendations are consistent with medical standards of care. **Effective: June 8, 2016**

SB 123: Treatment for sexually transmitted diseases

With certain restrictions, SB123 permits a physician to prescribe antibiotic drugs to the sexual partner of a person clinically diagnosed with a sexually transmitted disease without the physical examination of the partner or partners. **Effective: May 16, 2016**

Miscellaneous

SB 6: Requiring drug screening and testing of applicants for TANF program

The purpose of this bill is to require the Secretary of DHHR to create a three-year pilot program to drug test individuals applying for benefits from the Temporary Assistance to Needy Families (TANF) Program. Applicants for whom a reasonable suspicion of substance abuse exists shall be required to submit to a drug test. The bill contains specific provisions for a first, second, third failed drug test, including being permanently ineligible for the TANF Program. **Effective: June 8, 2016**

HB4315: Relating to air-ambulance fees for emergency treatment or air transportation
The purpose of this bill is to establish that any air-ambulance provider which does not have a contract with the plan (PEIA), that provides air transportation or related emergency or treatment services to an employee or dependent of an employee covered by the plan, may not charge a combined amount for those services which exceeds the reimbursement amount then in effect for the federal Medicare program, including any applicable Geographic Practice Cost Index.
Effective June 10, 2016

Pharmacy/Prescriptions/Substance Abuse

SB 431: Authorizing pharmacists and pharmacy interns dispense opioid antagonists
The purpose of this bill is to permit a pharmacist or pharmacist intern to dispense naloxone to a person in accordance with a protocols developed by the Board of Pharmacy, in consultation with the Bureau of Public Health. The bill also limits the liability associated with the administration, possession and use of an opioid antagonist. Lastly, the bill provides that the controlled substance monitoring database will now be used to monitor the prescribing and distribution of opioid antagonists. **Effective: June 10, 2016**

SB 454: Licensing and regulating medication-assisted treatment programs for substance use disorders
The purpose of this bill is to regulate medication assisted treatment programs for substance abuse, including methadone clinics and office based suboxone clinics. Upon the bill becoming effective, all current facilities will transition to new licensure standards. The clinics will be permitted to apply for and obtain a provisional license with OFLAC while it is trying to obtain its initial full licensure. **Effective: June 10, 2016**

SB627: Permitting physician to decline prescribing controlled substance
The purpose of this bill is to provide that a physician is not subject to disciplinary sanctions, criminal punishment, and may not be held liable by a patient or third party, for declining to prescribe, or declining to continue to prescribe, any controlled substance to a patient which the physician is treating if in the reasonably prudent medical judgment of the physician he or she believes the patient is misusing the controlled substance in an abusive manner or unlawfully diverting a controlled substance legally prescribed. **Effective: June 8, 2016**

HB 4033: Adding criminal penalties for the unauthorized practice of pharmacists care
The purpose of this bill is to clarify what activities constitute the illegal practice of a pharmacists or a pharmacy technician, including practicing with an expired, suspended or lapsed license. The penalty for the unauthorized practice of pharmacists care can result in a fine of $10,000. **Effective: June 10, 2016**

HB 4038: Relating to insurance requirements for the refilling of topical eye medication
The purpose of this bill is to set forth insurance coverage requirements for the refilling of topical eye medication. The bill permits a person to obtain an early refill of a 30 day prescription for topical eye medication at 21 days. **Effective: June 10, 2016**

HB 4314: Prohibiting the sale of powdered or crystalline alcohol
The purpose of this bill is to prohibit the sale of powdered or crystalline alcohol and pure caffeine. The commissioner is prohibited from listing or stocking powdered alcohol in inventory. The bill also contains new related criminal penalties. **Effective: June 10, 2016**

HB 4347: Providing pregnant women priority to substance abuse treatment
The purpose of this bill is to require substance abuse treatment or recovery service providers that accept Medicaid to give pregnant women priority in accessing services. **Effective: June 10, 2016**

HB 4728: Relating to schedule three controlled substances
The purpose of this bill is to add human chorionic gonadotropin to the list of Schedule III drugs. There is an exception of the use of the drug on a nonhuman species and when approved by the FDA. **Effective: June 9, 2016**

HB 4428: Clarifying that optometrists may continue to exercise the same prescriptive authority which they possessed prior to hydrocodone being reclassified
The purpose of this bill is to permit an optometrist to prescribe a 72 hour supply of hydrocodone or hydrocodone combination drugs. **Effective: June 10, 2016**

Professions/Licensing

SB 47: Rewriting licensing requirements for practice of medicine and surgery and podiatry
This bill was mostly "clean up" and non-substantive in its amendments. The bill does add several new exemptions to medical licensure including: a member of an air ambulance treatment team or organ harvesting team; a physician serving as volunteer for a charitable function; and a physician treating a visiting sports team.
Effective: June 8, 2016

SB 338: Compiling and maintaining Central State Mental Health Registry
The purpose of this bill is to prohibit children under 14 years of age from being included on a mental health registry and requires the court to begin the process of removing children under 14 years of age from the registry. **Effective: June 8, 2016**

HB 4594: Relating to pre-doctoral psychology internship qualifications
The purpose of this bill is to alter the requirements for eligibility to practice psychology. Currently, an applicant is required to have a least one year of experience subsequent to the receiving a degree in psychological services. This bill would change that to a requirement of 1800 hours of a pre-doctoral internship in psychological services. **Effective: June 9, 2016**

Regulation

HB4537: Relating to the regulation of chronic pain clinics
The purpose of this bill is to update the definition of "chronic pain", and to remove "a facility that is affiliated with an accredited medical school at which training is provided for medical or

osteopathic students, residents or fellows, podiatrists, dentists, nurses, physician assistants, veterinarians or any affiliated facility to the extent that it participates in the provision of the instruction" from the list of exempted facilities. **Effective: June 10, 2016**

Telemedicine

HB 4463: Permitting the practice of telemedicine
The purpose of this bill is to permit the practice of telemedicine. The bill defines telemedicine and the establishment of the physician-patient relationship. It also establishes standard of care considerations and record keeping requirements. The Board of Medicine and the Board of Osteopathic Medicine will promulgate legislative rules implement the provisions of the bill. **Effective: June 9, 2016**

May 4, 2016