DEPARTMENT OF HEALTH

General and city health districts

- Authorizes the Ohio Department of Health (ODH) to require general or city health districts to enter into shared services agreements, and authorizes ODH to offer financial and technical assistance to boards of health to encourage the sharing of services.

- Authorizes ODH to reassign substantive authority for mandatory programs from a general or city health district to another general or city health district under certain circumstances.

- Authorizes the ODH Director to require general or city health districts to apply for accreditation by July 1, 2018, and to be accredited by July 1, 2020, as a condition of receiving funding from ODH.

- Requires the ODH Director, by July 1, 2016 to conduct an evaluation of health districts' preparation for accreditation.

- Eliminates a requirement that two or more city health districts be contiguous to form a single city health district.

- Eliminates the requirements (1) that two or more general health districts be contiguous to form a combined general health district and (2) that not more than five contiguous general health districts may combine to form a general health district.

- Requires the ODH Director to adopt rules to assure annual completion of two hours of continuing education by each member of a board of health and specifies the topics of education.

- Eliminates the Public Health Standards Task Force that assists and advises the ODH Director in the adoption of standards for boards of health.

- Requires the ODH Director, not later than July 1, 2014, to establish by rule a standardized process by which all general and city health districts must collect and report to the Director information about public health quality indicators, and a policy and procedures for sharing the reported health data with other specified persons.

Patient Centered Medical Home Program

- Establishes in ODH the Patient Centered Medical Home Program.

- Requires ODH to establish a patient centered medical home certificate, specifies the requirements and goals to be achieved through voluntary certification, and permits ODH to establish an application and annual renewal fee for certification.

- Requires each certified patient centered medical home to report health care quality and performance information to ODH.

- Requires ODH to submit a report to the Governor and General Assembly three and five years after ODH adopts rules for certifying patient centered medical homes.

Abortion informed consent and fetal ultrasound requirements

- Requires a physician who is to perform or induce an abortion when there is a detectable fetal heartbeat to comply with specific informed consent requirements.

- Modifies the definition of "medical emergency" for purposes of the informed consent requirements.

- Requires a person who intends to perform or induce an abortion on a pregnant woman to determine the presence of a detectable fetal heartbeat of the unborn human individual the pregnant woman is carrying.

- Requires that the method of determining the presence of a detectable fetal heartbeat be consistent with the person's good faith understanding of standard medical practice or consistent with rules adopted by the ODH Director.

- Allows the ODH Director to promulgate rules specifying the appropriate methods of performing an examination for the presence of a fetal heartbeat and specifies that the rules must require only that an examination for a fetal heartbeat be performed externally.

- Prohibits a person from knowingly and purposefully performing or inducing an abortion on a pregnant woman before determining the presence of a detectable fetal heartbeat unless there is a medical emergency.

- Provides that the failure to determine the presence of a detectable fetal heartbeat prior to the performance or inducement of an abortion on a pregnant woman may be the basis for a civil action for compensatory and exemplary damages or disciplinary action.

- Allows a woman on whom an abortion is performed in violation of the informed consent requirements to file a civil action for wrongful death of the woman's unborn child.

- Requires a person who is to perform or induce an abortion on a pregnant woman to inform the pregnant woman in writing that the unborn human individual the pregnant woman is carrying has a fetal heartbeat and the statistical probability of bringing the unborn human individual possessing a detectable fetal heartbeat to term.

- Provides that if a person who is to perform or induce an abortion fails to provide the pregnant woman with the heartbeat and probability information, that person is guilty of performing or inducing an abortion without informed consent when there is a detectable fetal heartbeat.

- Makes the offense of performing or inducing an abortion without informed consent when there is a detectable fetal heartbeat a misdemeanor of the first degree on a first offense and a felony of the fourth degree on each subsequent offense.

- Allows the ODH Director to adopt rules that specify information regarding the statistical probability of bringing an unborn human individual possessing a detectable fetal heartbeat to term based on the gestational age of the unborn human individual.

- Provides that a pregnant woman on whom an abortion is performed or induced prior to a determination of a detectable fetal heartbeat or without receiving the required information:

    --Is not guilty of violating those provisions;

    --Is not guilty of attempting to commit, conspiring to commit, or complicity to commit a violation; and

    --Is not subject to a civil penalty.

Ambulatory surgical facilities

- Specifies in statute provisions similar to preexisting ODH rules requiring each ambulatory surgical facility (ASF) to maintain an infection control program and generally have a written transfer agreement with a local hospital.

- Requires the ODH Director to conduct inspections of ASFs that are not certified by the federal Centers for Medicare and Medicaid Services, deny license renewals unless certain conditions are met, and specify ASF inspection forms in rules.

- Requires an ASF to notify the ODH Director within certain time frames when it modifies its most recent written transfer agreement or operating procedures or

protocols or becomes aware of an event that adversely affects a consulting physician's ability to practice or admit patients to a local hospital.

Public hospitals and written transfer agreements

- Prohibits a public hospital from entering into a written transfer agreement with an ASF in which nontherapeutic abortions are performed or induced.

- Prohibits a public hospital from authorizing a physician to use staff membership or professional privileges to meet the criteria for a variance from the requirement that an ASF in which nontherapeutic abortions are performed or induced have a written transfer agreement with a local hospital.

Prioritized distribution of funds for family planning

- Establishes levels of priority regarding the distribution of public funds used for family planning services, including funds received from the federal government.

Management of long-term care facility residents' financial affairs

- Increases the maximum amount that a nursing home, residential care facility, or veterans' home that manages a resident's financial affairs may keep in a noninterest bearing account.

Nursing facilities' plans of correction

- Requires a nursing facility's plan of correction regarding a deficiency to include additional information, including a detailed description of an ongoing monitoring and improvement process to be used at the facility.

- Permits ODH to consult with the Ohio Departments of Medicaid and Aging and the Office of the State Long-Term Care Ombudsman Program in certain circumstances when determining whether a nursing facility's plan of correction or modification of an existing plan meets ODH's requirements for approval.

Nursing facility technical assistance

- Eliminates a requirement that ODH provide advice and technical assistance and conduct on-site visits to nursing facilities for the purpose of improving resident outcomes.

Distribution of household sewage treatment permit fees

- Reallocates the distribution of money collected from state household sewage treatment system permit fees by:

--Decreasing the percentage of money allocated to fund installation and evaluation of sewage treatment system new technology pilot projects; and

--Increasing the percentage of money allocated for use by the ODH Director to administer and enforce the Household and Small Flow On-Site Sewage Treatment Systems Law and rules adopted under it.

Water systems

- Exempts a water system that will be used in agriculture and that does not provide water for human consumption from obtaining a permit or license, paying fees, or complying with any rule adopted under the continuing statutes governing private water systems, which are systems that provide water for human consumption.

Ohio Cancer Incidence Surveillance System

- Authorizes ODH to designate, by contract, a state university as an agent to implement the Ohio Cancer Incidence Surveillance System.

- Repeals provisions expressly governing the confidentiality of cancer information provided to or acquired by an Ohio cancer registry or ODH, but continues general provisions governing the confidentiality of protected health information.

Zoonotic disease program

- Authorizes the ODH Director, if ODH administers a program on zoonotic diseases (which are contagious diseases spread between animals and humans), to charge a local board of health a fee for each service the program provides to the board.

Hope for a Smile Program (VETOED)

- Would have established the Hope for a Smile Program with a specified objective of improving the oral health of school-age children, particularly those who are indigent and uninsured (VETOED).

- Would have created a state income tax deduction, to be used by a dentist or dental hygienist, equal to the fair market value of the services provided for free under the Program (VETOED).

Other provisions

- Requires the ODH Director to adopt rules governing the distribution of funds in fiscal years 2014 and 2015 to assist families in purchasing hearing aids for children.

- Eliminates the January 1 deadline for the ODH Director to determine the annual adjustments in charges that may be imposed for copies of medical records.
- Eliminates a requirement that trauma centers report to the ODH Director information on preparedness and capacity to respond to disasters, mass casualties, and bioterrorism.
- Abolishes the Council on Stroke Prevention and Education.
- Requires ODH to process an application for a Women, Infants, and Children (WIC) vendor contract within 45 days if the applicant already has a WIC vendor contract.
- Creates in the state treasury the Department of Health Medicaid Fund and requires that all funds ODH receives for the purpose of paying the expenses ODH incurs under the Medicaid program be deposited into the Fund.

General and city health districts

Expansion of ODH's authority over health districts

(R.C. 3701.13)

The act authorizes the Ohio Department of Health (ODH) to require general or city health districts to enter into shared services agreements under a continuing law[111] that permits a political subdivision to enter into an agreement with another political subdivision whereby a contracting political subdivision agrees to exercise any power, perform any function, or render any service for another recipient political subdivision that the recipient political subdivision is otherwise legally authorized to exercise, perform, or render. ODH must prepare and offer to boards of health a model contract and memorandum of understanding that are easily adaptable for use by the boards when entering into shared services agreements. ODH also may offer financial and other technical assistance to boards of health to encourage the sharing of services.

The act authorizes ODH to reassign substantive authority for mandatory programs from a general or city health district to another general or city health district when an emergency exists, or when the board of health of the general or city health district has neglected or refused to act with sufficient promptness or efficiency or has not been lawfully established.

[111] R.C. 9.482, not in the act.

Accreditation of general and city health districts

(R.C. 3701.13)

As a condition precedent to receiving funding from ODH, the act authorizes the ODH Director to require general or city health districts to apply for accreditation by July 1, 2018, and to be accredited by July 1, 2020, by an accreditation body approved by the ODH Director. By July 1, 2016, the ODH Director must conduct an evaluation of general and city health district preparation for accreditation, including an evaluation of each district's reported public health quality indicators (see "**Standardized reporting of public health data**," below).

Formation of combined general or city health districts

(R.C. 3709.01, 3709.051, and 3709.10)

The act eliminates the requirement that city health districts be contiguous to form a single city health district. The result is that two or more city health districts may be united to form a single city health district by a majority affirmative vote of the legislative authority of each city affected by the union, or by petition of at least 3% of the qualified electors residing within each of the two or more contiguous city health districts.

The act also eliminates the requirement that general health districts be contiguous to form a single general health district, and eliminates the limitation that not more than five general health districts may combine to form a single general health district. The act's revisions result in authorization for an unlimited number of noncontiguous general health districts to form a single general health district, if approved by an affirmative majority vote of the district advisory councils of the districts being combined.

Continuing education for board of health members

(R.C. 3701.342)

Under continuing law, the ODH Director must adopt rules establishing minimum standards for board of health. The act adds a provision requiring that the minimum standards assure annual completion of two hours of continuing education by each member of a board of health. The minimum standards must provide that the continuing education credits pertain to ethics, public health principles, and a member's responsibilities. Credits may be earned in these topics at pertinent presentations that may occur during regularly scheduled board meetings throughout the calendar year or at other programs available for continuing education credit. The ODH Director may

assist boards of health in coordinating approved continuing education programs sponsored by health care licensing boards, commissions, or associations.

The minimum standards also must provide that continuing education credits earned for the purpose of license renewal or certification by licensed health professionals serving on boards of health may be counted to fulfill the two-hour continuing education requirement.

Elimination of Public Health Standards Task Force

(R.C. 3701.342; R.C. 3701.343 (repealed))

The act eliminates the nine-member Public Health Standards Task Force that assisted and advised the ODH Director in formulating and evaluating public health services standards for boards of health. Under prior law, the ODH Director adopted the standards after consulting with the Task Force.

Standardized reporting of public health data

(R.C. 3701.98)

The act requires the ODH Director, not later than July 1, 2014, to establish both of the following by rule adopted under the Administrative Procedure Act:[112]

(1) A standardized process by which all general and city health districts must collect and report to the Director information regarding public health quality indicators.

(2) A policy and procedures for sharing the reported health data, with payers, providers, general and city health districts, and public health professionals.

The rules must identify the public health quality indicators that are to be a priority for general and city health districts and the information to be collected and reported regarding those indicators. The ODH Director must work with the Association of County Health Commissioners in identifying the indicators.

Patient Centered Medical Home Program

(R.C. 3701.921, 3701.922, 3701.94, 3701.941, 3701.942, 3701.943, and 3701.944)

The act establishes the Patient Centered Medical Home (PCMH) Program in ODH. The act specifies that a PCMH model of care is an advanced model of primary

[112] Rulemaking under the Administrative Procedure Act (R.C. Chapter 119.) requires notice and a public hearing.

care in which care teams attend to the multifaceted needs of patients, providing whole person comprehensive coordinated patient centered care.

The act's PCMH Program is established separately from the continuing PCMH Education Program. The ODH Director's authority to establish pilot projects that evaluate and implement the PCMH model of care under the PCMH Education Program is eliminated.

Voluntary PCMH certification program

As part of the PCMH Program, ODH is required by the act to establish a voluntary PCMH certification program. Through certification of PCMHs, ODH is to seek to do all of the following:

(1) Expand, enhance, and encourage the use of primary care providers, including primary care physicians, advanced practice registered nurses, and physician assistants, as personal clinicians;

(2) Develop a focus on delivering high-quality, efficient, and effective health care services;

(3) Encourage patient centered care and the provision of care that is appropriate for a patient's race, ethnicity, and language;

(4) Encourage the education and active participation of patients and their families or legal guardians, as appropriate, in decision making and care plan development;

(5) Provide patients with consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care;

(6) Ensure that PCMHs develop and maintain appropriate comprehensive care plans for patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

(7) Ensure that PCMHs plan for transition of care from youth to adult to senior;

(8) Enable and encourage use of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables those professionals to practice to the fullest extent of their professional licenses.

Certification requirements

A primary care practice that seeks PCMH certification must submit an application and pay any application fee ODH establishes. ODH may also require an annual renewal fee. If ODH establishes a fee, the fee must be in an amount sufficient to cover the cost of any on-site evaluations.

Each primary care practice with PCMH certification must do all of the following:

(1) Meet any standards developed by national independent accrediting and medical home organizations, as determined by ODH;

(2) Develop a systematic follow-up procedure for patients, including the use of health information technology and patient registries;[113]

(3) Implement and maintain health information technology that meets the requirements of federal law;[114]

(4) Report to ODH health care quality and performance information, including any data necessary for monitoring compliance with certification standards and for evaluating the impact of PCMHs on health care quality, cost, and outcomes;

(5) Meet any process, outcome, and quality standards ODH specifies;

(6) Meet any other requirements ODH establishes.

Data collection

The act authorizes ODH to contract with a private entity to evaluate the effectiveness of certified PCMHs. ODH may provide to the entity any health care quality and performance information data that ODH has. ODH may also contract with national independent accrediting and medical home organizations to provide on-site evaluation of primary care practices and verification of data collected by ODH.

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[113] According to the National Center for Biotechnology Information, U.S. National Library of Medicine, "patient registry" refers to an organized system that uses observational study methods to collect uniform data to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes (www.ncbi.nlm.nih.gov/books/NBK49448/).

[114] 42 U.S.C. 300jj.

Report

The act requires ODH to submit two reports to the Governor and General Assembly evaluating the PCMH Program. The first report is due no later than three years after ODH adopts rules establishing the standards and procedures for certifying a primary care practice as a PCMH, the types of medical practices that constitute primary care practices eligible for certification, and the health care quality and performance information that a certified PCMH must report to ODH. The second report is due no later than five years after those rules are adopted. Each of the reports must include all of the following:

(1) The number of patients receiving primary care services from certified PCMHs, the number and characteristics of those patients with complex or chronic conditions, and to the extent available, information regarding the income, race, ethnicity, and language of the patients;

(2) The number and geographic distribution of certified PCMHs;

(3) Performance of and quality of care measures implemented by certified PCMHs;

(4) Preventative care measures implemented by certified PCMHs;

(5) Payment arrangements of certified PCMHs;

(6) Costs related to implementation of the PCMH Program and payment of care coordination fees;

(7) The estimated effect of certified PCMHs on health disparities;

(8) The estimated savings from establishing the PCMH Program, as those savings apply to the fee for service, managed care, and state-based purchasing sectors.

Abortion informed consent and fetal ultrasound requirements

Information provided before an abortion procedure

(R.C. 2317.56)

Under prior law, except when there was a medical emergency or medical necessity, one or more physicians or one or more agents of one or more physicians was required to do each of the following in person, by telephone, by certified mail, return receipt requested, or by regular mail evidenced by a certificate of mailing at least 24 hours prior to the performance or inducement of an abortion:

(1) Inform the pregnant woman of the name of the physician who is scheduled to perform or induce the abortion;

(2) Give the pregnant woman copies of certain published materials from ODH;

(3) Inform the pregnant woman that the materials given are published by the state and that they describe the embryo or fetus and list agencies that offer alternatives to abortion. The pregnant woman may choose to examine or not examine the materials. A physician or an agent of a physician may choose to be disassociated from the materials and may choose to comment or not comment on the materials.

The act provides that *the physician who is to perform or induce the abortion or the physician's agent* is required to provide the pregnant woman with the above-described information, rather than one or more physicians or one or more agents of one or more physicians.

Under the act, if it has been determined that the unborn human individual the pregnant woman is carrying has a detectable heartbeat, the physician who is to perform or induce the abortion must comply with the informed consent requirements established by the act (see "**Requirements before abortion in case of fetal heartbeat**," below) in addition to complying with the informed consent requirements generally applicable to all abortions.

Under continuing law, except when there is a medical emergency or medical necessity, an abortion can be performed or induced only if, among other things, prior to the performance or inducement of the abortion, the pregnant woman signs a form consenting to the abortion and certifies certain information on that form. The act requires that the form contain the name and contact information of the physician who provided to the pregnant woman the required information.

For the purposes of determining whether information must be provided before an abortion procedure, prior law defined "medical emergency" as a condition of a pregnant woman that, in the reasonable judgment of the physician who is attending the woman, creates an immediate threat of serious risk to the life or physical health of the woman from the continuation of the pregnancy necessitating the immediate performance or inducement of an abortion. The act modifies the definition of "medical emergency" by providing that it means a condition that in the physician's good faith medical judgment, based upon the facts known to the physician at that time, so complicates the woman's pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily

function of the pregnant woman that delay in the performance or inducement of the abortion would create.[115]

Determination of fetal heartbeat before an abortion

(R.C. 2919.191(A) and (C))

Under the act, a person who intends to perform or induce an abortion on a pregnant woman must determine whether there is a detectable fetal heartbeat of the unborn human individual the pregnant woman is carrying. The method of determining the presence of a fetal heartbeat must be consistent with the person's good faith understanding of standard medical practice.

Under the act, the ODH Director may promulgate rules specifying the appropriate methods of performing an examination for the presence of a fetal heartbeat of an unborn individual based on standard medical practice. The rules must require only that an examination must be performed externally. The rules are to be adopted under R.C. 111.15.

If rules have been adopted by the ODH Director, the method of determining the presence of the fetal heartbeat chosen must be one that is consistent with the rules.

The act requires the person who determines the presence or absence of a fetal heartbeat to record in the pregnant woman's medical record the estimated gestational age of the unborn human individual, the method used to test for a fetal heartbeat, the date and time of the test, and the results of the test.

Prohibition against an abortion before determining fetal heartbeat

(R.C. 2919.191(B))

The act provides that, except when a medical emergency exists that prevents compliance with the requirements described in this paragraph, a person is prohibited from performing or inducing an abortion on a pregnant woman prior to determining if the unborn human individual the pregnant woman is carrying has a detectable fetal heartbeat. Any person who performs or induces an abortion on a pregnant woman because of a medical emergency must note in the pregnant woman's medical records that a medical emergency necessitating the abortion existed and must also note the medical condition of the pregnant woman that prevented compliance with the requirement. The person must maintain a copy of the notes in the person's own records for at least seven years after the notes are entered into the medical records.

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[115] R.C. 2919.16, not in the act.

The person who performs the examination for the presence of a fetal heartbeat must give the pregnant woman the option to view or hear the fetal heartbeat.

Abortion permitted if no fetal heartbeat

(R.C. 2919.191(D))

The act provides that a person is not in violation of the provisions described above if that person has performed an examination for the presence of a fetal heartbeat in the fetus utilizing standard medical practice, that examination does not reveal a fetal heartbeat or the person has been informed by a physician who has performed the examination for fetal heartbeat that the examination did not reveal a fetal heartbeat, and the person notes in the pregnant woman's medical records the procedure utilized to detect the presence of a fetal heartbeat.

Penalties for abortion before determining fetal heartbeat

(R.C. 2919.191(E) and (F))

The act provides that, unless there is a medical emergency that prevents compliance, a person is prohibited from knowingly and purposefully performing or inducing an abortion on a pregnant woman before determining whether the unborn human individual the pregnant woman is carrying has a detectable heartbeat. The failure of a person to satisfy this requirement prior to performing or inducing an abortion on a pregnant woman may be the basis for either of the following:

(1) A civil action for compensatory and exemplary damages;

(2) Disciplinary action by the State Medical Board.

Statistical probability rules

(R.C. 2919.191(G) and 2919.192(C))

Under the act, the ODH Director may determine and specify in rules (to be adopted pursuant to R.C. 111.15 and based upon available medical evidence) the statistical probability of bringing an unborn human individual to term based on the gestational age of an unborn human individual who possesses a detectable fetal heartbeat.

Civil action for wrongful death

(R.C. 2919.191(H))

Under the act, a woman on whom an abortion is performed in violation of the requirement for determining the presence of a fetal heartbeat or who has not been notified of the required information regarding a detectable fetal heartbeat may file a civil action for the wrongful death of the woman's unborn child. The woman may receive at the mother's election at any time prior to final judgment damages in an amount equal to $10,000 or an amount determined by the trier of fact after consideration of the evidence subject to the same defenses and requirements of proof, except any requirement of live birth, as would apply to a suit for the wrongful death of a child who had been born alive.

Requirements before abortion in case of fetal heartbeat

(R.C. 2919.192(A), (B), and (E))

If a person who intends to perform or induce an abortion on a pregnant woman has determined that the unborn human individual the pregnant woman is carrying has a detectable heartbeat, the person generally is prohibited from performing or inducing the abortion until all of the following requirements have been met and at least 24 hours have elapsed after the last of the requirements is met:

(1) The person intending to perform or induce the abortion must inform the pregnant woman in writing that the unborn human individual the pregnant woman is carrying has a fetal heartbeat.

(2) The person intending to perform or induce the abortion must inform the pregnant woman, to the best of the person's knowledge, of the statistical probability of bringing the unborn human individual possessing a detectable fetal heartbeat to term based on the gestational age of the unborn human individual or, if the ODH Director has specified statistical information regarding the probability of bringing the unborn human individual to term, must provide to the pregnant woman that information.

This prohibition does not apply if the person who intends to perform or induce the abortion believes that a medical emergency exists that prevents compliance with the requirements described above.

Whoever violates the prohibition is guilty of performing or inducing an abortion without informed consent when there is a detectable fetal heartbeat, a misdemeanor of the first degree on a first offense and a felony of the fourth degree on each subsequent offense.

Effect on other abortion consent laws

(R.C. 2919.192(D))

The act specifies that the provisions of R.C. 2919.192 (described above) do not have the effect of repealing or limiting any other provisions of Ohio law relating to informed consent for an abortion, including the provisions specifying the information to be provided before an abortion procedure.

Pregnant woman not subject to criminal or civil penalties

(R.C. 2919.193)

The act provides that a pregnant woman upon whom an abortion is performed or induced in violation of the act's fetal heartbeat detection and notification requirements (R.C. 2919.191 or 2919.192) is not guilty of violating any of those requirements; is not guilty of attempting to commit, conspiring to commit, or complicity in committing a violation of any of those requirements; and is not subject to a civil penalty based on the abortion being performed or induced in violation of any of those requirements.

Definitions

(R.C. 2919.19)

The following terms are defined for the purposes of the act's fetal heartbeat detection and notification requirements (R.C. 2919.191, 2919.192, and 2919.193):

- "Fetal heartbeat" – cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac.
- "Fetus" – the human offspring developing during pregnancy from the moment of conception and includes the embryonic stage of development.
- "Gestational age" – the age of an unborn human individual as calculated from the first day of the last menstrual period of a pregnant woman.
- "Gestational sac" – the structure that comprises the extraembryonic membranes that envelop the fetus and that is typically visible by ultrasound after the fourth week of pregnancy.
- "Medical emergency" – a condition that in the physician's good faith medical judgment, based upon the facts known to the physician at that time, so complicates the woman's pregnancy as to necessitate the

immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or inducement of the abortion would create.

- "Physician" – a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the State Medical Board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in Ohio.

- "Pregnancy" – the human female reproductive condition that begins with fertilization, when the woman is carrying the developing human offspring, and that is calculated from the first day of the last menstrual period of the woman.

- "Serious risk of the substantial and irreversible impairment of a major bodily function" – any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function. A medically diagnosed condition that constitutes a "serious risk of the substantial and irreversible impairment of a major bodily function" includes pre-eclampsia, inevitable abortion, and premature rupture of the membranes, may include, but is not limited to, diabetes and multiple sclerosis, and does not include a condition related to the woman's mental health.

- "Standard medical practice" – the degree of skill, care, and diligence that a physician of the same medical specialty would employ in like circumstances. As applied to the method used to determine the presence of a fetal heartbeat for purposes of the act's requirements (R.C. 2919.191), "standard medical practice" includes employing the appropriate means of detection depending on the estimated gestational age of the fetus and the condition of the woman and her pregnancy.

- "Unborn human individual" – an individual organism of the species *Homo sapiens* from fertilization until live birth.

Ambulatory surgical facilities

(R.C. 3702.30 and 3702.302 to 3702.308)

Overview

The act requires each ambulatory surgical facility (ASF) to (1) maintain an infection control program and (2) in general, have a written transfer agreement with a local hospital that specifies an effective procedure for the transfer of patients from the facility to the hospital when medical care beyond the care that can be provided at the ASF is necessary. These requirements are similar to those in preexisting ODH rules establishing quality standards for specified types of health care facilities subject to ODH licensure.[116] As a result of the act, these rules will need to be amended to conform with the act's requirements. In addition, the act requires that an ASF notify the ODH Director when certain events occur and specifies certain requirements related to ASF inspections.

Infection control programs

Relative to an ASF's infection control program, the act specifies that the purposes of the program are to minimize infections and communicable diseases and facilitate a functional and sanitary environment consistent with standards of professional practice. To achieve these purposes, the act requires ASF staff managing a program to create and administer a plan designed to prevent, identify, and manage infections and communicable diseases; ensure that the program is directed by a qualified professional trained in infection control; ensure that the program is an integral part of the ASF's quality assessment and performance improvement program; and implement, in an expeditious manner, corrective and preventive measures that result in improvement.

Under the rules referenced above, an ASF must establish and follow written infection control policies and procedures for the surveillance, control and prevention, and reporting of communicable disease organisms by both contact and airborne routes. These must be consistent with infection control guidelines issued by the U.S. Centers for Disease Control and Prevention. The policies and procedures must address use of protective clothing and equipment; storage, maintenance, and distribution of sterile supplies and equipment; disposal of biological waste (including blood, body tissue, and fluid) in accordance with Ohio law; standard precautions or body substance isolation (or the equivalent); and tuberculosis and other airborne diseases.[117]

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[116] O.A.C. 3701-83-09(D) and 3701-83-19(E). An ASF is one of six types of health care facilities subject to these quality standards and licensing provisions (R.C. 3702.30(A)(4)).

[117] O.A.C. 3701-83-09(D).

Written transfer agreements

Requirement

The act generally requires each ASF to have a written transfer agreement with a local hospital that specifies an effective procedure for the safe and immediate transfer of patients from the ASF to the hospital when medical care beyond the care that can be provided at the ASF is necessary. This includes situations when emergencies occur or medical complications arise. A copy of the agreement must be filed with the ODH Director, and an ASF must update an agreement every two years and file the updated agreement with the Director.

The act specifies that an ASF is not required to have a written transfer agreement if either of the following is the case:

(1) The ASF is a provider-based entity of a hospital and the ASF's policies and procedures to address such situations are approved by the governing body of the facility's parent hospital and implemented. Under federal law, "provider-based entity" is defined as a provider of health care services or a rural health clinic that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider and that is under the ownership and administrative and financial control of the main provider. (A provider-based entity comprises both the physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at that facility.)[118]

(2) The ODH Director has granted the ASF a variance pursuant to the procedure specified in the act.

The act's requirement is similar to a requirement in ODH's preexisting rules under which an ASF is to have a written transfer agreement with a hospital for the transfer of patients in the event of "medical complications, emergency situations, and for other needs as they arise." But the rule does not require a formal agreement when the ASF is a provider-based entity of a hospital and the ASF's policies and procedures to accommodate medical complications, emergency situations, and other needs as they arise are in place and approved by the governing body of the parent hospital.[119]

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[118] 42 C.F.R. 413.65(a)(2).

[119] O.A.C. 3701-83-19(E).

Variances

Application. The act authorizes the ODH Director to grant a variance from the written transfer agreement requirement if the ASF submits to the Director a complete variance application prescribed by the Director and the Director determines (after reviewing the application) that the ASF is capable of achieving the purpose of the written transfer agreement in the absence of one. The act specifies that the Director's determination is final.

Under the act, a variance application is complete if it contains or includes as attachments all of the following:

--A statement explaining why application of the requirement would cause the ASF undue hardship and why the variance will not jeopardize the health and safety of any patient;

--A letter, contract, or memorandum of understanding signed by the ASF and one or more consulting physicians who have admitting privileges at a minimum of one local hospital, memorializing the physician or physicians' agreement to provide back-up coverage when medical care beyond the level the ASF can provide is necessary;

--For each consulting physician described above, all of the following:

- A signed statement in which the physician attests that the physician is familiar with the ASF and its operations and agrees to provide notice to the ASF of any changes in the physician's ability to provide back-up coverage;
- The estimated travel time from the physician's main residence or office to each local hospital where the physician has admitting privileges;
- Written verification that the ASF has a record of the name, telephone numbers, and practice specialties of the physician;
- Written verification from the State Medical Board that the physician possesses a valid certificate to practice medicine and surgery or osteopathic medicine and surgery;
- Documented verification that each hospital at which the physician has admitting privileges has been informed in writing by the physician that the physician is a consulting physician for the ASF and has agreed to provide back-up coverage for the ASF when medical care beyond the care the ASF can provide is necessary;

- A copy of the ASF's operating procedures or protocols that, at a minimum, do all of the following: (1) address how back-up coverage by consulting physicians is to occur, including how back-up coverage is to occur when consulting physicians are temporarily unavailable, (2) specify that each consulting physician is required to notify the ASF, without delay, when the physician is unable to expeditiously admit patients to a local hospital and provide for continuity of care, and (3) specify that a patient's medical record maintained by the ASF must be transferred contemporaneously with the patient when the patient is transferred from the ASF to a hospital;

- Any other information the ODH Director considers necessary.

A preexisting ODH rule requires an ASF to submit an application for a variance containing the specific nature of the request and the rationale for the request; the specific building or safety requirement in question, with a reference to the relevant rule; the time period for which the variance is requested; and a statement of how the ASF will meet the intent of the requirement in an alternative manner.[120]

Decision. The act specifies that the ODH Director's decision to grant, refuse, or rescind a variance is final. The Director must consider each application for a variance independently without regard to any decision the Director may have made on a prior occasion to grant or deny a variance to that ASF or another ASF.

The act's requirement is similar to one in a preexisting ODH rule.[121] That rule:

--Authorizes the Director to grant a variance if the Director determines that the requirement has been met in an alternative manner;

--Specifies that the Director's refusal to grant a variance is final and does not create any rights to an administrative hearing;

--Prohibits the Director's granting of a variance from being construed as constituting precedence for the granting of any other variance; and

--Specifies that variance requests must be considered on a case-by-case basis.

Conditions; revocation. The act also authorizes the ODH Director to impose conditions on any variance the Director has granted. The Director may at any time rescind the variance for any reason, including a determination by the Director that the

[120] O.A.C. 3701-83-14(B).

[121] O.A.C. 3701-83-14(C), (F), and (G).

ASF is failing to meet one or more of the conditions or no longer adequately protects public health and safety. The act specifies that the Director's decision to rescind a variance is final.

Similar authorizations are included in a preexisting ODH rule.[122]

Duration. The act specifies that a variance is effective for the period of time specified by the ODH Director, except that it cannot be effective beyond the date the ASF's license expires. If a variance is to expire on the date the ASF's license expires, the ASF may submit to the Director an application for a new variance with its next license renewal application.

A preexisting ODH rule permits the Director to stipulate a time period for which a variance is to be effective. The time period could be different from the time period sought by the ASF in the written variance request.[123]

Inspections

The act requires that rules the ODH Director must adopt under continuing law establishing quality standards for health care facilities include provisions specifying the inspection form that must be used during ASF inspections. The act also requires the Director to conduct an inspection of any ASF that is not certified by the U.S. Centers for Medicare and Medicaid as an ambulatory surgical center each time the ASF submits a license renewal application. Under preexisting ODH rules, inspections are not required but could be made at any time the Director considers necessary or for the purpose of investigating alleged violations of law governing health care facilities.[124]

The act prohibits the Director from renewing an ASF license unless all of the following conditions are met:

(1) The inspector completes each item on the inspection form that must be used during ASF inspections. Until rules are adopted under the act specifying the form to be used, the inspector is to use the form approved by the Director on September 29, 2013 (the act's 90-day effective date).

(2) The inspection demonstrates that the ASF complies with all quality standards established by the Director in rules.

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[122] O.A.C. 3701-83-14(E).

[123] O.A.C. 3701-83-14(D).

[124] O.A.C. 3701-83-06(A) and (E).

(3) The Director determines that the most recent version of the updated written transfer agreement that the ASF files with the Director is satisfactory, unless the Director has granted a variance from the written transfer agreement requirement.

Notifications

The act requires an ASF to notify the ODH Director under all of the following circumstances:

(1) When the ASF modifies any provision of the most recent written transfer agreement it has filed with the Director. Notification under these circumstances must occur not later than the business day after the modification is finalized. For this purpose, a business day does not include Saturday, Sunday, or a legal holiday.[125]

(2) When the ASF modifies its operating procedures or protocols that address back-up coverage by consulting physicians and medical record maintenance and transfers. Notification under these circumstances must occur not later than 48 hours after the modification is made.

(3) When the ASF becomes aware of an event, including disciplinary action by the State Medical Board, that may affect a consulting physician's certificate to practice or the physician's ability to admit patients to a hospital identified in a variance application. Notification under these circumstances must occur not later than one week after the ASF becomes aware of the event's occurrence.

Preexisting ODH rules do not contain similar notification requirements.

Severability clause

If any provision of the act's new sections of law regarding ASFs (R.C. 3702.302 to 3702.307) is enjoined, the act specifies that the injunction does not affect any remaining provision of those sections, any provision of the section of law governing ASFs (R.C. 3702.30) that was in effect when the act was enacted, or any provision of the rules adopted under that section.

Public hospitals and written transfer agreements

(R.C. 3727.60)

The act prohibits a public hospital from entering into a written transfer agreement with an ASF in which nontherapeutic abortions are performed or induced. It

[125] R.C. 1.14, not in the act.

also prohibits a public hospital from authorizing a physician who has been granted staff membership or professional privileges at the public hospital to use that membership or those professional privileges as a substitution for, or alternative to, a written transfer agreement for the purpose of obtaining a variance from the requirement that an ASF in which nontherapeutic abortions are performed or induced have a written transfer agreement with a local hospital. (See "**Ambulatory surgical facilities, Written transfer agreements, Variances**," above.)

The act defines "public hospital" as a hospital registered with ODH that is owned, leased, or controlled by the state or any agency, institution, instrumentality, or political subdivision of the state. A public hospital includes any state university hospital, state medical college hospital, joint hospital, or public hospital agency. A "nontherapeutic abortion" is an abortion that is performed or induced when (1) the life of the mother would not be endangered if the fetus were carried to term or (2) the pregnancy was not the result of rape or incest reported to a law enforcement agency.[126]

Prioritized distribution of funds for family planning

(R.C. 3701.027, 3701.033, 5101.101, 5101.46, and 5101.461)

The act requires that ODH and the Ohio Department of Job and Family Services (ODJFS), when distributing funds for family planning services, award them first to public entities that (1) have applied for funding, (2) are operated by state or local government entities, and (3) provide or are able to provide family planning services. If any funds remain after distributing funds to those public entities, the act permits ODH and ODJFS to distribute funds to nonpublic entities in the following order of descending priority:

(1) Nonpublic entities that are federally qualified health centers (FQHCs), FQHC look-alikes, or community action agencies;

(2) Nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services;

(3) Nonpublic entities that provide family planning services, but do *not* provide comprehensive primary and preventive care services.

Federal funds

The act specifies that the funds subject to the priority levels described above include federal funds received under (1) the Maternal and Child Health Block Grant

[126] R.C. 9.04, not in the act.

(Title V of the Social Security Act), (2) the Family Planning Program (Title X of the Public Health Service Act), (3) the Social Services Block Grant (Title XX of the Social Security Act), and (4) the Temporary Assistance for Needy Families Block Grant (TANF, Title IV-A of the Social Security Act), to the extent that TANF funds are being used by Ohio to provide Title XX social services.

Exemptions

The act exempts from the prioritized distribution of funds both of the following: (1) the Medicaid program and (2) funds awarded by ODH as women's health services grants, which have their own order of priority.[127]

Management of long-term care facility residents' financial affairs

(R.C. 3721.15)

Under continuing law, a home (including a nursing home, residential care facility, and veterans' home) that manages a resident's financial affairs must deposit the resident's funds in excess of a specified amount in an interest-bearing account, separate from any of the home's operating accounts. Under former law, this requirement applied to a resident's funds in excess of $100. Under the act, a home is not required to place a resident's funds in an interest-bearing account unless the funds exceed $1,000.

Nursing facilities' plans of correction

(R.C. 5165.69)

Nursing facilities are required to undergo surveys to determine whether they continue to meet the requirements for certification to participate in the Medicaid program. Continuing law requires a nursing facility that receives a statement of deficiencies following a survey to submit to ODH a plan of correction for each finding cited in the statement. The act requires a nursing facility's plan of correction to include additional information.

Under the act, the part of a plan of correction that describes the actions the nursing facility will take to correct each finding must be detailed and include actions the facility will take to protect residents situated similarly to the residents affected by the causes of the findings. A plan of correction also must include both of the following:

[127] R.C. 3701.046, not in the act.

(1) A detailed description of an ongoing monitoring and improvement process to be used at the nursing facility that is focused on preventing any recurrence of the causes of the findings;

(2) If the plan concerns a finding assigned a severity level indicating that a resident was harmed or that immediate jeopardy exists, (a) detailed analyses of the facts and circumstances of the finding, including identification of its cause, (b) a detailed explanation of how the actions the nursing facility will take to correct the finding relate to the cause of the finding, and (c) a detailed explanation of the relationship between the ongoing monitoring and improvement process and the cause of the finding.

The act requires ODH to approve a nursing facility's plan of correction, and any modification of an existing plan, if it includes all of the information that the act and continuing law require. This is in addition to the continuing law requirement that ODH approve a plan or any modification that conforms to the requirements for approval established in federal regulations, guidelines, and procedures issued by the U.S. Secretary of Health and Human Services under federal Medicare and Medicaid laws.

The act permits ODH to consult with the Ohio Departments of Medicaid and Aging and the Office of the State Long-Term Care Ombudsman Program when determining whether a plan of correction concerning a finding assigned a severity level indicating that a resident was harmed or immediate jeopardy exists, or modification of such a plan, conforms to the requirements for approval. ODH has sole authority to make the determination regardless of whether it consults with the other agencies.

Nursing facility technical assistance

(R.C. 3721.027; R.C. 3721.026 (repealed))

The act eliminates a requirement that the ODH Director establish a unit within ODH to provide advice and technical assistance and to conduct on-site visits to nursing facilities for the purpose of improving resident outcomes.

Distribution of household sewage treatment permit fees

(R.C. 3718.06)

The act reallocates the distribution of money collected from state household sewage treatment system installation and alteration permit fees as follows:

(1) Decreases to not less than 10% (from not less than 25%) the percentage allocated to fund installation and evaluation of sewage treatment new technology pilot projects; and

(2) Increases to not more than 90% (from not more than 75%) the percentage used by the ODH Director to administer and enforce the Household and Small Flow On-Site Sewage Treatment Systems Law and rules adopted under it.

Water systems

(R.C. 3701.344)

The act exempts a water system that will be used in agriculture and that does not provide water for human consumption from obtaining a permit or license issued under, paying fees assessed or levied under, or complying with any rule adopted under the continuing statutes governing private water systems. A private water system is any water system for the provision of water for human consumption if the system has fewer than 15 service connections and does not regularly serve an average of at least 25 individuals daily at least 60 days out of the year.

Ohio Cancer Incidence Surveillance System

(R.C. 3701.261, 3701.262, 3701.264, and 3701.99; R.C. 3701.263 (repealed))

The act authorizes ODH to designate, by contract, a state university as an agent to implement the Ohio Cancer Incidence Surveillance System (OCISS). "State university" means the following: University of Akron, Bowling Green State University, Central State University, University of Cincinnati, Cleveland State University, Kent State University, Miami University, Ohio University, Ohio State University, Shawnee State University, University of Toledo, Wright State University, and Youngstown State University.

The OCISS is a population-based cancer registry established by the ODH Director that collects and analyzes cancer incidence data in Ohio. Continuing law requires each physician, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer to report each case of cancer to ODH. ODH is required to record in the registry all reports of cancer it receives.

Confidentiality of cancer reports

Prior law included confidentiality provisions that applied only to information on cancer provided to or obtained by a cancer registry and ODH. It specified that this information was confidential and was to be used only for statistical, scientific, and medical research for the purpose of reducing the morbidity or mortality of malignant disease. The act eliminates these confidentiality provisions. However, both federal law

and Ohio law unchanged by the act include general provisions governing the confidentiality of protected health information.[128]

Zoonotic disease program

(R.C. 3701.96)

The act specifies that if ODH administers a zoonotic disease program, the ODH Director is authorized to charge a local board of health a fee for each service the program provides to the board.[129] The fee amount must be determined by the Director and be commensurate with ODH's cost to provide the service. The board must pay the fee associated with a service at the time the service is provided.

According to the federal Centers for Disease Control and Prevention (CDC), zoonotic diseases are contagious diseases spread between animals and humans. They are caused by bacteria, viruses, parasites, and fungi carried by animals and insects. Examples of zoonotic diseases include anthrax, dengue, Ebola hemorrhagic fever, *Escherichia coli* infection, Lyme disease, malaria, plague, Rocky Mountain spotted fever, *salmonellosis*, and West Nile virus infection.[130]

Hope for a Smile Program (VETOED)

(R.C. 3701.139 and 5747.01(A)(32))

The Governor vetoed provisions that would have created the Hope for a Smile Program. The vetoed provisions specified that the Program's primary objective was to improve the oral health of school-age children, with services targeted at those who are indigent and uninsured. The Program was to be a collaboration between ODH, dental and dental hygiene academic programs, and professional associations.

The vetoed provisions would have:

--Required the ODH Director, with assistance from the Director of Administrative Services, to use the state's purchasing power to purchase or secure three buses equipped as mobile dental units. Each bus would have been assigned to one

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[128] *See* the Health Insurance Portability and Accountability Act of 1996, 104 Pub. L. No. 191, 42 U.S.C. 1320d *et seq*; 45 C.F.R. 16.304; and R.C. 3701.17, not in the act.

[129] According to an ODH representative, ODH has been administering some form of a zoonotic disease program since 1965. Prior to 2005, the program operated as two separate programs—the Rabies Program and the Vectorborne Disease Program. In 2005, these two programs merged to become the Zoonotic Disease Program. (Electronic correspondence from ODH (May 30, 2013).)

[130] CDC, *What are zoonotic diseases?*, available at www.cdc.gov/24-7/cdcfastfacts/zoonotic.html.

region of Ohio (northern, central, or southern). Dental professionals and faculty and staff of dental and dental hygiene programs would have staffed the buses.

--Authorized the program to (1) accept grants, donations, and awards, (2) seek Medicaid and private insurance reimbursement, and (3) apply for money allocated by the U.S. Department of Labor or other entities for workforce or economic development initiatives.

--Authorized dentists and dental hygienists who provided services free of charge under the program to take a state income tax deduction, equal to the fair market value of the services, beginning with the tax year starting on January 1, 2013.

--Required the ODH Director to appoint an advisory council to consult with the Director in adopting program rules and give input for an annual report on program achievements.

Financial assistance to purchase hearing aids for children

(Sections 285.10 and 285.20)

The act requires the ODH Director to adopt rules governing the distribution of the additional $200,000 it appropriates per year for fiscal years 2014 and 2015 to assist families in purchasing hearing aids for children under 21. The rules must (1) establish eligibility criteria to include families with incomes at or below 400% of the federal poverty line and (2) develop a sliding scale of disbursements based on family income. The act authorizes the Director to adopt any other rules necessary to distribute these funds.

Charges for copies of medical records

(R.C. 3701.741 and 3701.742)

The act eliminates a requirement that adjustments to charges for copies of medical records be made not later than January 1 of each year. Continuing law specifies the maximum amounts that may be charged and provides for an annual adjustment based on the Consumer Price Index (CPI). Prior law required that this adjustment be made by January 1 based on the preceding 12-month period. Under the act, amounts specified in statute plus any previous adjustments must be increased or decreased by the average percentage of increase or decrease in the CPI for the immediately preceding calendar year over the calendar year immediately preceding that year.

The act eliminates a requirement that the ODH Director provide a list of the adjusted amounts on request but maintains a requirement that the list be available on ODH's web site.

Trauma center preparedness report

(R.C. 149.43; R.C. 3701.072 (repealed))

Under prior law, the ODH Director was required to adopt rules requiring a trauma center to report to the Director information on the center's preparedness and capacity to respond to disasters, mass casualties, and bioterrorism. The Director had to review the information and, after the review, could evaluate the center's preparedness and capacity. The act eliminates the reporting requirement and the accompanying authority to evaluate a trauma center's preparedness and capacity.

Council on Stroke Prevention and Education

(R.C. 3701.90, 3701.901, 3701.902, 3701.903, 3701.904, 3701.905, 3701.906, and 3701.907 (repealed))

The act abolishes the Council on Stroke Prevention and Education, which was established within ODH in 2001 to do the following:

- Develop and implement a comprehensive statewide public education program on stroke prevention, targeted to high-risk populations and to geographic areas where there is a high incidence of stroke;
- Develop or compile for primary care physicians recommendations that address risk factors for stroke, appropriate screening for risk factors, early signs of stroke, and treatment strategies;
- Develop or compile for physicians and emergency health care providers recommendations on the initial treatment of stroke;
- Develop or compile for physicians and other health care providers recommendations on the long-term treatment of stroke;
- Develop or compile for physicians, long-term care providers, and rehabilitation providers recommendations on rehabilitation of stroke patients; and
- Take other actions consistent with the purpose of the Council.

The Council was required to meet at least once annually, at the call of the chair, to review and make amendments as necessary to the recommendations developed or compiled by the Council.

System for Award Management web site

(R.C. 3701.881)

Continuing law requires an individual to undergo a database review as part of a criminal records check if the individual is under final consideration for employment with (or is referred by an employment service to) a home health agency in a position that involves providing direct care to an individual. The ODH Director is permitted to adopt rules also requiring individuals already employed by (or referred to) home health agencies in such positions to undergo the database reviews.

Continuing law specifies various databases that are to be checked as part of a database review. The ODH Director is permitted to specify additional databases in rules. The Excluded Parties List System, which is maintained by the U.S. General Services Administration, is one of the databases specified in statute. The act specifies that the Excluded Parties List System is available at the federal web site known as the System for Award Management.

WIC vendor contracts

(Section 285.40)

In Ohio, ODH administers the federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The act requires that during fiscal years 2014 and 2015 ODH review and process a WIC vendor contract application not later than 45 days after it is received if on that date the applicant is a WIC-contracted vendor and meets all of the following requirements:

(1) Submits a complete WIC vendor application with all required documents and information;

(2) Passes the required unannounced preauthorization visit within 45 days of submitting a complete application;

(3) Completes the required in-person training within 45 days of submitting the complete application.

ODH must deny the application if the applicant fails to meet all of the requirements. After an application has been denied, the applicant may reapply for a

contract to act as a WIC vendor during the contracting cycle of the applicant's WIC region.

Department of Health Medicaid Fund

(R.C. 3701.832)

The act creates in the state treasury the Department of Health Medicaid Fund. All funds ODH receives for the purpose of paying the expenses that ODH incurs under the Medicaid program must be deposited into the Fund. ODH is required to use the money in the Fund to pay the expenses that ODH incurs under the Medicaid program.