Rules & Policies Agenda for Board Meeting
June 8, 2022

A. Rule Review Update
B. Podiatric Licensure Rules
C. Rules Sent for Initial Circulation
D. Telehealth Rules
E. Legislative Update
MEMORANDUM

TO: Betty Montgomery, President
    Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Rule Review Update

DATE: May 31, 2022

Attached please find the Rule Schedule and Spreadsheet for June 2022.

**Requested Action**: No action requested.
RULES TO JUNE BOARD MEETING

**Approve for filing with CSI**

**Podiatric Licensure Rules**
- 4731-12-01
- 4731-12-02
- 4731-12-03
- 4731-12-04
- 4731-12-05
- 4731-12-06
- 4731-12-07

**Public Notice of Rules Procedures**
- 4731-2-01

**Examinations**
- 4731-5-01
- 4731-5-02
- 4731-5-03
- 4731-5-04

**Demonstration of Proficiency in Spoken English**
- 4731-6-04

**Ready to file with CSI**

**Massage Therapy Rules**
- 4731-1-01
- 4731-1-02
- 4731-1-03
- 4731-1-04
- 4731-1-05
- 4731-1-07
- 4731-1-08
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- 4731-1-18
- 4731-1-19

**Light Based Medical Device Rules**
- 4731-18-01
- 4731-18-02
- 4731-18-03

**Controlled Substance & Weight Loss Rules**
- 4731-11-03
- 4731-11-04
- 4731-11-04.1

**Rules Filed with CSI**

**Telehealth Rules**
- 4731-11-09
- 4731-37-01
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<th>Rule Description</th>
<th>Sent for Initial Comment</th>
<th>Board Approval to File with CSI</th>
<th>CSI filing</th>
<th>CSI recommendation</th>
<th>JCARR filing</th>
<th>Rules Hearing</th>
<th>JCARR Hearing</th>
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**Notes:**
- **Rules Hearing:** Date of hearing.
- **JCARR Hearing:** Date of JCARR hearing.
- **Board Adoption:** Date of board adoption.
- **New Effective Date:** Date the rule becomes effective.
- **Current Review Date:** Date the rule is reviewed.

**Dates:**
- 10/25/19, 11/13/19, 02/12/22, 07/26/19, 05/11/22, 01/25/21, 04/23/21, 03/10/21, 03/18/21, 03/15/21, 03/29/21, 05/12/21, 05/31/21, 05/31/26

**Revisions:**
- Revised filings on 11/24, 11/3 - orig.
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MEMORANDUM

TO: Betty Montgomery, President
Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Podiatric Licensure Rules, Chapter 4731-12, Ohio Administrative Code

DATE: May 16, 2022

The attached rules related to podiatric licensure were circulated to interested parties. The deadline for comment was May 6, 2022. Two comments were received and are attached for your review.

Samuel Makanjuola, DPM, PGY-1, UH Regional Hospitals, stated that he is in full support of the proposed changes. Michael Mathy, Executive Director of the Ohio Foot and Ankle Medical Association, stated that the association is pleased to see the rule modifications and that they have no recommended changes or additions to the proposed rules.

**Requested Action:** Approve draft rules for filing with the Common Sense Initiative.
4731-12-01 Definitions.

(A) "APMLE" means the American Podiatric Medical Licensing Examination prepared by the National Board of Podiatric Medical Examiners.

(B) "Board" means the State Medical Board of Ohio.

(C) "CPME" means the Council on Podiatric Medical Education.

(D) "Examination in Podiatric Medicine and Surgery" means the examination to determine competency to practice podiatric medicine and surgery under section 4731.52 of the Revised Code.

(E) "License" means a license to practice podiatric medicine and surgery issued under section 4731.56 of the Revised Code.

(F) "NBPME" means the National Board of Podiatric Medical Examiners.

(G) "PMLexis" means the Podiatric Medical Licensing Examination prepared by the National Board of Podiatric Medical Examiners.

(H) "Training Program" means an internship, residency, or clinical fellowship program that meets the requirements of division (A)(2) of section 4731.573 of the Revised Code.
4731-12-01 Preliminary education for licensure in podiatric medicine and surgery.

Production of a diploma from a college of podiatric medicine and surgery in good standing as determined by the board at the time the diploma was issued constitutes prima facie evidence that the individual has completed the requisite preliminary education under section 4731.53 of the Revised Code.
4731-12-02  Preliminary education for licensure and standing of colleges of podiatric surgery and medicine.

(A) For the purposes of sections 4731.52 and 4731.572 of the Revised Code, and rule 4731-12-07 of the Administrative Code, a college of podiatric medicine and surgery in the United States shall be defined as being in good standing if, at the time the diploma was issued, the institution was accredited by the CPME or its predecessor accrediting organizations.

(B) Production of a diploma from a college of podiatric medicine and surgery in good standing, at the time the diploma was issued, constitutes prima facie evidence that an applicant for a license has met the requirements of divisions (A)(1)(b) and (A)(1)(c) of section 4731.52 of the Revised Code. An applicant producing a diploma from a college of podiatric medicine and surgery located outside the United States must present evidence sufficient to establish to the board's satisfaction that the educational program met or exceeded the standards established by the CPME.
Standing of colleges of podiatric surgery and medicine.

(A) A college of podiatric medicine and surgery in the United States shall be defined as being in good standing at the time the diploma was issued for the purposes of section 4731.53 of the Revised Code if the institution is accredited by the "Council on Podiatric Medical Education," or its predecessor accrediting organizations as determined by the board.

(B) To meet the requirement of section 4731.53 of the Revised Code that an applicant present a diploma from a college of podiatric medicine and surgery in good standing as defined by the board at the time the diploma was issued, an applicant presenting a diploma from a college located outside the United States must present evidence sufficient to establish to the board's satisfaction that the educational program completed at such school meets or exceeds the standards established by the "Council on Podiatric Medical Education" for colleges of podiatric medicine and surgery in the United States.
4731-12-03 Podiatric Examination.

(A) The examination in podiatric medicine and surgery shall be all parts of the APMLE. An applicant shall have passed all parts and achieved a recognized passing performance on each part.
Eligibility for the examination in podiatric medicine and surgery; passing average.

(A) An applicant for a certificate to practice podiatric medicine and surgery is eligible for consideration to take the examination in podiatric medicine and surgery if, in addition to meeting the other requirements of sections 4731.52 and 4731.53 of the Revised Code, the applicant holds a diploma from a college in good standing as defined in rule 4731-12-02 of the Administrative Code.

(B) The examination in podiatric medicine and surgery shall consist of parts I, II and III of the national board of podiatric medical examiners examination. Prior to applying for a certificate to practice podiatric medicine and surgery, and prior to sitting for part III of the national board of podiatric medical examiners examination, an applicant shall have passed parts I and II of the national board of podiatric medical examiners examination.

(C) An applicant shall obtain diplomate or passing status with the national board of podiatric medical examiners on parts I, II and III of the national board examination in order to be considered as having passed the examination in podiatric medicine and surgery.
Eligibility for licensure.

The board shall issue a license to each individual who meets all applicable requirements under section 4731.52 of the Revised Code, and who passes the examination in podiatric medicine and surgery in accordance with rule 4731-12-03 of the Administrative Code, or has passed one of the following examinations:

(A) The "PMLexis" administered between June 12, 1990 and December 4, 2000, in addition to the holding of a passing status or diplomate status with the NBPME.

(B) An examination of a state of the United States, United States territory, or district administered before June 12, 1990, that was, in part, a written examination and

   (1) Taken without previous or subsequent failure of the examination offered by the NBPME; and

   (2) Taken without previous or subsequent failure of the PMLexis or part III of the APMLE.
Eligibility for licensure in podiatric medicine and surgery by endorsement from another state.

(A) An applicant for a license to practice podiatric medicine and surgery who holds a license from another state, United States territory, or the District of Columbia, shall be eligible for licensure consideration without examination if, in addition to any other requirements of sections 4731.51 to 4731.61 of the Revised Code and Chapter 4731-12 of the Administrative Code, the requirements of paragraphs (B) to (E) of this rule are met.

(B) If the license being endorsed is based upon an examination administered between June 12, 1990 and December 4, 2000, the license shall be based upon the passing of the "PMLexis" in addition to the holding of a passing status or diplomate status with the national board of podiatric medical examiners.

(C) If the license being endorsed is based upon an examination administered after December 4, 2000, the license shall be based on passing parts I, II and III of the national board of podiatric medical examiners examination.

(D) If the license being endorsed is based upon an examination administered before June 12, 1990, it shall have been:

   (1) Administered by the state, United States territory, or district issuing the license, and, have been in part, a written examination;

   (2) Taken without having failed the national board of podiatric medical examiners examination unless an intervening passing status or diplomate status on that examination has been achieved; and

   (3) Taken without having failed to achieve a minimum passing score on the PMLexis or part III of the national board of podiatric medical examiners examination unless an intervening passing status on that examination has been achieved. For purposes of this rule, a minimum passing score will be that figure recommended by the national board of podiatric medical examiners/federation of podiatric medical boards.

(E) An applicant for endorsement licensure shall file an application in the manner provided in section 4731.52 of Revised Code, furnish satisfactory proof that he or she is more than eighteen years of age and of good moral character and provide other facts and materials as the board requires.

(F) The license being endorsed shall be current and in good standing and shall be a full and unlimited license to practice podiatric medicine and surgery. An exception may
be made by the board in those cases where an applicant cannot renew his or her license in the other jurisdiction for purposes of endorsement due to residency or similar requirements.
Application procedures for licensure in podiatric medicine and surgery; investigation.

(A) Pursuant to division (A) of section 4731.52 of the Revised Code, all applicants for a license shall submit to the board an application under oath in the manner determined by the board, and provide such other facts and materials as the board requires. No application shall be considered submitted to the board until the appropriate fee has been received by the board.

(B) No application shall be considered complete until the applicant has complied with the requirements of paragraph (A) of rule 4731-4-02 of the Administrative Code and the board has received the results of the criminal records checks.

(C) The board reserves the right to thoroughly investigate all materials submitted as part of an application. The board may contact individual agencies or organizations for recommendations or other information about applicants as the board deems necessary. Applicants may be requested to appear before the board or a representative thereof as part of the application process.

(D) If an applicant for any license or certificate issued under section 4731.56, 4731.572, or 4731.573, fails to complete the application process within six months of initial application filing, the board may notify the applicant in writing of its intention to consider the application abandoned. If no response to that notice is received by the board within thirty days, the board shall consider the application as abandoned and no further processing shall be undertaken with respect to that application.

(E) If the application process extends for a period longer than six months, the board may require updated information as it deems necessary.

(F) No application being investigated under section 4731.22 of the Revised Code, may be withdrawn without approval of the board.

(G) Application fees are not refundable.
TO BE RESCINDED
*** DRAFT - NOT YET FILED ***

4731-12-05 Application procedures for licensure in podiatric medicine and surgery; investigation.

(A) All applicants for licensure in podiatric medicine and surgery shall file an application in the manner provided in section 4731.52 of the Revised Code, and provide such other facts and materials as the board requires including proof of completion of a minimum of one year of postgraduate training in a podiatric internship, residency or clinical fellowship program accredited by the "Council on Podiatric Medical Education."

(B) No application shall be considered filed until the appropriate fee has been received by the board.

(C) No application shall be considered complete until the applicant has complied with the requirements of paragraph (A) of rule 4731-4-02 of the Administrative Code and the board has received the results of the criminal records checks and any other forms required to be submitted pursuant to paragraph (A) of rule 4731-4-02 of the Administrative Code.

(D) All application materials submitted to the board by applicants for licensure in podiatric medicine and surgery will be thoroughly investigated. The board will contact individual agencies or organizations for recommendations or other information about applicants as the board deems necessary. Applicants may be requested to appear before the board or a representative thereof as part of the application process.

(E) Applications to take the examination for licensure in podiatric medicine and surgery in Ohio shall be filed at the board offices not less than sixty days prior to the first day of the examination. Under special circumstances, later filing may be permitted at the discretion of the board.
(A) For purposes of section 4731.572 of the Revised Code, the following definitions apply:

(1) "Approved college of podiatric medicine and surgery in good standing" means a college of podiatric medicine and surgery accredited by the "Council on Podiatric Medical Education," or its predecessor accrediting organizations.

(2) "A current, unrestricted license" means a license or other authority granted by the appropriate entity or governmental body which lawfully permits the applicant to practice podiatric medicine and surgery without governmental restriction or limitation.

(B) The duties of the applicant shall be set forth upon the application and approved by the board.

(C) By signing the application for a visiting podiatric faculty certificate, the dean of the school and the medical director of each affiliated teaching hospital are responsible for assuring that the holder of the certificate does not engage in practice outside its scope. They are further responsible for reporting to the board any belief that practice outside its scope has occurred.

(D) An individual shall be granted only one visiting podiatric faculty certificate, and shall be ineligible to apply for its renewal.
(A) A training certificate is mandatory for participation in a training program unless the participant holds a license to practice podiatric medicine and surgery. The participation in the program prior to receiving an acknowledgment letter or a training certificate from the board is the unlicensed practice of medicine pursuant to section 4731.34 of the Revised Code.

(B) An individual may not begin participation in a training program unless the individual has been issued a diploma from a college of podiatric medicine and surgery in good standing.

(C) Evidence that the applicant for a training certificate has been accepted or appointed to a training program meeting the requirements of division (A)(2) of section 4731.573 of the Revised Code must include a certification from the training program of both of the following:

1. The training program will verify that the applicant has been issued a diploma before permitting the applicant to begin participation in the training program; and

2. The training program will notify the board if a holder of a training certificate has not been issued a diploma before the start date of the training program.

(D) The holder of a training certificate shall immediately notify the board in writing if the holder has not been issued a diploma before the start date of the training program.

(E) Upon the board's receipt of an application for a training certificate, or upon the board's receipt of written notice from an applicant for a license that the applicant intends to participate in a training program, and after verifying that the applicant has paid the appropriate fee, the board may issue to the applicant an acknowledgment letter. Fees are neither refundable nor transferable.

1. Upon receipt of that acknowledgment letter, the applicant may begin participating in the training program that meets the requirements of section 4731.573 of the Revised Code, and this chapter of the Administrative Code, to which the applicant has been appointed while the application is being processed. The acknowledgment letter will serve as proof that the board has received the application and that the applicant is entitled to continue participation in the training program.

2. If an applicant has not received an acknowledgment letter or training certificate from the board within forty-five days after submitting an application, then the applicant shall immediately inform the board and the director of his or her training program in writing.

3. An acknowledgment letter issued under this rule shall authorize participation in a training program for one hundred twenty days, unless prior to that time the
board:

(a) Issues the certificate; or

(b) Issues an order in accordance with Ohio law suspending without a prior hearing the authority to participate; or

(c) Accepts a withdrawal of the application; or

(d) Issues a notice of opportunity for hearing in accordance with Chapter 119. of the Revised Code, in which case the authority to participate shall continue until the board's issuance of a final order granting or denying the application, or until the end of the training year, whichever comes first; or

(e) In the case of an applicant for a license, advises the applicant in writing that a substantial question of a violation of this chapter or the rules adopted under it exists and that investigation is continuing, in which case the authority to participate shall continue until one of the following occur:

(i) The board issues a license; or

(ii) The board issues a final order in accordance with Chapter 119. of the Revised Code; or

(iii) The training year ends.

Except as provided in this rule, participation in a training program pursuant to an acknowledgment letter cannot be renewed or extended beyond one hundred twenty days.

(F) If at the end of one hundred twenty days following issuance of an acknowledgment letter to an applicant for a training certificate the board has commenced but not yet concluded investigation or inquiry into issues of possible violations of Chapter 4731. of the Revised Code, it shall issue a training certificate to the applicant but shall not be deemed to have waived any issues which would constitute grounds to impose discipline under Chapter 4731. of the Revised Code.

(G) If the applicant or training certificate holder changes training programs, the board must be notified in writing immediately. A new application need not be completed and a new training certificate will not be issued. The training certificate will continue to be valid until its date of expiration.

(H) A person who holds a suspended license to practice podiatric medicine and surgery is not eligible for a training certificate. Such a person must restore that license in accordance with sections 4731.222 and 4731.281 of the Revised Code before
beginning postgraduate training in Ohio. A person whose license to practice podiatric medicine and surgery has been permanently revoked or permanently denied is ineligible to participate in a training program in Ohio.
Podiatric training certificates.

(A) Upon the board's receipt of an application for a training certificate, or upon the board's receipt of written notice from an applicant for a certificate to practice podiatric medicine and surgery under section 4731.53 of the Revised Code, that the applicant intends to participate in a training program described in paragraph (A) of this rule, and after verifying that the applicant has paid the appropriate fee, the board will issue to the applicant an acknowledgment letter. Upon receipt of that acknowledgment letter the applicant may begin participating in the program that meets the requirements of section 4731.573 of the Revised Code, and this chapter of the Administrative Code, to which he or she has been appointed while the application is being processed. That acknowledgment letter will serve as proof that the board has received the application and that the applicant is entitled to continue participation in the training program. If an applicant has not received an acknowledgment letter from the board within forty-five days of submitting an application, then the applicant shall immediately inform the board and the director of his or her training program in writing.

(B) An acknowledgment letter issued under this rule shall authorize participation in a training program for one hundred and twenty days, unless prior to that time the board:

1. Issues the certificate; or

2. Issues an order in accordance with Ohio law suspending without a prior hearing the authority to participate; or

3. Accepts a withdrawal of the application; or

4. Issues a notice of opportunity for hearing in accordance with Chapter 119. of the Revised Code, in which case the authority to participate shall continue until the board's issuance of a final order granting or denying the application, or until the end of the training year, whichever comes first; or

5. In the case of an applicant for a certificate under section 4731.53 of the Revised Code, advises the applicant in writing that a substantial question of a violation of this chapter or the rules adopted under it exists and that investigation is continuing, in which case the authority to participate shall continue until one of the following occur:

   a. The board issues a certificate; or

   b. The board issues a final order in accordance with Chapter 119. of the Revised Code; or
Revised Code; or

(c) The training year ends.

Except as provided above, participation in a training program pursuant to an acknowledgment letter cannot be renewed or extended beyond one hundred twenty days.

(C) If at the end of one hundred and twenty days following issuance of an acknowledgment letter to an applicant for a training certificate the board has commenced but not yet concluded investigation or inquiry into issues of possible violations of Chapter 4731. of the Revised Code, it shall issue a training certificate to the applicant but shall not be deemed to have waived any issues which would constitute grounds to impose discipline under Chapter 4731. of the Revised Code.

(D) If the applicant or training certificate holder changes training programs before the end of the training year while maintaining the same finishing date of his or her postgraduate training year (e.g., June thirtieth), the board must be notified in writing immediately. A new application need not be completed. However, acknowledgment by the board of receipt of written notification of change in training programs will be required prior to starting the new training program. The new training certificate will only be valid for the remainder of the training year for which the applicant has been issued a current certificate.

(E) A training certificate shall be valid for one training year, but may, at the discretion of the board, be renewed annually for a maximum of five years. Renewal applications are mailed approximately April first for those who initiated their training on July first. Interns, residents, or clinical fellows who began their training after July first of the training year will be mailed their renewal application approximately three months prior to the expiration of their training certificate.

(F) This rule and section 4731.573 of the Revised Code do not apply to or prohibit any graduate of a podiatric school or college from performing those acts that may be prescribed by or incidental to participation in an accredited podiatric internship, residency, or fellowship program accredited by the "Council on Podiatric Medical Education."

(G) A person who holds a suspended certificate to practice podiatric medicine and surgery under section 4731.53 of the Revised Code is not eligible for a training certificate. Such a person must restore that certificate in accordance with sections 4731.222 and 4731.281 of the Revised Code before beginning postgraduate training in Ohio. A person whose certificate has been permanently revoked or permanently
denied is ineligible to participate in postgraduate training in Ohio.
Dr. Makanjuola:

Thank you for your comments. They will be shared with the Medical Board.

Kimberly Anderson
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Samuel Makanjuola <smakanju@kent.edu>

I have reviewed the proposed rescind and proposed new 4731-12-01 through 4731-12-07 and would like to comment that I am in full support of the current proposed changes as they seem to clarify and simplify the process. They also bring various aspects up to date with current Podiatric training and processes.

As a note, I look forward to further changes to scope of practice to further reflect up to date Podiatric training.

Thank you.
Dr. Samuel Makanjuola DPM, PGY-1
Podiatric Medicine & Surgery
UH Regional Hospitals

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May 6, 2022

Kimberly Anderson  
Chief Legal Counsel  
State Medical Board of Ohio  
30 East Broad Street, 3rd Floor  
Columbus, Ohio 43215

Dear Ms. Anderson,

On behalf of our over 600 members across the state, the Ohio Foot and Ankle Medical Association (OHFAMA) appreciates the opportunity to submit comments on proposed language on several rules relating to the licensing of podiatric physicians and surgeons.

Overall, the proposed rules streamline and modify existing rules to reflect recent changes to state statutes and current practices in podiatric education and training.

OHFAMA is pleased to see rules relating to application procedures (4731-12-05) and podiatric training certificates (4731-12-07) being modified to be more consistent with similar rules governing our colleagues who trained at allopathic and osteopathic medical schools.

We have no recommended changes or additions to proposed rules 4731-12-01 through 4731-12-07 at this time.

Thank you again for the opportunity to provide input on the proposed podiatry licensure rules. Please contact me at 614-457-6269 or via email at mmathy@ohfama.org if we can be of further assistance.

Sincerely,

Michael Mathy, CAE  
Executive Director
MEMORANDUM

TO: Betty Montgomery, President
   Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Rules Sent for Initial Circulation, Rules 4731-2-01, Rule 4731-6-04, and Chapter 4731-5, OAC

DATE: May 31, 2022

At the May meeting, the Board authorized initial circulation of the following rules:

Rule 4731-2-01 Public Notice of Rules Procedures-Proposed No Change
Rule 4731-6-04 Demonstration of Proficiency in Spoken English-Proposed No Change
Rule 4731-5-01 Admission to Examinations-Proposed Rescission
Rule 4731-5-02 Examination Failure; Inspection and Regrading-Proposed Recission
Rule 4731-5-03 Conduct During Examinations-Proposed Rescission
Rule 4731-5-04 Termination of Examinations-Proposed Rescission

The rules were circulated to interested parties and posted on the Board’s website. The deadline for providing comments was Friday, May 27, 2022. No comments were received.

**Requested Action:** Motion of the Board approving the proposed no change and rescission for filing with the Common Sense Initiative.
Rule 4731-2-01 | Public notice of rules procedures.

(A) Prior to proposing to adopt, amend, or rescind any rule by the state medical board, public notice shall be given at least thirty days prior to the date set for the public hearing, by publication of that notice in the register of Ohio. The notice shall include a statement of the board's intention to consider adopting, amending, or rescinding a rule; a synopsis of the proposed rule, amendment, or rule to be rescinded or a general statement of the subject matter of the proposed rule, amendment or rescission; a statement of the reason or purpose for adopting, amending, or rescinding the rule; and the date, time, and place of the public hearing on the proposed action.

(B) The board may give whatever other notice it reasonably considers necessary including, but not limited to, the following:

(1) The board shall post the notice of the public rules hearing on the board's web site. The board may also post the full text of the proposed rules on its web site.

(2) The board may maintain a mailing list of all persons who have made a prior written request to receive a copy of each public notice provided for in paragraph (A) of this rule, and copies of such notices shall be sent by regular mail or electronic mail to each person on the mailing list at least thirty days prior to the date set for the hearing. Upon request, the board shall also promptly send a copy of any notice provided for in paragraph (A) of this rule by regular mail or electronic mail to any person not appearing on its mailing list. The board may assess a reasonable fee, not to exceed the cost of copying and mailing, for notices sent to persons according to this rule.

(3) Copies of the notice of the public rules hearing and the full text of the proposed rules shall be available at the board's offices at least thirty days prior to the date of the public rules hearing.

(C) Prior to the effective date of a rule, amendment, or rescission, the board shall make a reasonable effort to inform those affected by the rule, amendment, or rescission. The method of notification may include posting the full text of the rule as adopted or amended on the board's web site, publishing the rules in the board's newsletter, and/or sending by regular mail or electronic mail a notice of the action to all persons whose name appears on the mailing list maintained by the board under paragraph (A) of this rule, or to any person or his attorney who provided evidence, oral testimony, and/or a written statement which were made part of the record of the public hearing held under section 119.03 of the Revised Code. The board may assess a reasonable fee, not to exceed the cost of copying and mailing, for notices sent to persons in accordance with this rule.

Supplemental Information
Authorized By: 4731.05, 119.03
Amplifies: 119.03
Five Year Review Date: 12/7/2022
Demonstration of proficiency in spoken English, pursuant to section 4731.142 of the Revised Code, requires successful completion of the "Test of English as a Foreign Language, Internet-based Test" ("TOEFL iBT"). Successful completion of the TOEFL iBT requires a total score of ninety or higher and the following minimum scores or higher by section:
(A) Writing: no minimum;
(B) Speaking: twenty-six;
(C) Listening: twenty-six; and
(D) Reading: no minimum.

Supplemental Information

Authorized By: 4731.05
Amplifies: 4731.142
Five Year Review Date: 6/9/2022
Rule 4731-5-01 | Admission to examinations.

(A) Applicants shall present themselves promptly at the time set for the commencement of each examination. Tardy arrival, without reasonable explanation, may be grounds for dismissal from the examination at the discretion of the proctor in charge.

(B) No applicant shall be permitted entrance to examinations unless the applicant:

(1) Has submitted a completed application and such other information and documentation as required by the board;

(2) Has submitted the statutory fee;

(3) Has in his or her possession a signed admission card issued to that applicant by the board; and

(4) Has in his or her possession a recent color passport-type photograph substantially identical to that submitted with the application.

(C) The signed admission card and the photograph required by paragraph (B) of this rule shall be turned in at the close of the examination. Any set of answers lacking the admission card and photograph, no matter how complete and satisfactory otherwise, may be rejected.

Supplemental Information

Authorized By: 4731.15, 4731.05
Amplifies: 4731.13, 4731.16, 4731.55
Five Year Review Date: 6/9/2022
TO BE RESCINDED

Rule 4731-5-02 | Examination failure; inspection and regrading.

(A) No applicant shall be entitled to a hearing pursuant to Chapter 119. of the Revised Code on the issue of examination failure.

(B) An applicant's examination papers may be inspected by the applicant or the applicant's attorney for ninety days subsequent to the announcement of the examination results. Within ninety days of the announcement of examination results, the board may, upon receipt of a written request by the applicant or the applicant's attorney, regrade by hand the applicant's examination.

Supplemental Information

Authorized By: 4731.15, 4731.05
Amplifies: 4743.02, 119.06
Five Year Review Date: 6/9/2022
Rule 4731-5-03 | Conduct during examinations.

(A) No applicant shall, under any circumstances, communicate in any way with any other applicant, or have in his or her possession any books, notes, calculators, watches with computer or memory ability, or data of any kind, or question the proctors in reference to the meaning or interpretation of any question under consideration, but may question proctors relative to procedure.

(B) A violation of paragraph (A) of this rule shall constitute fraud in passing the examination, or fraud, misrepresentation, or deception in applying for or securing any license or certificate issued by the board under division (A) of section 4731.22 of the Revised Code.

Supplemental Information

Authorized By: 4731.05, 4731.15
Amplifies: 4731.13, 4731.16, 4731.55
Five Year Review Date: 6/9/2022
Rule 4731-5-04 | Termination of examinations.

(A) If any applicant withdraws from the sight of the proctors without permission, that applicant's examination may be immediately terminated and the applicant may be ordered to leave the site of the examination at the discretion of the proctor in charge. If an applicant is permitted to withdraw from the room due to temporary illness or other just cause, that applicant shall be permitted to return only upon the knowledge and consent of a proctor.

(B) If any applicant engages in conduct that interferes with, delays, obstructs, or disrupts the due conduct of the examination, that applicant's examination may be terminated and the applicant may be ordered to leave the site of the examination at the discretion of the proctor in charge.

(C) Termination or invalidation of examination under this chapter of the Administrative Code or Chapter 4731. of the Revised Code shall not be grounds for reimbursement of examination fees.

Supplemental Information

Authorized By: 4731.05, 4731.15
Amplifies: 4731.13, 4731.16, 4731.55
Five Year Review Date: 6/9/2022
The Board received thirteen (13) comments on the telehealth rules approved by the Board for filing with CSI during the CSI comment period of May 16, 2022 to May 31, 2022. This memo analyzes the written comments to rules 4731-37-01 and 4731-11-09 and provides recommendations regarding changes to the rules while they are currently under CSI review. Recommendations for clarifying language changes are also included. Attached to this memo are: (1) the revised proposed telehealth rules with recommended changes; (2) a spreadsheet summarizing the comments and their recommended disposition; and (3) the actual written comments.

Proposed new rule 4731-37-01 Telehealth

Definition of asynchronous communication technology in 4731-37-01(A)(3)

The Board received one comment from Cleveland Clinic suggesting expanding the definition beyond what is allowed under federal law to include text messaging without visualization of the patient, further defined in the federal rule as electronic mail. The current, proposed definition was previously revised after receiving substantial and differing stakeholder input as to the wording of the definition. The term is now defined by referencing the definition of the term in 42 CFR § 410.78 for consistency with federal law.

No changes recommended: No other comments received during the comment period suggested expanding beyond what is allowed under federal law. The current definition is in alignment with federal law and provides consistency with an accepted and operational standard.

Definition of “Consent for Telehealth Treatment” in 4731-37-01(A)(6)

Two comments (Cleveland Clinic and AMCNO) expressed that this definition creates a different standard for consent for treatment for telehealth than for in-person care.

No changes recommended: This consent for telehealth treatment definition is the result of substantial input from stakeholders during prior stakeholder engagement including the
Ohio Hospital Association and Central Ohio Primary Care  The definition exists for patient protection and simply expresses that there should be communication with the patient explaining the risks and benefits of, and alternatives to treatment through a remote evaluation. In some telehealth business models, the patient does not have a prior or future patient relationship with a health care professional and will likely see a different health care professional for each singular episode of care. Explaining the risk, benefits and alternatives simply and adequately educates the patient to be able to consent to telehealth treatment.

Absence of out of state practice language in 4731-37-01(B)

Three comments (OAND, OSRC, and The Ohio Council for Behavioral Health & Family Service Providers) were concerned that this paragraph limits health care professionals from providing telehealth services when the patient is located in another state.

**No change recommended:** The comments acknowledge that telehealth occurs in the state where the patient is located. Accordingly, the telehealth rules and laws for the state where the patient is located when the telehealth services occur apply. In its telehealth rules, the Medical Board regulates telehealth services provided by health care professionals (as defined in 473-37-01(A)) to patients located in this state. To be clear, the proposed rules do not prohibit providing telehealth services to patients located out of state. Rather, the proposed rules only address the provision of telehealth services that occur in this state because that is the limit of the Medical Board's authority and jurisdiction. The Medical Board has received previous comments during initial circulation of the rules from the Ohio State Medical Association and the Ohio Psychiatric Physicians Association stating that the Medical Board’s rules should be confined to telehealth services delivered to patients located in this state. As The Ohio Council’s comment suggests, Board staff plans to provide guidance on obtaining information on out of state practice in Frequently Asked Questions (FAQs) that will accompany the rules on the Board’s website when the rules are finalized.

**4731-37-01(B)(4) Referral provisions**

The Board received seven (7) comments (ATA Action, ATA Action representing six other telehealth companies, OSU Wexner Medical Center/OSU Physicians, 20/20 Now, Teladoc Health, MDLIVE, and OHA) regarding the referral provisions in this paragraph of the proposed rules. Several of the comments called the referral provisions anticompetitive. Additional concerns include that the language is overly prescriptive and overly complicated; holds telehealth providers to a higher standard than in-person health care providers; limits patient access to telehealth; and drives up health care costs. Most of the comments were concerned with how restrictive the referral options in (B)(4)(a) are when a telehealth provider determines that an in-person visit is necessary to meet the standard of care for a patient that needs immediate, but not emergency department care. Some comments also expressed concern about the referral provisions in (B)(4)(b)-(d), while others only saw issues with (B)(4)(a).
Recommended change: There is consensus among the seven comments that there should be a referral when it is clear that a telehealth visit will not meet the standard of care for a patient and the telehealth provider cannot see the patient in-person. Further, there is consensus among the seven comments that the current referral provisions, particularly in (B)(4)(a), are overly restrictive. Several of the comments proposed replacing the current referral provisions with some version of the language suggested by OSUWMC or recent FSMB language. The following revisions, which incorporate these comments, are recommended to 4731-37-01(B)(4):

(4) If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional shall see the patient in a reasonable timeframe or make the appropriate referral to another health care professional to meet the standard of care. Do the following:

(a) If a patient must be seen immediately, but not in an emergency department, the health care professional shall immediately schedule the patient for an in-person visit with the health care professional and promptly conduct that visit or immediately refer the patient for an in-person visit with one of the following licensed health care professionals who can provide the services in-person that are appropriate for the patient and the condition for which the patient presents:

(i) Another health care professional or an advanced practice registered nurse with whom the health care professional has a cross-coverage agreement.

(ii) In the case of a physician, a physician assistant with whom the physician has a supervision agreement or an advanced practice registered nurse with whom the physician has a standard care arrangement; or

(iii) In the case of a physician assistant, a physician with whom the physician assistant has a supervision agreement; or

(iv) Any health care professional requested by the patient who is appropriate for the condition with which the patient presents.

(b) If the patient does not need to be seen immediately, the health care professional shall do one of the following:

(i) Schedule the patient for an in-person visit and conduct that visit within an amount of time that is appropriate for that patient and their condition presented; or

(ii) Refer the patient to a health care professional in the same specialty to conduct an in-person visit within an amount of time that is appropriate for the patient and their condition.

(c) If the patient must be seen by a specialist other than the health care professional, the health care professional shall make a referral to a specialist, licensed in this state, whom the healthcare professional knows has an appropriate scope of practice for the medical condition of the patient.

(d) (a) If the patient needs emergency care, the health care professional shall assist the patient in obtaining emergency care by doing one of the following:
(1) If the patient is able to safely travel or be transported to the emergency department without emergency transport services, help the patient identify the closest emergency department and, if necessary, in the health care professional's discretion, provide notification to the emergency department of the patient's potential arrival;
(2) If the patient is unable to safely travel or be transported to the emergency department without emergency transport services, advise the patient to call 911 and remain on the videoconference, telephone, or other synchronous communication technology with the patient; or
(3) If patient is incapacitated, call for emergency services and remain on the videoconference, telephone, or other synchronous communication technology with the patient.

(e) (b) The health care professional shall document the in-person visit or the referral in the patient's medical record.

(f) (c) All referrals must shall be made in an amount of time that is appropriate for that patient and their condition presented.

Transmission of patient records in 4731-37-01(C)(4)

One comment (Teladoc) stated that this provision should be amended to obtain patient consent for the transmission of patient records.

No change recommended: During the initial circulation of the proposed rules, OHA, University Hospitals, and the Ohio Department of Mental Health and Addiction Services suggested revisions which removed the request for and obtaining of patient authorization in paragraph (C)(4) to reflect current practice and for consistency with the HIPAA Privacy Rule. The current proposed rule reflects those suggested revisions, current practice, and is consistent with the HIPAA Privacy Rule.

Formal consultation receipt and review of records in 4731-37-01(D)(3)

One comment (Teladoc) stated that this paragraph is unreasonable as it is difficult for a health care professional to know whether they have received all of the patient records for a formal consultation.

Change recommended: The following clarifying changes are recommended:

(D) A health care professional must shall comply with the following requirements to provide telehealth services that involve a formal consultation with another health care professional:
(1) The health care professional who seeks a formal consultation shall document the acknowledgement of the patient or if applicable, the patient's legal representative, before seeking the telehealth services formal consultation with the consulting health care professional;
(2) The consulting health care professional must shall meet the licensure or certification requirements in division (C) of section 4743.09 of the Revised Code; and
(3) The health care professionals who seeks a formal consultation shall send the medical records relevant to the patient’s medical condition to the consulting health care professional who shall involved in the formal consultation must have received and reviewed all the medical records of the patient relevant to the medical condition which is the subject of the consultation before the formal consultation occurs, unless this is not possible due to an emergency situation.

Additional clarifying change to 4731-37-01(C)

To comply with the LSC Rules Drafting Manual, the following grammatical change is recommended:

(C) A health care professional must shall comply with all standard of care requirements to provide telehealth services to a patient including but not limited to:

Proposed new rule 4731-11-09 Controlled substance and telehealth prescribing

Emergency Situation Exception to in-person visit requirement in 4731-11-09 (E)(4)

One comment (Cleveland Clinic) expressed concern that “emergency situation” is not defined broadly enough for this exception to the rule’s requirement of an in-person visit for a new patient before the prescribing a schedule II controlled substance. The comment suggests expanding the definition to “a more likely and reasonable emergency circumstance” when a patient “needs a schedule II substance immediately and cannot get in for an outpatient visit that includes a physical examination in an appropriate amount of time without potential adverse effects.”

No change recommended: 4731-11-09(A)(4) defines “emergency situation” as a situation involving an “emergency medical condition” as that term is defined in R.C. 1753.28. “Emergency medical condition” means “a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) Serious impairment to bodily functions; (c) Serious dysfunction of any bodily organ or part.” R.C. 1753.28.

The narrow in-person visit requirement in 4731-11-09(D) was authorized in the new telehealth law as a safeguard to protect new patients from inappropriate prescribing of schedule II controlled substances. In addition to the emergency situation exception, there are three other exceptions for hospice or palliative care, substance use disorder, and treatment of a mental health condition. Given the ongoing opioid overdose epidemic and the existence of three other exceptions to a narrow requirement only applicable to new patients being prescribed schedule II
controlled substances, the proposed rule’s current definition of “emergency situation” is reasonable and grounded in the Ohio Revised Code. The commenter’s proposed revision to include any situation where the patient could have “potential adverse effects” from not getting a schedule II substance immediately is overly broad, speculative, and does not provide support from the Ohio Revised Code. The Medical Board has not received any other comments suggesting the current definition of “emergency situation” applicable to the exception in 4731-11-09(E)(4) is unreasonable.

Other clarifying changes in 4731-11-09

Proposed new rule 4731-11-09 specifically includes references to both physician and physician assistant. The following revision correcting an unintended omission of physician assistant is recommended:

(G) Nothing in this rule shall be construed to imply that one in-person physician or physician assistant examination demonstrates that a prescription has been issued for a legitimate medical purpose within the course of professional practice.

Actions Requested:
(1) Discuss and approve revised proposed new rules 4731-37-01 and 4731-11-09 for submission to CSI as part of the ongoing CSI review of these rules.
(A) As used in Chapters 4730, 4731, 4759, 4761, and 4778 of the Administrative Code:

(1) "Telehealth services" means health care services provided through the use of information and communication technology by a health care professional licensed in Ohio, within the professional's scope of practice, who is located at a site other than the site where the patient is receiving the services or the site where another health care professional with whom the provider of the services is formally consulting regarding the patient is located.

(2) "Synchronous communication technology" means audio and/or video technology that permits two-way, interactive, real-time electronic communication between the health care professional and the patient or between the health care professional and the consulting health care professional regarding the patient.

(3) "Asynchronous communication technology", also called store and forward technology, has the same meaning as asynchronous store and forward technologies as that term is defined in 42 C.F.R. 410.78 (effective January 1, 2022).

(4) "Remote monitoring device" means a medical device cleared, approved, or authorized by the United States food and drug administration for the specific purpose which the health care professional is using it and which reliably transmits data electronically and automatically.

(5) "Health care professional" means any of the following:

(a) A physician assistant licensed under Chapter 4730. of the Revised Code;

(b) A physician licensed under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(c) A dietitian licensed under Chapter 4759. of the Revised Code;

(d) A respiratory care professional licensed under Chapter 4761. of the Revised Code; or

(e) A genetic counselor licensed under Chapter 4778. of the Revised Code.

(6) "Consent for telehealth treatment" means a process of communication between a patient or, if applicable, the patient's legal representative and the health care professional discussing the risks and benefits of, and alternatives to, treatment through a remote evaluation that results in the agreement to treatment that is documented in the medical record or signed authorization for the patient to be treated through an evaluation conducted through appropriate technology, as
specified in this rule, when the health care professional is in a location remote from the patient.

(7) "Formal consultation" means when a health care professional seeks the professional opinion of another health care professional regarding the diagnosis or treatment recommended for the patient’s medical condition presented, transfers the relevant portions of the patient’s medical record to the consulting health care professional, and documents the formal consultation in the patient's medical record.

(8) As used in this rule, "advanced practice registered nurse" means an individual who holds a current, valid license issued under Chapter 4723. of the Revised Code that authorizes the practice of nursing as an advanced practice registered nurse and is designated as any of the following: clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

(B) A health care professional may provide telehealth services to a patient located in this state. The health care professional shall comply with all of the following requirements:

(1) The standard of care for a telehealth visit is the same as the standard of care for an in-person visit.

(2) The health care professional shall follow all standard of care requirements which include but are not limited to the standard of care requirements in paragraph (C) of this rule.

(3) The health care professional may provide the telehealth services through the use of synchronous or asynchronous communication technology provided that the standard of care for an in-person visit can be met for the patient and the patient's medical condition through the use of the technology selected. Telephone calls, as a synchronous communication technology, may only be used for telehealth services when all of the elements of a bona fide health care visit meeting the standard of care are performed. Telephone calls that are routine or simply involve communication of information do not constitute a telehealth service.

(4) If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional shall see the patient in a reasonable timeframe or make the appropriate referral to another health care professional to meet the standard of care.

(a) If the patient needs emergency care, the health care professional shall assist the patient in obtaining emergency care by doing one of the following:
(i) If the patient is able to safely travel or be transported to the emergency department without emergency transport services, help the patient identify the closest emergency department and, if necessary, in the health care professional's discretion, provide notification to the emergency department of the patient's potential arrival;

(ii) If the patient is unable to safely travel or be transported to the emergency department without emergency transport services, advise the patient to call 911 and remain on the videoconference, telephone, or other synchronous communication technology with the patient; or

(iii) If patient is incapacitated, call for emergency services and remain on the videoconference, telephone, or other synchronous communication technology with the patient.

(b) The health care professional shall document the in-person visit or the referral in the patient's medical record.

(c) All referrals shall be made in an amount of time that is appropriate for that patient and their condition presented.

(C) A health care professional shall comply with all standard of care requirements to provide telehealth services to a patient including but not limited to:

(1) The health care professional shall verify the patient's identity and physical location in Ohio, and communicate the health care professional's name and type of active Ohio license held to the patient if the health care professional has not previously treated the patient. This may be done verbally as long as it is documented by the health care professional in the patient's medical record;

(2) The health care professional shall document the consent for telehealth treatment of the patient or, if applicable, the patient's legal representative;

(3) The health care professional shall provide the telehealth services in a manner that complies with the privacy and security requirements for the patient and their protected health information required by the law of this state and federal law. Also, the health care professional shall ensure that any username or password information and any electronic communications between the health care professional and the patient are securely transmitted and stored;

(4) If applicable, the health care professional shall forward the medical record to the patient's primary care provider, other health care provider, or to an appropriate health care provider to whom the patient is referred as provided in paragraph (B)(4) of this rule;
(5) The health care professional shall, through interaction with the patient, complete a medical evaluation that is appropriate for the patient and the condition with which the patient presents and that meets the minimal standards of care for an in-person visit, which may include portions of the evaluation having been conducted by other Ohio licensed healthcare providers acting within the scope of their professional license;

(6) The health care professional shall establish or confirm, as applicable, a diagnosis and treatment plan, which for those health care professionals designated as prescribers in section 4729.01 of the Revised Code, includes documentation of the necessity for the utilization of a prescription drug. The diagnosis and treatment plan shall include the identification of any underlying conditions or contraindications to the recommended treatment;

(7) The health care professional shall promptly document in the patient's medical record the patient's or, if applicable, the patient's legal representative, consent for telehealth treatment, pertinent history, evaluation, diagnosis, treatment plan, underlying conditions, any contraindications, and any referrals to appropriate health care providers, including primary care providers or health care facilities;

(8) The health care professional shall provide appropriate follow-up care or recommend follow-up care with the patient's primary care provider, other appropriate health care provider, or health care facility in accordance with the minimal standards of care;

(9) The health care professional shall make the medical record of the visit available to the patient or if applicable, the patient's legal representative, upon request.

(D) A health care professional shall comply with the following requirements to provide telehealth services that involve a formal consultation with another health care professional:

(1) The health care professional who seeks a formal consultation shall document the acknowledgement of the patient or if applicable, the patient's legal representative, before seeking the telehealth services formal consultation with the consulting health care professional;

(2) The consulting health care professional shall meet the licensure or certification requirements in division (C) of section 4743.09 of the Revised Code; and

(3) The health care professional who seeks a formal consultation shall send the medical records relevant to the patient's medical condition to the consulting health care professional who shall review the medical records of the patient relevant to the medical condition which is the subject of the consultation before the formal consultation occurs, unless this is not possible due to an
(E) While providing telehealth services, a health care professional that is a physician or a physician assistant who holds a valid prescriber number issued by the state medical board and who has been granted physician-delegated prescriptive authority shall comply with the following requirements regarding prescription drugs:

(1) The physician or physician assistant may only prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug that is not a controlled substance to a patient through the provision of telehealth services by complying with all requirements of this rule;

(2) The physician or physician assistant may only prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug to a patient that is a controlled substance through the provision of telehealth services by complying with the following requirements:

(a) Federal law governing prescription drugs that are controlled substances;

(b) The requirements of this rule; and

(c) The requirements in rule 4731-11-09 of the Administrative Code.

(F) A physician or physician assistant may provide telehealth services through the use of remote monitoring devices provided that:

(1) The patient or, if applicable, the patient's legal representative, gives consent to the use of remote monitoring devices;

(2) The medical devices that enable remote monitoring have been cleared, approved, or authorized by the United States food and drug administration for the specific purpose for which the physician or physician assistant are using it for the patient, and the remote monitoring devices otherwise comply with all federal requirements.

(G) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following:

(1) For a physician:

(a) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code;

(b) "Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code;
(c) "A departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(2) For a physician assistant:

(a) "A departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to a patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code;

(b) "Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4730.25 of the Revised Code;

(c) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the board," as that clause is used in division (B)(3) of section 4730.25 of the Revised Code.

(3) For a dietitian:

(a) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter or the rules adopted by the board," as that clause is used in division (A)(1) of section 4759.07 of the Revised Code;

(b) "A departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (A)(11) of section 4759.07 of the Revised Code.

(4) For a respiratory care professional:

(a) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter or the rules adopted by the board," as that clause is used in division (A)(7) of section 4761.09 of the Revised Code;

(b) "A departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in
division (A)(10) of section 4761.09 of the Revised Code.

(5) For a genetic counselor:

(a) "Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4778.14 of the Revised Code;

(b) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the board," as that clause is used in division (B)(3) of section 4778.14 of the Revised Code; or

(c) "A departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances whether or not actual injury to the patient is established," as that clause is used in division (B)(4) of section 4778.14 of the Revised Code.
Controlled substance and telehealth prescribing.

(A) As used in this rule:

(1) "Hospice care" means the care of a hospice patient as that term is defined in section 3712.01 of the Revised Code.

(2) "Palliative care" has the same meaning as in section 3712.01 of the Revised Code.

(3) "Medication assisted treatment" and "substance use disorder" have the same meanings as in rule 4731-33-01 of the Administrative Code.

(4) "Mental health condition" means any mental health condition, illness, or disorder as determined by the diagnostic criteria in the "Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision" (DSM-5-TR). This is a well-known and readily available text. It may be found at libraries, bookstores, or on the internet at www.psychiatry.org..

(5) "Emergency situation" means a situation involving an "emergency medical condition" as that term is defined in section 1753.28 of the Revised Code.

(B) A physician, or a physician assistant who holds a valid prescriber number issued by the state medical board and who has been granted physician-delegated prescriptive authority shall comply with the requirements of federal law governing prescription drugs that are controlled substances to prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug that is a controlled substance to a person.

(C) When the physician, or physician assistant who holds a valid prescriber number issued by the state medical board and who has been granted physician-delegated prescriptive authority prescribes, personally furnishes, otherwise provides, or causes to be provided a prescription drug that is a controlled substance during the provision of telehealth services, the physician or physician assistant shall comply with all requirements in rule 4731-37-01 of the Administrative Code.

(D) The physician, or physician assistant who holds a valid prescriber number issued by the state medical board and who has been granted physician-delegated prescriptive authority shall conduct a physical examination of a new patient as part of an initial in-person visit before prescribing a schedule II controlled substance to the patient except as provided in paragraph (E) of this rule.

(E) As an exception to paragraph (D) of this rule, a physician or physician assistant may prescribe a controlled substance to a new patient as part of the provision of telehealth services for any of the following patient medical conditions and situations:

(1) The medical record of a new patient indicates that the patient is receiving
hospice or palliative care;

(2) The patient has a substance use disorder, and the controlled substance is FDA approved for and prescribed for medication assisted treatment or to treat opioid use disorder.

(3) The patient has a mental health condition and the controlled substance prescribed is prescribed to treat that mental health condition;

(4) The physician or physician assistant determines in their clinical judgment that the new patient is in an emergency situation provided that the following occurs:

(a) The physician or physician assistant prescribes only the amount of a schedule II controlled substance to cover the duration of the emergency or an amount not to exceed a three-day supply whichever is shorter;

(b) After the emergency situation ends, the physician or physician assistant conducts the physical examination as part of an initial in-person visit before any further prescribing of a drug that is a schedule II controlled substance; or

(5) The prescribing of a controlled substance through telehealth services is being done under an exception permitted by federal law governing prescription drugs that are controlled substances.

(F) When prescribing a controlled substance through the provision of telehealth services under one of the exceptions in paragraph (E) of this rule, the physician or physician assistant shall document one of the reasons listed in paragraph (E) for the prescribing in the medical record of the new patient in addition to the documentation already required to meet the standard of care in rule 4731-37-01 of the Administrative Code.

(G) Nothing in this rule shall be construed to imply that one in-person physician or physician assistant examination demonstrates that a prescription has been issued for a legitimate medical purpose within the course of professional practice.

(H) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following:

(1) For a physician:

(a) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code;

(b) "Selling, giving away, personally furnishing, prescribing, or administering
drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code; or

(c) "A departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(2) For a physician assistant:

(a) "A departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to a patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code;

(b) "Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4730.25 of the Revised Code; or

(c) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the board," as that clause is used in division (B)(3) of section 4730.25 of the Revised Code.

(I) This rule shall not apply to any prescribing situations specifically authorized by the Revised Code or Administrative Code.
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<tr>
<td>Gerard Isenberg, MD</td>
<td><a href="mailto:jjohns@amcno.org">jjohns@amcno.org</a></td>
<td>The Academy of Medicine of Cleveland &amp; Northern Ohio (AMCNO)</td>
<td>4731-37-01(A)(6) definition of &quot;Consent for telehealth treatment&quot; - &quot;We are concerned that this language creates different standard of consent for virtual versus in-person care. It is not necessary for a physician to outline alternatives to treatment for a standard office visit, and a virtual visit should be no different. We are also concerned the language surrounding “risks and benefits and alternatives to,” is vague, and may leave a physician unsure as to his or her responsibility under this language. For example, do the “risk, benefits and alternatives,” need to be specifically spelled out and explained to the patient, or just attested to? We would appreciate clarification on this language, and respectfully request there not be a different standard of consent for virtual versus in-person visits.”</td>
<td>No change recommended</td>
</tr>
<tr>
<td>Kyle Zebley</td>
<td><a href="mailto:kzebley@ataaction.org">kzebley@ataaction.org</a></td>
<td>ATA Action</td>
<td>4731-37-01(B)(4)- Referral provisions contradict the plain language and intent of HB 122; hold telehealth providers to a higher standard of care for referrals than that required for in-person health care providers and thus place telehealth providers at a competitive disadvantage without any clinical justification, and drive up healthcare costs for Ohio consumers. Suggests revising language to provide clear guidance for telehealth provider continuity of care requirements. Agrees with OSUWMC proposed language: &quot;If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make the appropriate referral as is standard of care, which could include scheduling the patient for a telehealth or in-person visit with another health care professional.” The provision in (B)(4)(d) requiring a telehealth provider to help the patient identify the closest emergency room could risk patient safety by delaying their arrival to the emergency room.</td>
<td>Changes incorporating comment recommended to 4731-37-01(B)(4).</td>
</tr>
<tr>
<td>Alexis Apple</td>
<td><a href="mailto:aapple@ataaction.org">aapple@ataaction.org</a></td>
<td>on behalf of 1-800 Contacts, The American Telemedicine Association, ATA Action, Babylon Health, BlueStar TeleHealth, Circle Medical - A UCSF Health Affiliate, Hims, One Medical</td>
<td>4731-37-01(B)(4) Referral provisions contradict the plain language and intent of HB 122; hold telehealth providers to a higher standard of care for referrals than that required for in-person health care providers and thus place telehealth providers at a competitive disadvantage without any clinical justification, and drive up healthcare costs for Ohio consumers. Suggests revising language to provide clear guidance for telehealth provider continuity of care requirements. Agrees with modified version of OSUWMC proposed language: &quot;If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make [an] appropriate referral as is standard of care, which could include scheduling the patient [or providing information to the patient] for a telehealth or in-person visit with another health care professional.” The provision in (B)(4)(d) requiring a telehealth provider to help the patient identify the closest emergency room could risk patient safety by delaying their arrival to the emergency room.</td>
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<tr>
<td>Soley Hernandez</td>
<td><a href="mailto:hernandez@theohiocouncil.org">hernandez@theohiocouncil.org</a></td>
<td>The Ohio Council of Behavioral Health &amp; Family Service Providers</td>
<td>4731-37-01(B) – Understands that the “State Medical Board’s jurisdiction only extends to physician’s licensed and practicing in Ohio and therefore why 4731-37-01 (B) indicates a health care professional may provide telehealth services to a patient located in this state and paragraph (C) requires verification of the patient’s location in Ohio. However, many providers have experienced situations where clients have left the state for emergency situations and required treatment while out of state. The Counselor, Social Worker, and Marriage and Family Therapist board has a requirement in 4757-5-13 requiring licensees of the board providing services to client(s) outside the state of Ohio to comply with the laws and rules of the jurisdiction where the client is located at the time services are rendered. With the rapid expansion of telehealth and varying licensure requirements by state, many states have allowed for out of state practitioners to provide services during emergency services. We would recommend consideration of similar language in paragraph (C)[1]. However, understanding that CSWMFT licenses cannot prescribe and this creates an additional complication, an alternate option would be to provide guidance for physician’s on how to handle/document emergency situations when patients are not in Ohio and request telehealth treatment.”</td>
<td>No change recommended</td>
</tr>
<tr>
<td>Andrew Thomas, MD and L. Arick Forrest, MD</td>
<td><a href="mailto:William.Hayes@osumc.edu">William.Hayes@osumc.edu</a></td>
<td>Ohio State University Wexner Medical Center and OSU Physicians</td>
<td>4731-37-01(B)(4) – referral provisions overly complicate processes for physicians; are overly prescriptive and could stifle the use of telehealth; and require a more detailed referral process for telehealth services than for similar situations that arise during an in-person visit. Our recommendation is to replace the entire section, except (e) and (f) with “If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make the appropriate referral as is standard of care, which could include scheduling the patient for a telehealth or in-person with another health care professional.” “If the Board has concerns about providers who only have telehealth capacity to see patients and lack the relationships and infrastructure to ensure patients have access to alternative services, then we recommend applying these detailed scenarios to only this class of providers.”</td>
<td>Changes incorporating comment recommended to 4731-37-01(B)(4).</td>
</tr>
<tr>
<td>Charles Scott</td>
<td>chuckscott@for 2020now.com</td>
<td>20/20 Now</td>
<td>4731-37-01(B)(4) – opposes the referral provisions because they are anticompetitive; will have a negative financial impact on physicians that use telemedicine and the companies that provide equipment, software, staff, and management services to those physicians; will reduce patient access to care; and hold telehealth providers to a higher standard of care than in-person health care providers. Suggests eliminating current language and substituting the following language from FSMB: “If a patient is inappropriate for care via telemedicine technologies or experiences an emergent situation, complication, or side effects after an encounter using telemedicine technologies, physicians should have a standing plan in place and have the responsibility to refer the patient to appropriate care (e.g., acute care, emergency room, or another provider) to ensure patient safety. It is insufficient for physicians to simply refer all patients to the emergency department; each situation should be evaluated on an individual basis and referred based on its severity and urgency.”</td>
<td>Changes incorporating comment recommended to 4731-37-01(B)(4).</td>
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<tr>
<td>Steven Shook, MD</td>
<td>Barnhart, Blair <a href="mailto:barnhab@ccf.org">barnhab@ccf.org</a></td>
<td>Cleveland Clinic</td>
<td>(1) 4731-37-01(A)(3) definition of asynchronous communication should be expanded beyond federal rule definition to include text messages without visualization of the patient. (2) 4731-37-01(A)(6) definition of “Consent for telehealth treatment” - definition holds practitioner to a different and heightened standard of care for telehealth. (3) 4731-11-09(E)(4) - concerned that “emergency situation” is not defined broadly enough for this exception to the rule’s requirement of an in-person visit for a new patient before the prescribing a schedule II controlled substance. The comment suggests expanding the definition to “a more likely and reasonable emergency circumstance” when a patient “needs a schedule II substance immediately and cannot get in for an outpatient visit that includes a physical examination in an appropriate amount of time without potential adverse effects.”. (4) 4731-11-09(E)(5) - pleased with this language.</td>
<td>(1) No change recommended. (2) No change recommended. (3) No change recommended. (4) Positive comment - no change requested.</td>
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<tr>
<td>Geoff Colver</td>
<td><a href="mailto:colver@theohiocouncil.org">colver@theohiocouncil.org</a></td>
<td>Ohio Association for the Treatment of Opioid Dependence</td>
<td>“OATOD writes to formally express our support for the Medical Board’s proposed rules pending before CSI that address the implementation of HB 122.”</td>
<td>Positive comment- no change requested.</td>
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<td>Name</td>
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<tr>
<td>Claudia Duck Tucker</td>
<td><a href="mailto:ctucker@teladochealth.com">ctucker@teladochealth.com</a></td>
<td>Teladoc Health</td>
<td>Teladoc is &quot;concerned that the proposed telehealth rule would stifle competition and threaten access to health care via telehealth by holding telehealth providers to a higher standard than those delivering care in person and burdening telehealth providers with clinically unnecessary bureaucratic responsibilities.&quot; (1) 4731-37-01(B)(4)(a): for a patient that must be seen immediately, but not in an emergency department, Teladoc suggests eliminating the language to immediately schedule the patient for an in-person visit and also amending the referral provision to &quot;refer patient to their primary care provider if they have one or recommend that they seek in-person care.&quot; (2) 4731-37-01(B)(4)(b): for a patient that does not need to be seen immediately, Teladoc suggests amending provision to eliminate scheduling the patient for an in-person visit and instead &quot;refer the patient to a health care professional within an amount of time that is appropriate for the patient and their condition. (3) 4731-37-01(B)(4)(d) - suggests rewriting this provision to state &quot;If the patient needs emergency care, the health care professional shall tell the patient to call 911 and stay on the phone. If the patient is incapacitated, the provider shall call emergency services for the patient.&quot; (4) 4731-37-01(C)(4) - suggests amending the formal consultation review of records provision to require receipt and review of &quot;the medical records of the patient provided by the patient and the health care professional relevant to the medical condition which is the subject of the consultation&quot;. (5) Change incorporating comment recommended to 4731-37-01(B)(4).</td>
<td>(1), (2), and (3) Changes incorporating comment recommended to 4731-37-01(B)(4). (4) No change recommended. (5) Change incorporating comment recommended to 4731-37-01(D)(3).</td>
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<tr>
<td>Kim Clarke Maisch</td>
<td><a href="mailto:Kim.Maisch@cigna.com">Kim.Maisch@cigna.com</a></td>
<td>MDLIVE</td>
<td>4731-37-01(B)(4) - referral provisions hold telehealth providers to a higher standard than in-person health care providers and would limit telehealth utilization by all providers due to the complex documentation and referral requirements. Suggests replacing (B)(4) with the following modified version of the Ohio State University Wexner Medical Center proposed language: &quot;If a health care professional determines at any time during the provision of tele-health services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make [an] appropriate referral as is standard of care, which could include scheduling the patient [or providing information to the patient] for a telehealth or in-person visit with another health care professional.&quot; Change incorporating comment recommended to 4731-37-01(B)(4).</td>
<td>No change recommended.</td>
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<tr>
<td>Mavko, Kay, LD</td>
<td><a href="mailto:kmavko@columbus.rr.com">kmavko@columbus.rr.com</a></td>
<td>Ohio Academy of Nutrition and Dietetics</td>
<td>4731-37-01(B) - the language exceeds the authority of R.C. 4743.09 because that statute &quot;does not appear to specifically prohibit&quot; healthcare professionals from providing telehealth services to patients located outside of this state if permitted by the laws and rules of the state in which the patient is located. This part of the rule will result in inconvenience and disruption of care for patients. OAND suggests revising language to add in the underlined text: &quot;A health care professional may provide telehealth services to patients located outside of this state, and to patients with whom the health care professional has an established provider/patient relationship and are located outside of Ohio. The health care professional is subject to all applicable laws and rules of the state where the patient is located and shall comply with all of the following requirements.&quot; No change recommended.</td>
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<td>McGlone, Sean</td>
<td><a href="mailto:Sean.McGlone@ohiohospitals.org">Sean.McGlone@ohiohospitals.org</a></td>
<td>Ohio Hospital Association</td>
<td>4731-37-01(B)(4) - OHA believes that 4731-37-01(B)(4)(b), (c), and (d) are sufficient to cover the full range of scenarios when a telehealth provider determines that an in-person visit is necessary to meet the standard of care. OHA strongly encourages the removal of subsection (B)(4)(a) because it has significant concerns with health care providers' ability to operationalize this subsection and is further concerned that this provision is overly restrictive on the type of provider to whom a patient can be referred. Change incorporating comment recommended to 4731-37-01(B)(4).</td>
<td>No change recommended.</td>
</tr>
<tr>
<td>Sue Ciarlariello</td>
<td><a href="mailto:dpc@pacainc.com">dpc@pacainc.com</a></td>
<td>Ohio Society for Respiratory Care</td>
<td>4731-37-01(B) - OSRC states that this paragraph &quot;could limit valuable access to patients under our care, diminish patient safety monitoring, and require a regular unnecessary travel inconvenience for patients and their families.&quot; Suggests amending rule provision to add the underlined phrase &quot; &quot;A health care professional may provide telehealth services to patients located in this state and to patients with whom the health care professional has an established provider/patient relationship and are located outside of Ohio. The health care professional is subject to all applicable laws and rules of the state where the patient is located and shall comply with all of the following requirements:&quot; No change recommended.</td>
<td></td>
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</table>
May 27, 2022

Nathan Smith
Ohio State Medical Board
30 E. Broad St., 30th Floor
Columbus, OH 43215

Sent via Email to Medical Board at: Nathan.Smith@med.ohio.gov and Common Sense Initiative Office at: CSIPublicComments@governor.ohio.gov

RE: Rule 4731-37-01

Dear Mr. Smith:

Thank you for the opportunity to comment on Rule 4731-37-01: Telehealth. We appreciate the ongoing discussion the board has had on this issue with interested parties.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO), founded in 1824, is the region’s professional medical association, and the oldest professional association in Ohio. We are a non-profit 501(c)6 representing physicians and medical students from all the contiguous counties in Northern Ohio. We are proud to be the stewards of Cleveland’s medical community of the past, present and future.

The mission of the Academy of Medicine of Cleveland & Northern Ohio is to support physicians in being strong advocates for all patients and promote the practice of the highest quality of medicine. With that in mind, we offer the following comments.

Proposed Language: A(6)

"Consent for telehealth treatment" means a process of communication between a patient or, if applicable, the patient’s legal representative and the health care professional discussing the risks and benefits of, and alternatives to, treatment through a remote evaluation that results in the agreement to treatment that is
documented in the medical record or signed authorization for the patient to be treated through an evaluation conducted through appropriate technology, as specified in this rule when the health care professional is in a location remote from the patient.

We are concerned that this language creates different standard of consent for virtual versus in-person care. It is not necessary for a physician to outline alternatives to treatment for a standard office visit, and a virtual visit should be no different. We are also concerned the language surrounding “risks and benefits and alternatives to,” is vague, and may leave a physician unsure as to his or her responsibility under this language. For example, do the “risk, benefits and alternatives,” need to be specifically spelled out and explained to the patient, or just attested to? We would appreciate clarification on this language, and respectfully request there not be a different standard of consent for virtual versus in-person visits.

Thank you again for the opportunity to provide comment.

Gerard Isenberg, MD
President, AMCNO
May 18, 2022

Sean McCullough
Director, Ohio Common Sense Initiative
Office of Governor Mike DeWine
77 S. High St., 30th Floor
Columbus, OH 43215

RE: PROPOSED RULE 4731-37-01 RELATED TO TELEHEALTH

Dear Director McCullough:

On behalf of ATA Action, I am writing to express our opposition to certain provisions in proposed rule 4731-37-01 regarding telehealth services and request that the Common Sense Initiative consider the anti-competitive nature of the language forwarded in the proposed rule. We are concerned that proposed rule 4731-37-01 will lead to a decrease in the use of appropriate telehealth technologies and, as a result, potentially drive providers of high-quality, affordable health care out of business in the state.

ATA Action, the American Telemedicine Association’s affiliated trade association focused on advocacy, advances policy to ensure all individuals have permanent access to telehealth services across the care continuum. ATA Action supports the enactment of state and federal telehealth policies to secure telehealth access for all Americans, including those in rural and underserved communities. ATA Action recognizes that telehealth and virtual care have the potential to truly transform the health care delivery system by improving patient outcomes, enhancing safety and effectiveness of care, addressing health disparities, and reducing costs if only allowed to flourish.

During his State of the State address this year, Governor DeWine specifically highlighted his signing of House Bill 122 and noted that in “the last two years, we’ve realized that when you need health care and behavioral health services, a virtual visit can save time and money… So we’ve eased restrictions on telehealth services to expand access to care.”

However, we fear that language in the proposed rules will not only contradict the plain language and intent of House Bill 122 but ultimately make Ohio less competitive in the field of health care and drive up the cost of health care in the state. Our organization is particularly concerned by the referral and follow-up care provisions as currently written in 4731-37-01(B)(4) which undermine a central objective of House Bill 122 and the Governor’s office: expanding access to qualified providers who can deliver health care services whenever and wherever Ohioans need it, all in an affordable and convenient manner. The language reads as follows:

(4) If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional shall do the following:
   (a) If the patient must be seen immediately but not in an emergency department, the health care professional shall immediately schedule the patient for an in-person visit with the health care professional and promptly conduct that visit or refer the patient for an in-person visit with one of
the following licensed health care professionals who can provide the services in-person that are appropriate for the patient and the condition for which the patient presents:

(i) Another health care professional or an advanced practice registered nurse with whom the health care professional has a cross-coverage agreement,

(ii) In the case of a physician, a physician assistant with whom the physician has a supervision agreement or an advanced practice registered nurse with whom the physician has a standard care arrangement;

(iii) In the case of a physician assistant, a physician with whom the physician assistant has a supervision agreement; or

(iv) Any health care professional requested by the patient who is appropriate for the condition with which the patient presents.

(b) If the patient does not need to be seen immediately, the health care professional shall do one of the following:

(i) Schedule the patient for an in-person visit and conduct that visit within an amount of time that is appropriate for that patient and their condition presented; or

(ii) Refer the patient to a health care professional in the same specialty to conduct an in-person visit within an amount of time that is appropriate for the patient and their condition.

(c) If the patient must be seen by a specialist other than the health care professional, the health care professional shall make a referral to a specialist, licensed in this state, whom the healthcare professional knows has an appropriate scope of practice for the medical condition of the patient.

(d) If the patient needs emergency care, the health care professional shall help the patient identify the closest emergency department and, if necessary, in the health care professional's discretion, provide notification to the emergency department of the patient’s potential arrival.

When a provider first interacts with a patient via telehealth, it is unknown whether the patient will ultimately require care beyond what can be provided virtually. Under the Board’s proposed rule, any Ohio-licensed provider who seeks to deliver telehealth services would thus need to be prepared to meet the referral standard for each potential scenario: patients who need a) immediate non-emergency care, b) non-immediate care, c) specialty care, and d) emergency care. These referral standards, which to our knowledge do not exist in any other state, would increase business operations costs for telehealth providers and create significant back-end logistical barriers that may push some providers out of the market entirely.

Meeting the referral requirements for several of these scenarios contemplates mandating that telehealth providers – or their contracted partners – be within a narrow geographic proximity of any potential patient in the entire state. This restriction would not only defeat a central purpose of House Bill 122 but also place telehealth providers at a significant competitive disadvantage compared to their counterparts rendering care in person, all without any clinical justification from the Board. Closer inspection of the requirements that would be imposed upon telehealth providers by each of these scenarios were these rules to be adopted as currently written reveals their costly and blatantly anticompetitive nature.

**Mandating an in-person presence near the patient:** The first example of the rules’ anti-competitive nature comes in 4731-37-01(B)(4)(a). This referral requirement relating to telehealth providers treating patients who must been seen immediately but not in an emergency setting **effectively mandates that Ohio-licensed providers either operate a physical location to conduct an in-person visit with the patient or maintain formalized cross-coverage relationships with providers nearby any potential patient.**
As ATA Action and multiple stakeholders have shared with the Ohio Medical Board, such a mandate would preclude Ohio-licensed providers from rendering care to any patient who is not located within that provider’s vicinity unless the provider had somehow established cross-coverage relationships throughout every part of the state. This is not only impractical but would also be the first such restriction in the nation to ATA Action’s knowledge, a restriction that would make it much more difficult for providers operating telehealth businesses in Ohio under House Bill 122 to open and maintain their practices.

If implemented, this could drastically reduce – rather than expand – the number of Ohio-licensed providers offering telehealth services in the state, restricting patient access to care in the process. For example, a family physician in Toledo would no longer be able to offer telehealth services to his or her college-age patients who attend Ohio State in Columbus unless that physician had a contractual relationship with other providers in Columbus or the patient was willing to travel back home. The clinically unsubstantiated requirement forwarded by the Board would thus burden Ohio patients with spending their valuable time and money making these journeys to the physical offices of their preferred providers.

Requirements for other scenarios contemplated in the proposed rule hold telehealth services to a higher standard than care delivered in person, making it more difficult for telehealth providers to operate their businesses and treat patients effectively when compared to their in-person counterparts.

**Requiring a specific referral:** Language in 4731-37-01(B)(4)(c) mandates that telehealth providers refer patients who need to see a specialist to a specific specialist. When Ohio patients go to a provider’s office in person and the provider determines that the patient needs more specialized care, the provider is not required to provide the patient with a referral to a specific specialist “whom the healthcare professional knows has an appropriate scope of practice for the medical condition of the patient.” Rather, current practice would be for providers to communicate to the patient which kind of specialist could treat them best. Again, this language necessitates from providers a certain level of “local knowledge” that runs counter to the purpose of House Bill 122, an insurmountable obstacle for many Ohio-licensed telehealth providers to overcome. If the Board intends to hold telehealth providers to heightened referral obligations, ATA Action questions whether similar guidance will be issued for providers delivering care in person.

**Heightened responsibilities for emergency referrals:** Additionally, we are concerned with language in 4731-37-01(B)(4)(d) relating to patients who need emergency care. We agree that health care professionals – whether delivering care through telehealth technologies or other tools – should have in place the appropriate protocols to deal with emergency situations if and when they occur. In many situations, that would include immediately notifying emergency services. The proposed rule, however, would require telehealth providers to help patients identify the closest emergency room. In addition to placing a specific responsibility on telehealth providers that is not placed on providers at physical locations, this provision could potentially put patients’ lives at risk in delaying their visits to the emergency room. It would not help patients experiencing a heart attack or stroke to have their providers spend time walking them through which emergency room is closest. In such situations, it is absolutely vital that the patient gets to a health care facility as soon as possible. Any provision related to patients requiring emergency services should mandate that health care professionals have in place appropriate protocols to deal with emergency situations if and when they occur. Again, that would often include immediately notifying emergency services.

***

**ATA ACTION**
901 N. Glebe Road, Ste 850 | Arlington, VA 22203
Info@ataaction.org
Proposed revision: ATA Action agrees with the State Medical Board that, in the interest of patient safety, the standard of care must be the same for all health care services – regardless of whether providers render that care in person or virtually. We also recognize that there are some health care issues which can only be addressed properly via a face-to-face interaction between a patient and his or her provider. Accordingly, our members have protocols in place to ensure that telehealth providers who determine that telehealth technologies are not sufficient to meet the standard of care can connect patients with in-person providers.

We recommend the Board revise 4731-37-01(B)(4) to provide clear guidance as to telehealth providers’ continuity of care obligations. We agree with the proposed language suggested by Ohio State University Wexner Medical Center (OSUWMC) in their March 1, 2022 comment letter to the State Medical Board:

*If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make the appropriate referral as is standard of care, which could include scheduling the patient for a telehealth or in-person visit with another health care professional.*

The Board may also consider promulgating referral language similar to that proposed by the Federation of State Medical Boards (FSMB) in its recently approved document titled “The Appropriate Use of Telemedicine Technologies in the Practice of Medicine.” The FSMB’s language reads as follows:

*If a patient is inappropriate for care via telemedicine technologies or experiences an emergent situation, complication, or side effects after an encounter using telemedicine technologies, physicians should have a standing plan in place and have the responsibility to refer the patient to appropriate care (e.g. acute care, emergency room, or another provider) to ensure patient safety. It is insufficient for physicians to simply refer all patients to the emergency department; each situation should be evaluated on an individual basis and referred based on its severity and urgency.*

Permitting patients and providers to interact with each other via telehealth technologies without placing arbitrary restrictions on these telehealth interactions is becoming standard practice in states across the country. Implementing referral requirements that place arbitrary and unnecessary burdens on telehealth providers will not only put providers of virtual care at a competitive disadvantage but also drive up health care costs for Ohio consumers, something Governor DeWine has already recognized.

Research done by insurance company Cigna found that telehealth patients save more than $100 dollars per visit when compared to those who see providers in person – savings they lose when their access to telehealth services is impeded. According to recent research presented at the American Academy of Pediatrics National Conference, telehealth visits save families an average of $50 in travel costs and an hour of time in their busy schedules. If the rules are approved in their current form, Ohio patients – especially those in rural and other underserved communities – will be forced to spend that money and time traveling to brick-and-mortar offices just to get the health care they could have received comfortably and conveniently from their homes or places of work. Put simply, making it more difficult for patients and providers to interact via telehealth will make it more expensive for Ohioans to get the care they need.
Thank you for the opportunity to comment. As written, proposed rule 4731-37-01 would place anticompetitive burdens on providers hoping to operate telehealth practices in Ohio and levy unnecessary costs on Ohio patients. We urge the Initiative to consider the effects that the proposed rule will have on Ohio businesses and consumers in the interest of ensuring that Ohioans have access to high-quality, affordable health care when and where they need it. Please let us know if there is anything else that we can do to help you promote practical telehealth policy in Ohio. If you have any questions or would like to discuss the telehealth industry’s perspective further, please contact me at kzebley@ataaction.org.

Kind regards,

Kyle Zebley
Executive Director
ATA Action
Hello,

On behalf of the American Telemedicine Association, ATA Action, and six other organizations we are writing to express our opposition to certain provisions in proposed rule 4731-37-01 regarding telehealth services and request that the Common Sense Initiative consider the anti-competitive nature of the language forwarded in the proposed rule. We are concerned that proposed rule 4731-37-01 will lead to a decrease in the use of appropriate telehealth technologies and, as a result, have the unintended consequence of forcing high-quality, affordable health care to leave the state. Please see the attached letter for more details.

Please let us know if you have any questions. Thanks so much!

ALEXIS APPLE
Project Coordinator
901 N. Glebe Road, Ste. 850 | Arlington, VA 22203
Main: 571.464.0501 | Mobile: 570.898.2558
ataaction.org

CAUTION: This is an external email and may not be safe. If the email looks suspicious, please do not click links or open attachments and forward the email to csc@ohio.gov or click the Phish Alert Button if available.
May 31, 2022

Sean McCullough
Director, Ohio Common Sense Initiative
Office of Governor Mike DeWine
77 S. High St., 30th Floor
Columbus, OH 43215

RE: PROPOSED RULE 4731-37-01 RELATED TO TELEHEALTH

Dear Director McCullough:

On behalf of the undersigned organizations, we are writing to express our opposition to certain provisions in proposed rule 4731-37-01 regarding telehealth services and request that the Common Sense Initiative consider the anti-competitive nature of the language forwarded in the proposed rule. We are concerned that proposed rule 4731-37-01 will lead to a decrease in the use of appropriate telehealth technologies and, as a result, have the unintended consequence of forcing high-quality, affordable health care to leave the state.

During his State of the State address this year, Governor DeWine specifically highlighted his signing of House Bill 122 and noted that in “the last two years, we’ve realized that when you need health care and behavioral health services, a virtual visit can save time and money… So we’ve eased restrictions on telehealth services to expand access to care.”

Language in the proposed rules may have the unintended consequence of not only contradicting the plain language and intent of House Bill 122 but ultimately make Ohio less competitive in the field of health care and drive up the cost of health care in the state. Our organizations are particularly concerned by the referral and follow-up care provisions as currently written in 4731-37-01(B)(4) which undermine a central objective of House Bill 122 and the Governor’s office: expanding access to qualified providers who can deliver health care services whenever and wherever Ohioans need it, all in an affordable and convenient manner. The language reads as follows:

(4) If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional shall do the following:

(a) If the patient must be seen immediately but not in an emergency department, the health care professional shall immediately schedule the patient for an in-person visit with the health care professional and promptly conduct that visit or refer the patient for an in-person visit with one of the following licensed health care professionals who can provide the services in-person that are appropriate for the patient and the condition for which the patient presents:

(i) Another health care professional or an advanced practice registered nurse with whom the health care professional has a cross-coverage agreement,
(ii) In the case of a physician, a physician assistant with whom the physician has a supervision agreement or an advanced practice registered nurse with whom the physician has a standard care arrangement;
(iii) In the case of a physician assistant, a physician with whom the physician assistant has a supervision agreement; or
(iv) Any health care professional requested by the patient who is appropriate for the condition with which the patient presents.

(b) If the patient does not need to be seen immediately, the health care professional shall do one of the following:

(i) Schedule the patient for an in-person visit and conduct that visit within an amount of time that is appropriate for that patient and their condition presented; or

(ii) Refer the patient to a health care professional in the same specialty to conduct an in-person visit within an amount of time that is appropriate for the patient and their condition.

(c) If the patient must be seen by a specialist other than the health care professional, the health care professional shall make a referral to a specialist, licensed in this state, whom the healthcare professional knows has an appropriate scope of practice for the medical condition of the patient.

(d) If the patient needs emergency care, the health care professional shall help the patient identify the closest emergency department and, if necessary, in the health care professional’s discretion, provide notification to the emergency department of the patient’s potential arrival.

When a provider first interacts with a patient via telehealth, it is unknown whether the patient will ultimately require care beyond what can be provided virtually. Under the Board’s proposed rule, any Ohio-licensed provider who seeks to deliver telehealth services would thus need to be prepared to meet the referral standard for each potential scenario: patients who need a) immediate non-emergency care, b) non-immediate care, c) specialty care, and d) emergency care. These referral standards, which to our knowledge do not exist in any other state, would increase business operations costs for any provider using telehealth technologies and create significant back-end logistical barriers that may push some providers out of the market entirely.

Further, meeting the referral requirements for several of these scenarios contemplates mandating that telehealth providers – or their contracted partners – be within a narrow geographic proximity of any potential patient in the entire state. This restriction would not only defeat a central purpose of House Bill 122 but also place telehealth providers at a significant competitive disadvantage compared to their counterparts rendering care in person, all without any clinical justification from the Board. It also limits effective cross-state utilization of Ohio-licensed providers when needed. Closer inspection of the requirements that would be imposed upon telehealth providers by each of these scenarios were these rules to be adopted as currently written reveals their costly and anti-competitive nature.

*Mandating an in-person presence near the patient:* The first example of the rules’ anti-competitive nature comes in 4731-37-01(B)(4)(a). This referral requirement relating to telehealth providers treating patients who must be seen immediately but not in an emergency setting effectively mandates that Ohio-licensed providers either operate a physical location to conduct an in-person visit with the patient or maintain formalized cross-coverage relationships with providers nearby any potential patient.

The undersigned organizations and additional stakeholders have shared with the State Medical Board of Ohio that such a mandate would preclude Ohio-licensed providers from rendering care to any patient who is not located within that provider’s vicinity or for whom the provider does not have the staff to immediately schedule unless the provider had somehow established cross-coverage relationships throughout every part of the state. This is not only impractical but would also be the first such restriction in the nation to our knowledge, a restriction that would make it much more difficult for providers operating telehealth businesses in Ohio under House Bill 122 to open and maintain their practices.
If implemented, this rule could drastically reduce – rather than expand – the number of Ohio-licensed providers offering telehealth services in the state, restricting patient access to care in the process. For example, a family physician in Toledo would no longer be able to offer telehealth services to his or her college-age patients who attend Ohio State in Columbus unless that physician had a contractual relationship with other providers in Columbus or the patient was willing to travel back home. The clinically unsubstantiated requirement forwarded by the Board would thus burden Ohio patients with spending their valuable time and money making these journeys to the physical offices of their preferred providers.

Requirements for other scenarios contemplated in the proposed rule hold telehealth services to a higher standard than care delivered in person, making it more difficult for telehealth providers to operate their businesses and treat patients effectively when compared to their in-person counterparts.

**Requiring a specific referral:** Language in 4731-37-01(B)(4)(c) mandates that telehealth providers refer patients who need to see a specialist to a specific specialist. When Ohio patients go to a provider’s office in person and the provider determines that the patient needs more specialized care, the provider is not required to provide the patient with a referral to a specific specialist “whom the healthcare professional knows has an appropriate scope of practice for the medical condition of the patient.” Rather, current practice would be for providers to communicate to the patient which kind of specialist could treat them best. Again, this language necessitates from providers a certain level of “local knowledge” that runs counter to the purpose of House Bill 122, an insurmountable obstacle for many Ohio-licensed telehealth providers to overcome. If the Board intends to hold telehealth providers to heightened referral obligations, we question whether similar guidance will be issued for providers delivering care in person. This also runs counter to long-standing anti-referral regulatory policies aimed at protecting patient choice, options, and care.

**Heightened responsibilities for emergency referrals:** Additionally, we are concerned with language in 4731-37-01(B)(4)(d) relating to patients who need emergency care. We agree that health care professionals – whether delivering care through telehealth technologies or other tools – should have in place the appropriate protocols to deal with emergency situations if and when they occur. In many situations, that would include immediately notifying emergency services. The proposed rule, however, would require telehealth providers to help patients identify the closest emergency room. In addition to placing a specific responsibility on telehealth providers that is not placed on providers at physical locations, this provision could potentially put patients’ lives at risk in delaying their visits to the emergency room. It would not help patients experiencing a heart attack or stroke to have their providers spend time walking them through which emergency room is closest. In such situations, it is absolutely vital that the patient gets to a health care facility as soon as possible. Any provision related to patients requiring emergency services should mandate that health care professionals have in place appropriate protocols to deal with emergency situations if and when they occur. Again, that would often include immediately notifying emergency services.

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Proposed revision: We agree with the State Medical Board that, in the interest of patient safety, the standard of care must be the same for all health care services – regardless of whether providers render that care in person or virtually. We also recognize that there are some health care issues which can only be addressed properly via an in-person interaction between a patient and his or her provider. Accordingly, our members have protocols in place to ensure that telehealth providers who determine that
telehealth technologies are not sufficient to meet the standard of care can connect patients with in-person providers.

We recommend the Board revise 4731-37-01(B)(4) to provide clear guidance as to telehealth providers’ continuity of care obligations. We agree with the proposed language suggested by the Ohio State University Wexner Medical Center (OSUWMC) in their March 1, 2022 comment letter to the State Medical Board with a few clarifying modifications as indicated in brackets:

If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make [an] appropriate referral as is standard of care, which could include scheduling the patient [or providing information to the patient] for a telehealth or in-person visit with another health care professional."

The Board may also consider promulgating referral language similar to that proposed by the Federation of State Medical Boards (FSMB) in its recently approved document titled “The Appropriate Use of Telemedicine Technologies in the Practice of Medicine.” The FSMB’s language reads as follows:

If a patient is inappropriate for care via telemedicine technologies or experiences an emergent situation, complication, or side effects after an encounter using telemedicine technologies, physicians should have a standing plan in place and have the responsibility to refer the patient to appropriate care (e.g. acute care, emergency room, or another provider) to ensure patient safety. It is insufficient for physicians to simply refer all patients to the emergency department; each situation should be evaluated on an individual basis and referred based on its severity and urgency.

Permitting patients and providers to interact with each other via telehealth technologies without placing arbitrary restrictions on these telehealth interactions is becoming standard practice in states across the country. Implementing referral requirements that place arbitrary and unnecessary burdens on telehealth providers will not only put providers utilizing virtual care at a competitive disadvantage but also drive up health care costs for Ohio consumers, something Governor DeWine has already recognized.

Research done by insurance company Cigna found that telehealth patients save more than $100 dollars per visit when compared to those who see providers in person – savings they lose when their access to telehealth services is impeded. According to recent research presented at the American Academy of Pediatrics National Conference, telehealth visits save families an average of $50 in travel costs and an hour of time in their busy schedules. If the rules are approved in their current form, Ohio patients – especially those in rural and other underserved communities – will be forced to spend that money and time traveling to brick-and-mortar offices just to get the health care they could have received effectively, comfortably, and conveniently from their homes or places of work. Put simply, making it more difficult for patients and providers to interact via telehealth will make it more expensive and burdensome for Ohioans to get the care they need.

Thank you for the opportunity to comment. As written, proposed rule 4731-37-01 would place anticompetitive burdens on providers hoping to operate telehealth practices in Ohio and levy unnecessary costs on Ohio patients. We urge the Initiative to consider the effects that the proposed rule will have on Ohio businesses and consumers in the interest of ensuring that Ohioans have access to high-
quality, affordable health care when and where they need it. Please let us know if there is anything else that we can do to help you promote practical telehealth policy in Ohio.

Undersigned member organizations,

1-800 Contacts
The American Telemedicine Association
ATA Action
Babylon Health
BlueStar TeleHealth
Circle Medical - A UCSF Health Affiliate
Hims
One Medical
Good afternoon,

Thank you for the opportunity to comment on the Medical Board’s updated telehealth rules. We understand the State Medical Board’s jurisdiction only extends to physician’s licensed and practicing in Ohio and therefore why 4731-37-01 (B) indicates a health care professional may provide telehealth services to a patient located in this state and paragraph (C) requires verification of the patient’s location in Ohio. However, many providers have experienced situations where clients have left the state for emergency situations and required treatment while out of state.

The Counselor, Social Worker, and Marriage and Family Therapist board has a requirement in 4757-5-13 requiring licensees of the board providing services to client(s)s outside the state of Ohio to comply with the laws and rules of the jurisdiction where the client is located at the time services are rendered. With the rapid expansion of telehealth and varying licensure requirements by state, many states have allowed for out of state practitioners to provide services during emergency services. We would recommend consideration of similar language in paragraph (C)(1). However, understanding that CSWMFT licenses cannot prescribe and this creates an additional complication, an alternate option would be to provide guidance for physician’s on how to handle/document emergency situations when patients are not in Ohio and request telehealth treatment.

We are happy to answer any questions or discuss further if needed.

Have a good day,
Soley Hernandez, LISW-S
Associate Director
The Ohio Council of Behavioral Health & Family Services Providers
17 S. High Street, Suite 799, Columbus, OH  43215
hernandez@theohiocouncil.org  | 614-228-0747  | www.theohiocouncil.org

*Advocating Today for a Healthy Tomorrow*

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May 27, 2022

Stephanie Loucka  
Executive Director  
State Medical Board of Ohio  
30 East Broad Street, 3rd Floor  
Columbus, Ohio, 43215

Sean McCullough  
Director  
Ohio Common Sense Initiative Office  
77 South High Street, 30th Floor  
Columbus, Ohio 43215

Re: Telehealth Rule 4731-37-01 and Controlled substance and telehealth prescribing  
Rule 4731-11-09

Dear Director Loucka and Director McCullough:

On behalf of over 1,500 faculty physicians and over 900 residents and fellows at The Ohio State University Wexner Medical Center (OSUWMC) and OSU Physicians, Inc. (OSUP), we appreciate the State Medical Board of Ohio's revisions on the draft of this rule based on public comments that you received.

While the Board made many improvements to the previous draft of the rule, we continue to have concerns with 4731-37-01(B)(4). This section provides elaborate detail on what a health care provider must do should they determine that a telehealth visit with them will not meet the standard of care for the medical condition or if additional in-person care is necessary.

Our concerns with the language as it is written in the rule include:

- It overly complicates processes for physicians who already follow the standard of care, should patients need additional care
- Its overly prescriptive requirements could stifle the use of telehealth, a service that our patients are demanding
- We don't see this level of detail for similar situations that arise during an in-person visit in Board rules

Our recommendation is to replace the entire section, except (e) and (f) with "If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make the appropriate referral as is standard of care, which could include scheduling the patient for a telehealth or in-person with another health care professional."

This proposed language:
• Allows for making a telehealth referral to another provider if telehealth could be appropriate for the visit, which the current rule language would prohibit
• Avoids the need to revise the rule should additional scenarios arise
• Recognizes that there are already established referral processes that health care professionals follow when necessary

If the Board has concerns about providers who only have telehealth capacity to see patients and lack the relationships and infrastructure to ensure patients have access to alternative services, then we recommend applying these detailed scenarios to only this class of providers.

We appreciate your consideration of our recommendation and believe that it will protect the quality of care patients receive while facilitating the availability of telehealth services for our patients and providers.

Sincerely,

Andrew Thomas, MD, MBA
Interim Co-Leader & Chief Clinical Officer
OSU Wexner Medical Center

L. Arick Forrest, MD, MBA
Vice Dean for Clinical Affairs, OSU College of Medicine
Senior Associate Vice President for Health Sciences
President, The OSU Physicians, Inc
Medical Director, Ambulatory Services
May 27, 2022

Sean McCullough
Director, Ohio Common Sense Initiative Office of Governor Mike DeWine
77 S. High St., 30th Floor
Columbus, OH 43215

Common Sense Initiative Office at: CSIPublicComments@governor.ohio.gov

RE: PROPOSED RULE 4731-37-01 RELATED TO TELEHEALTH

Dear Director McCullough:

On behalf of 20/20NOW and the physicians and allied health care professionals that use our telemedicine platform and management services, I am writing to join the American Telemedicine Association (“ATA”) and others in opposition to several provisions in proposed rule 4731-37-01 regarding telehealth services. I encourage the Common Sense Initiative office to direct the Medical Board to revise the proposed rule because of:

- the anticompetitive nature of the proposed rule,
- the significant negative financial impact that the proposed rule will have on physicians that use telemedicine and the companies that provide equipment, software, staff, and management services to those physicians, and
- the harm to patients who will be denied access to quality care if the proposed rule is not revised to reflect the intent of HB 122, adopted last year to increase, not reduce, access to telemedicine to Ohio residents.

Our company shares the concern expressed by the ATA that proposed rule 4731-37-01 will lead to a decrease in the use of appropriate telehealth technologies. The rule, if adopted as proposed, will make it unnecessarily expensive and cumbersome for telemedicine providers and telemedicine platforms to operate in Ohio. If we are forced to wind down business in the state, we and the physicians we serve will face a significant financial loss. Of course, that also means that patients who benefit from access to eye care through telemedicine will be harmed because of reduced access to high-quality, convenient, and competitively priced eye care.

Telehealth is much more than a stepchild and after-thought to in-person care. Often, ocular telemedicine can be the introduction to eye care and serves as a gateway to further services, including in-person care when that is appropriate. Telehealth providers do not need to have a formal “cross-coverage relationship” with providers who are located close to the patient for this to occur.
Cross-coverage requirements such as those in the proposed rule restrict the potential for telehealth. It is impractical to require physicians to have formal connections in advance with the myriad of primary care doctors and specialists that may be appropriate to bring into a patient’s care. Additionally, requiring such relationships in advance will drastically limit access to providers who are available when and where patients need care. I don’t believe that this was the intent of HB 122.

The proposed rules will make it burdensome, if not impossible, for the many Ohio-licensed providers who use our technology and services to continue to deliver ocular telemedicine to their patients unless they have a brick-mortar presence or a relationship near of every potential patient. It will also require significant administrative resources (and expense) to coordinate care as the proposed rules would require. It also reduces and, in many cases, will eliminate patient autonomy as to which provider to choose when the telemedicine provider makes a referral for follow-up care.

We strongly agree with the ATA that the biggest issue continues to be the complicated four-part care escalation provisions. The different scenarios require a telehealth provider to be able to see patients in person, have cross-coverage relationship with someone who can, or be able to provide specific referrals to patients who can see the patient in-person. This is particularly impractical given that the telehealth provider might not be in position to know the schedule of the in-person provider’s or whether the provider accepts the patient’s insurance. Patients can and should have autonomy to play a role in choosing how and where to receive follow-up care.

We also agree that the Board is inappropriately asking telehealth providers to follow a higher standard of care than is required for in-person care. The Board has not explained the need for a complicated four-part rule when similar care-escalation requirements are not outlined for in-person settings. The existing Medical Board rules do not contain any such requirement. When a physician or an allied health care professional using our platform sees a need for a patient to have a professional referral, there are clear communication methods to get that information to the patient. These mirror what would be done if the patient was seen in-person.

The limitations on appropriate health care professional referrals in the proposed rule could lead to hindering a patient from receiving immediate care. In many cases, an urgent care or after-hours provider may be able to provide patient care immediately or faster than the health care practitioner or health care professional with whom the professional has a cross coverage arrangement. The proposed rule would limit the physician’s ability to make such a referral.

In summary, we encourage CSI to return the proposed rule to the Medical Board with instructions to eliminate the burdensome and unnecessary requirements that we, the ATA and others have identified. The Board may also consider promulgating referral language like that proposed by the Federation of State Medical Boards (FSMB) in its recently approved document titled “The Appropriate Use of Telemedicine Technologies in the Practice of Medicine.” The FSMB’s language reads as follows:

*If a patient is inappropriate for care via telemedicine technologies or experiences an emergent situation, complication, or side effects after an encounter using telemedicine technologies, physicians should have a standing plan in place and have the responsibility to refer the patient to appropriate care (e.g., acute care, emergency room, or another provider) to ensure patient safety. It is insufficient for physicians to*
simply refer all patients to the emergency department; each situation should be evaluated on an individual basis and referred based on its severity and urgency.

Thank you for your consideration.

Sincerely,

Charles Scott

Charles Scott
Chief Executive Officer

CC: Medical Board at: Nathan.Smith@med.ohio.gov
May 26, 2022

State Medical Board of Ohio
30 East Broad Street
3rd Floor
Columbus, OH 43215

RE: Rule: 4731-370-1- Telehealth and 4731-11-09 Controlled Substances and Telehealth Prescribing

Submitted electronically via:CSIPublicComments@governor.ohio.gov and Nathan.Smith@med.ohio.gov

Cleveland Clinic is a not-for-profit, integrated healthcare system dedicated to patient-centered care, teaching and research. With a footprint in Northeast Ohio, Florida and Nevada, Cleveland Clinic Health System operates 18 hospitals with approximately 4,900 staffed beds, 21 outpatient Family Health Centers, 11 ambulatory surgery centers and numerous physician offices. Cleveland Clinic employs over 3,400 salaried physicians and scientists. Last year, our system cared for 2.4 million unique patients, including 10 million outpatient visits and 309,000 hospital admissions and observations. Below are our comments in respect to the above captioned rules.

**Proposed Language - 4731-37-01 (A)(3)**
"Asynchronous communication technology", also called store and forward technology, has the same meaning as asynchronous store and forward technologies as that term is defined in 42 C.F.R. 410.78 (effective January 1, 2022).

**Cleveland Clinic Comments**
The definition the Medical Board proposes to incorporate from reference excludes “text messages without visualization of the patient.” We are concerned that this definition disallows the use of text based communication (also known as asynchronous eVisit), which is a tool used efficiently and safety by providers throughout the state to care for patients. The most common reasons that patient select an asynchronous eVisit include:

1. Adult Pink Eye/Red Eye
2. Low Back Pain
3. Sinus Symptoms
4. Urinary Symptoms (in women)
5. Vaginal Yeast Infection Symptoms
6. Dermatology/Skin Issues

Because of the success of this care, we published an article that we have included at the end of this letter.

Below are some detailed examples of how providers are able to use text based communications to gather adequate information to address the patient’s concern and designate a course of treatment:
1. An established patient sends a message through the MyChart patient communication tool to their urogynecologist, describing symptoms of a urinary tract infection (UTI). This provider has seen the patient previously for similar occurrences, and the patient is familiar with the signs and symptoms of a UTI. The provider orders a urinalysis and urine culture and prescribes an antibiotic to help with the symptoms.

2. Patient sends a MyChart message because they were on an antibiotic and now they have symptoms of a vaginal yeast infection – a common side effect of antibiotics. The provider prescribes an antifungal medication.

We urge the Medical Board to distinguish between text based communication and text messaging and explicitly allow provision of the former as a form of asynchronous communication technology.

**Proposed Language - 4731-37-01 (A)(6)**

"Consent for telehealth treatment" means a process of communication between a patient or, if applicable, the patient's legal representative and the health care professional discussing the risks and benefits of, and alternatives to, treatment through a remote evaluation that results in the agreement to treatment that is documented in the medical record or signed authorization for the patient to be treated through an evaluation conducted through appropriate technology, as specified in this rule, when the health care professional is in a location remote from the patient.

**Cleveland Clinic Comments**

When we last provided comments on this section, the Board responded by saying that “the consent for treatment language is in current rule 4731-11-09 and exists for patient protection.” While we agree patients should be protected, the language in 4731-11-09(G) – which is almost verbatim to the language of 4731-37-01(A)(6) – is referred to as “informed consent.” We remain unclear as to why the Board is holding a practitioner to a differing and heightened standard of care requirement in a telehealth situation if the practitioner is meeting the standard of care for the patient.

**Proposed Language - 4731-11-09 (E)(4)**

As an exception to paragraph (D) of this rule, a physician or physician assistant may prescribe a controlled substance to a new patient as part of the provision of telehealth services for any of the following patient medical conditions and situations:

(4) The physician or physician assistant determines in their clinical judgment that the new patient is in an emergency situation provided that the following occurs:

(a) the physician or physician assistant prescribes only the amount of a schedule II controlled substance to cover the duration of the emergency or an amount not to exceed a three-day supply whichever is shorter;
(b) after the emergency situation ends, the physician or physician assistant conducts the physical examination as part of an initial in-person visit before any further prescribing of a drug that is a schedule II controlled substance.

**Cleveland Clinic Comments**

The proposed regulation cross references the definition of “emergency medical condition” (EMC) in O.R.C. 1753.28. This definition of EMC, which is modeled after the Emergency Medical Treatment and Labor Act (EMTALA) definition, describes circumstances in which symptoms are sufficiently severe that a patient should seek “immediate medical attention” to avoid the potential for serious jeopardy to their health, impairment to bodily functions or dysfunction of a bodily organ or part.
We believe that this definition sets an extremely high bar for utilization of this exception – indeed, our expectation would be that patients experiencing this severity of symptoms should call 911 or travel to an emergency department for appropriate evaluation and stabilization. Instead, we urge the Medical Board to broaden the definition to allow the exception to apply to what we believe would be a more likely and reasonable emergency circumstance: those occasions when a patient needs a Schedule II controlled substance immediately and cannot get in for an outpatient visit that includes a physical examination in an appropriate amount of time without potential adverse effects.

**Proposed Language - 4731-11-09(E)(5)**
The prescribing of a controlled substance through telehealth services is being done under an exception permitted by federal law governing prescription drugs that are controlled substances.

**Cleveland Clinic Comments**
We were pleased by the Board’s inclusion of this language, as we believe it provides an important clarification that there may be circumstances outside the exceptions specified in the statute when it is allowable for a provider to prescribe a Schedule II controlled substance to a new patient without first conducting a physical examination.

Thank you for conducting a thoughtful process that allows us to provide input on such an important issues. Should you need further information, please don’t hesitate to contact me.

Sincerely,

Steven Shook, MD, MBA
Lead for Virtual Health
Sinus Infection Patient Uses eVisits to Get Back on His Feet
Going to the doctor when you’re not feeling well can be a necessary but arduous task.

Thanks to MyChart’s new eVisits feature, patients with certain minor ailments now have the ability to securely connect with a provider from the comfort of their own home.

Patient Paul Rigda says he recently had a fantastic experience using eVisits while suffering with a sinus infection.

“I think the eVisit was just as effective as an office visit... What made it even better is that I didn’t have to drive down, park and subject myself to other people who were sick. It was so nice to simply go online, get the medication I needed and start feeling better.”

eVisits can be used to address five common ailments: back pain, cough, urinary tract infection, sinus infection and vaginal yeast infection. To use it, no audio or video connection is needed.

Patients complete a questionnaire regarding their symptom history and a provider responds with a diagnosis and treatment instructions within one business day.
If medication is prescribed, the order is sent to the patient’s preferred pharmacy. While eVisits are not covered by insurance, they are low cost out of pocket.

“The ease of use is unbelievable,” says Rigda. “At first, I thought I’d be told that I’d have to come in anyway, but that didn’t happen. My provider was very efficient; not only with writing a prescription, but also with making some suggestions about over the counter products I could try to help ease my situation.”

According to a recent Cleveland Clinic survey, 82% of patients felt that eVisits saved them time compared to an in-person office visit.

“I think the eVisit was just as effective as an office visit,” he says. “I felt that the information I submitted was thoroughly read, taken into account and then a decision was reached. What made it even better is that I didn’t have to drive down, park and subject myself to other people who were sick. It was so nice to simply go online, get the medication I needed and start feeling better.”

Patient Stories
May 31, 2022

Delivered electronically to:

Nathan Smith – Ohio Medical Board
Office of the Common Sense Initiative (CSI)

Subj: Comments on the Medical Board’s Proposed Telehealth Rules (4731-37-01 / 4731-37-09)

Dear Mr. Smith of the Medical Board and CSI staff:

The Ohio Association for the Treatment of Opioid Dependence (OATOD) appreciates the opportunity to offer comments and recommendations to the above-referenced proposed rules. OATOD – a division of the Ohio Council of Behavioral Health and Family Services Providers – is a statewide advocacy coalition consisting of nineteen (19) private business organizations that operate seventy-nine (79) out of the ninety-eight (98) federally certified and state licensed opioid treatment programs (OTP) in Ohio. OTPs are the only recognized healthcare site where all three forms of medication-assisted treatment can be offered, and the exclusive healthcare entity authorized to provide methadone as treatment for opioid use disorder. OTPs are regulated by various state and federal agencies, including the Ohio Department of Mental Health and Addiction Services (OhioMHAS); the Ohio Board of Pharmacy (BOP); the U.S. Drug Enforcement Agency (DEA); and the Substance Abuse and Mental Health Services Administration (SAMHSA). Federal law also requires that OTPs receive accreditation by a nationally recognized accrediting body.

Telehealth has proven to be a helpful tool in the treatment of Ohioans seeking care for opioid use disorder (OUD) and substance use disorder (SUD) challenges, including prescribing certain medications for the treatment of such disorders. Accordingly, OATOD writes to formally express our support for the Medical Board’s proposed rules pending before CSI that address the implementation of HB 122.

Thank you for your time and consideration.

Respectfully,

Geof Collver
OATOD
May 31, 2022

Sean McCullough
Director, Ohio Common Sense Initiative
Office of Governor Mike DeWine
77 S. High St., 30th Floor
Columbus, OH 43215

Re: Proposed Rule 4731-37-01; Telehealth

Dear Director McCullough:

Teladoc Health appreciates the opportunity to comment on the Ohio State Medical Board’s proposed rule relating to telehealth. We respect the role of the Board in considering the appropriate rules and clinical practice guidelines that are designed to be protective of public health while ensuring patient access to high-quality care and promoting the proliferation of technological innovations in the field. Teladoc Health has been an active participant in Ohio telehealth policy over the last eight years, working with the Board in a collaborative manner to guarantee that perspectives other than those provided by traditional brick-and-mortar practices are heard. Our mission is built on a simple but revolutionary idea: that everyone should have access to first-rate health care delivered on patients’ terms.

With more than 5,000 employees, Teladoc Health is the world’s largest telehealth company. We deliver health care in 175 countries and in more than 40 languages. We partner with employers, hospitals, health systems, and more than 50 health insurance plans in all 50 states – including Ohio – to transform health care delivery. Teladoc Health provides health care services to more than 40 percent of Fortune 500 employers as well as thousands of small businesses, labor unions and public-sector employers which offer our virtual care services to their employees.

For context, Teladoc Health is offered as a benefit by over 9,500 Ohio employers, covering over 1.8 million patients in the state. Some of these employers include: Ohio State University, Marathon Petroleum, Honda Motor Company, Kraft Heinz Company, Macy’s, Procter & Gamble, and Owens Corning. Teladoc also contracts with Aetna, Molina Healthcare, and Northern Buckeye Health Plan to provide virtual care services for their commercial health plans.

While Teladoc Health appreciates the Board’s efforts to protect patient safety and ensure high-quality care, we are concerned that the proposed telehealth rule would stifle competition and threaten access to health care via telehealth by holding telehealth providers to a higher standard than those delivering care in person and burdening telehealth providers with clinically unnecessary bureaucratic responsibilities. Below please find our comments and recommendations for the Initiative’s consideration.

***

4731-37-01(B)(4)(a) reads as follows:

(4) If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional shall do the following:

(a) If the patient must be seen immediately but not in an emergency department, the health care professional shall immediately schedule the patient for an in-person visit with the health care professional and promptly conduct that visit or refer the patient for an in-person visit with one of the following licensed health care professionals who can provide the services in person that are appropriate for the patient and the condition for which the patient presents:
(i) Another health care professional or an advanced practice registered nurse with whom the health care professional has a cross-coverage agreement;
(ii) In the case of a physician, a physician assistant with whom the physician has a supervision agreement or an advanced practice registered nurse with whom the physician has a standard care arrangement;
(iii) In the case of a physician assistant, a physician with whom the physician assistant has a supervision agreement; or
(iv) Any health care professional requested by the patient who is appropriate for the condition with which the patient presents.

If implemented, this rule would require a so-called “hot hand-off” from a telehealth provider who determines that telehealth technologies are not sufficient to meet the standard of care for the patient’s presented condition to another health care provider who can evaluate the patient in person. In effect, this provision would compel telehealth providers to have cross-coverage agreements with bricks-and-mortar providers across the state to ensure that their patients – wherever in Ohio they may be – could be handed off to in-person providers in their vicinities. In regard to standard medical service referrals, this provision requires far more from telehealth providers than what is expected from providers delivering care in person, mirroring telehealth providers in onerous, clinically unsubstantiated, and telehealth-specific obligations. The extraneous logistical hurdles placed on providers of online care as a result of this rule’s adoption would place telehealth practices at an immediate competitive disadvantage in Ohio.

This proposed rule would also require telehealth providers to have access to another health care provider’s schedule and the ability to schedule a patient with an appointment “immediately.” Such a condition not only places additional logistical burdens on telehealth providers that are unique to providers of virtual care but also inhibits patient choice regarding which health care provider they would like to see. Instead of promoting the development of high-quality health care in a free and competitive market, the Board’s proposed rule would make it more difficult for budding telehealth practices to establish themselves in Ohio while placing constraints on Ohioans who want to make their own decisions about which care is most suited for them.

Teladoc Health recommends that the language be amended as follows, which will track with the recommendations of the federation of state medical boards and all other states that have a referral mechanism in place:

4731-37-01(B)(4)(a):

(4) If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional shall do the following:
(a) If the patient must be seen immediately but not in an emergency department, the health care professional shall refer the patient to their primary care provider if they have one or recommend they seek in-person care. Immediately schedule the patient for an in-person visit with the health care professional and promptly conduct that visit or refer the patient for an in-person visit with one of the following licensed health care professionals who can provide the services in person that are appropriate for the patient and the condition for which the patient presents:
(i) Another health care professional or an advanced practice registered nurse with whom the health care professional has a cross-coverage agreement;
(ii) In the case of a physician, a physician assistant with whom the physician has a supervision agreement or an advanced practice registered nurse with whom the physician has a standard care arrangement;
(iii) In the case of a physician assistant, a physician with whom the physician assistant has a supervision agreement; or
(iv) Any health care professional requested by the patient who is appropriate for the condition with which the patient presents.
4731-37-01(B)(4)(b) reads as follows:

(b) If the patient does not need to be seen immediately, the health care professional shall do one of the following:

(1) Schedule the patient for an in-person visit and conduct that visit within an amount of time that is appropriate for that patient and their condition presented; or

(2) Refer the patient to a health care professional in the same specialty to conduct an in-person visit within an amount of time that is appropriate for the patient and their condition.

This provision requires telehealth providers to schedule patients with non-emergent conditions who need to be evaluated in person for an in-person visit “within an amount of time that is appropriate for that patient and their condition presented” or refer patients to a specific specialist. In forcing telehealth providers to refer patients to specific specialists instead of requiring them to inform patients about the kind of specialist from whom they should seek care, the rules once again hold telehealth providers to a different standard than providers who render care in person, needlessly complicating the day-to-day operations of telehealth practices under the guise of patient safety.

Teladoc Health suggests the following amendment:

4731-37-01(B)(4)(b):

(b) If the patient does not need to be seen immediately, the health care professional shall do one of the following:

(1) Schedule the patient for an in-person visit and conduct that visit within an amount of time that is appropriate for that patient and their condition presented; or

(2) Refer the patient to a health care professional in the same specialty to conduct an in-person visit within an amount of time that is appropriate for the patient and their condition.

4731-37-01(B)(4)(d) reads as follows:

(d) If the patient needs emergency care, the health care professional shall help the patient identify the closest emergency department and, if necessary, in the health care professional’s discretion, provide notification to the emergency department of the patient’s potential arrival.

Teladoc believes that this provision should be amended to require the health care professional to have in place appropriate protocols to deal with emergency situations if and when they occur. Mandating that telehealth providers help patients with emergent conditions identify the closest emergency room and potentially provide notice to the identified emergency room of the patient’s impending arrival is not best practice in telehealth. For example, telehealth providers would be doing no favors to a patient experiencing a stroke were the provider to tell the patient the location of the nearest emergency room and call the emergency room to which the patient would go, seeing as the patient would be in dire need of immediate attention and potentially incapacitated. The same logic applies to serious behavioral health episodes during which the patient is contemplating suicide. In these cases and in many others, it is more appropriate for health care providers to call emergency services and remain in contact with the patient until help arrives. The proposed rule is overly prescriptive and does not reflect current best practice.

Uncertainty and confusion surrounding its tenets would only make delivering telehealth services in the state at best more difficult, at worst more dangerous.
Teladoc Health suggests the following amendment:

4731-37-01(B)(4)(d):

(d) If the patient needs emergency care, the health care professional shall tell the patient to call 911 and stay on the phone. If the patient is incapacitated, the provider shall call emergency services for the patient. The provider shall help the patient identify the closest emergency department and, if necessary, in the health care professional’s discretion, provide notification to the emergency department of the patient’s potential arrival.

4731-37-01(C)(4) reads as follows:

(C) A health care professional must comply with all standard of care requirements to provide telehealth services to a patient including but not limited to:

(4) If applicable, the health care professional shall forward the medical record to the patient’s primary care provider, other health care provider, or to an appropriate health care provider to whom the patient is referred as provided in paragraph (B)(4) of this rule.

This vague understanding of the “applicable” conditions under which a telehealth provider should forward a patient’s medical records to another provider would not only create more confusion among telehealth providers but also disregard patient consent to the exchange of their private medical information among different health care providers. This provision is yet another example of bureaucratic overreach that would needlessly complicate the efficient operations of telehealth companies and the effective delivery of high-quality health care.

Teladoc Health suggests the following amendment:

4731-37-01(C)(4):

(C) A health care professional must comply with all standard of care requirements to provide telehealth services to a patient including but not limited to:

(4) If applicable, With the patient’s consent, the health care professional shall forward the medical record to the patient’s primary care provider, other health care provider, or to an appropriate health care provider to whom the patient is referred— as provided in paragraph (B)(4) of this rule.

4731-37-01(D)(3)

(D) A health care professional must comply with the following requirements to provide telehealth services that involve a formal consultation with another health care professional:

(3) The health care professionals involved in the formal consultation must have received and reviewed all medical records of the patient relevant to the medical condition which is the subject of the consultation before the formal consultation occurs, unless this is not possible due to an emergency situation.

It is unreasonable to expect any health care professional to know at the time of diagnosis and treatment whether or not he or she has received all of the patient’s medical records relevant to the medical condition which is the subject of the consultation. A prudent health care provider makes a good faith effort to gather all relevant clinical information related to the medical condition as presented by the patient, including medical records, prior to diagnosis and treatment. However, it is unreasonable to expect even the most astute health care provider to know about a medical record that has been lost or purposefully withheld,
making it neither obtainable nor reviewable. It is not reasonable to hamper physicians offering consultations via telehealth with requirements whose stipulations cannot be met by any health care provider on a constant basis.

Teladoc Health suggests this subsection be amended to read as follows:

4731-37-01(D)(3)

The health care professionals involved in the consultation must have received and reviewed the medical records of the patient provided by the patient and the health care professional relevant to the medical condition which is the subject of the consultation before the consultation occurs, unless this is not possible due to an emergency situation.

***

Implementing the proposed rules as written would make it more difficult for telehealth companies to operate in Ohio, providing competitive advantages to bricks-and-mortar practices while inundating providers of high-quality virtual care with arbitrary and clinically unsubstantiated regulations. If the rules are approved, the resulting regulatory environment could drive telehealth’s most prominent and innovative businesses – along with the jobs they create – away from the state. Moreover, the 9,500 Ohio employers hoping to provide their employees with telehealth benefits would become less competitive with businesses in surrounding states immediately upon the rules’ taking effect, as no other state in the country places such substantial regulatory constraints on telehealth as those contemplated above.

As the Initiative seeks to strike a balance between regulating telehealth appropriately while enabling businesses in this up-and-coming industry to flourish, it is important to implement rules that accommodate all forms and modalities of care, not language which serves to protect the business interests of bricks-and-mortar practices. Telehealth is a dynamic and evolving method of health care delivery, and it has the ability to improve patients’ health outcomes and quality of life. This is only possible when telehealth providers are not at a competitive disadvantage or saddled with regulatory burdens that do nothing to improve the quality of care.

Thank you again for the opportunity to provide comments on this important issue.

Sincerely,

Claudia Duck Tucker
Teladoc Health
Senior Vice President, Government Affairs and Public Policy
Kim Clarke Maisch  
Government Affairs Principal

May 31, 2022

Mr. Sean McCullough  
Director, Ohio Common Sense Initiative  
Office of Governor Mike DeWine  
77 S. High St., 30th Floor  
Columbus, OH 43215

Dear Director McCullough:

On behalf of MDLIVE*, a leading provider of healthcare services utilizing telehealth in the U.S. and providing access to over 62 million individuals nationwide, we are writing to express our concerns with proposed rule 4731-37-01 promulgated by the Ohio Medical Board concerning telehealth.

MDLIVE* is committed to providing high quality care to our customers across the United States. In Ohio in the last two years alone, MDLIVE* has served over 45,370 patients seeking care in the areas of behavioral health, urgent and primary care and dermatology. This is significant, particularly in light of the dramatic shortage of providers in the behavioral health space at a time when patient mental health needs are increasing, and we know it is a top concern of Governor DeWine. However, the proposed rule before the Common Sense Initiative office, as promulgated by the Ohio Medical Board, would significantly impede MDLIVE*'s ability to continue to offer care services to the residents of Ohio.

Specifically, MDLIVE* is concerned about language in 4731-37-01(B)(4) regarding the referral process that will make it difficult, if not impossible, for a provider utilizing telehealth to comply and would impede access to current available health services for Ohioans. As a member of the American Telemedicine Association, we echo what they wrote in their letter to CSI dated May 18, 2022 that the “requirements... contemplated in the proposed rule hold telehealth services to a higher standard than care delivered in-person, making it more difficult for telehealth providers to operate their businesses and treat patients effectively when compared to their in-person counterparts.” In fact, we even go a step further to emphasize that the proposed rule has the potential to significantly limit telehealth utilization by all Ohio providers, including those with some in-person presence, given the complex documentation and referral needs necessary for compliance apart from long-standing continuity of care and referral practices.
MDLIVE\* currently has a process in place that allows our providers to give a general referral for a patient they believe needs to be seen by a specialist or that may need further services. We also have the ability to immediately connect a patient to 911 should they be in an emergency situation. Our policies and providers carefully consider and enable care consistent with the applicable standard of care, yet this proposed rule would require a level of referral or continued care that goes above and beyond what is required for any in-person visit.

These same concerns were raised with the Ohio Medical Board by numerous companies and trade associations but were unfortunately not accepted. So now we are asking CSI to intervene in this rule-making process given its stated mission to “reform Ohio’s regulatory policies to help make Ohio a jobs and business-friendly state.”

State legislatures all across the country have been rapidly updating their telehealth laws, as HB 122 did in Ohio, to respond to the COVID crisis and advance our health care infrastructure capabilities. The industry was supportive of HB 122 as it attempted to address the growing need for telehealth services in the state. Unfortunately, the proposed rule goes in the opposite direction of what lawmakers envisioned and would actually make the delivery of telehealth services more difficult.

To that end, acknowledging the need for the proposed rule to provide guardrails around referrals, MDLIVE\* agrees with the ATA and recommends 4731-37-01(B)(4) be replaced with the following modified version of the Ohio State University Wexner Medical Center proposed language:

“If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional will either see the patient in-person in a reasonable timeframe or make [an] appropriate referral as is standard of care, which could include scheduling the patient [or providing information to the patient] for a telehealth or in-person visit with another health care professional.”

We appreciate your consideration in allowing MDLIVE\* to help craft a proposed rule that helps patients gain greater access to telemedicine and allows the industry to flourish in Ohio.

Sincerely,

Kim Clarke Maisch
Cigna, Government Affairs Principal

*MDLIVE is a subsidiary of its parent company, Cigna Health Care Services
Dear Mr. Smith,

On behalf of the Ohio Academy of Nutrition and Dietetics (OAND) I would like to share concerns about the “Telehealth” administrative rule 4731-37-01 proposed by the State Medical Board of Ohio (SMBO) that will implement portions of 4743.09 ORC.

OAND is concerned about the language contained in 4731-37-01 (B) that states:

“A health care professional may provide telehealth services to a patient located in this state*. The health care professional shall comply with all of the following requirements:” ***

*(emphasis added )

Common reading of this language is confusing and potentially problematic for patients. It appears to restrict health care professionals licensed by SMBO and subject to the rule (including dietitians, respiratory therapists, and genetic counselors) from being able to provide telehealth services to some of their existing patients - simply because the patients are not “located” in this state – ie. they reside outside of Ohio or may be working or travelling outside of Ohio when services are provided.

Ohio has many regional, national, and internationally renowned medical centers that provide highly specialized care to patients who choose to come here from other locations for comprehensive treatment. When patients return home, follow-up care should be seamless and be provided by the team of professionals who are most familiar with the patient and the patient’s treatment plan. Indeed, this is one of the motivating reasons telehealth has become such an important part of health care.

Transitional and home-based care provided to patients after complex surgeries, organ transplants, and to those patients with rare diseases and disorders often requires a multi-disciplinary team – including dietitians who are experts in specialized nutrition care and medical nutrition therapy.

We believe that dietitians (and other health care professionals) need to be able to provide telehealth to patients with whom they have established patient/health care professional relationships – whether the patient lives in Ohio or outside of the state, and if they are working or travelling to other locations.

The telehealth rule’s enabling statute (4743.09 ORC), does not appear to specifically prohibit healthcare professionals (including dietitians, respiratory therapists, genetic counselors etc.) from providing telehealth services to patients located outside of this state if permitted by the laws and rules of the state in which the patient is located. In its current form we believe the language in 4731-37-01 (B)
SMBO has exceeded the authority of the law and will result in inconvenience and disruption of care for patients.

OAND respectfully requests that the State Medical Board of Ohio revise the “Telehealth” rule as follows:

4731-37-01 (B) “A health care professional may provide telehealth services to patients located in this state, and to patients with whom the health care professional has an established provider/patient relationship and are located outside of Ohio. The health care professional is subject to all applicable laws and rules of the state where the patient is located and shall comply with all of the following requirements.” ***

Thank you for considering OAND’s concerns as you review the impact that this rule will have on dietitians and other health professionals licensed by the State Medical Board of Ohio and the patients that they serve.

Sincerely,

Kay Mavko, MS, RDN, LD
State Regulatory Specialist
Ohio Academy of Nutrition and Dietetics
Cell: (614)668-9036

Ohio Academy of Nutrition and Dietetics (OAND)
PO Box 303
Lewis Center, Ohio 43035
Phone: 614/436-6131
Fax: 614/436-6181
E-mail: info@EatRightOhio.org
May 31, 2022

Sent via e-mail to:
CSIPublicComments@governor.ohio.gov

Mr. Sean McCullough
Director, Ohio Common Sense Initiative
77 S. High Street, 30th Floor
Columbus, OH 43215

Re: Ohio Hospital Association Comments on Ohio State Medical Board Proposed Rule 4731-37-01: Telehealth

Dear Director McCullough:

On behalf of the Ohio Hospital Association’s 250 hospitals and 15 health systems, we appreciate the opportunity to provide feedback on the Ohio State Medical Board’s proposed rules related to telehealth.

OHA wants to first commend the Medical Board for an extensive and open process of stakeholder engagement in the development of these complex rules. The Medical Board staff has been open to feedback from the hospital community and has incorporated many of our suggestions for clarification throughout the rulemaking process.

However, OHA does have one significant concern related to proposed 4731-37-01(B)(4)(a) that we believe will cause considerable confusion in the provider community and be very difficult to operationalize. Proposed section (B)(4) relates to situations where a health care provider delivering telehealth services determines that an in-person visit is necessary to meet the applicable standard of care. OHA agrees with the need to ensure the standard of care for telehealth services is the same as that for in-person services. And OHA agrees with the majority of section (B)(4)’s provisions in ensuring continuity of care for those patients for whom a telehealth visit may not be sufficient.

Nevertheless, OHA has significant concerns with health care providers’ ability to operationalize subsection (B)(4)(a). Subsection (B)(4)(a) relates to situations where the provider decides a telehealth visit is not sufficient and the patient must be seen in-person “immediately but not in an emergency department.” This reference is confusing because either a patient’s condition is emergent and needs to be addressed immediately, or it is non-emergent and does not need to be addressed immediately. The condition cannot be both “immediate” and “non-emergent” and such a category of patients is not in the provider lexicon. This category of patient (immediate/non-emergent) is confusing to providers, who would either refer a patient to an emergency department if it is an emergency, or schedule the patient for an in-person appointment within an amount of time that is appropriate for the patient and their condition.

When asked what type of patient would meet the profile of “immediate/non-emergent,” staff indicated that it would be a small universe of patients. However, in the absence of very clear Board guidance defining the patients to which subsection (B)(4)(a) applies, this standard is impossible to operationalize.

Importantly, the remainder of subsection (B)(4) captures the full universe of patients and renders subsection (a) unnecessary. Subsection (b) applies to those patients who do not need to be seen immediately (i.e. non-
emergent), and requires such patients to be seen within an amount of time appropriate for their condition. Subsection (c) applies to patients who need to be seen by a specialist. Subsection (d) applies to patients who need emergency care. Subsections (b), (c), and (d) are sufficient to cover the full range of scenarios that may arise when a telehealth provider determines that an in-person visit is necessary to meet the standard of care. In short, it is unclear to which patients subsection (a) would apply because of the inability to know who meets the “immediate/non-emergent” classification because of a lack of definition of a class of patients unfamiliar to health care providers.

Beyond the confusion caused by subsection (a)’s introduction of the nebulous “immediate/non-emergent” patient, the remainder of subsection (a) is overly restrictive in terms of the type of provider to whom such a patient can be referred. So, even if it is possible to clearly identify what patients are “immediate/non-emergent” (and we maintain it is not possible), subsection (a) limits the providers to whom a telehealth provider can refer them to: (i) a provider with whom the telehealth provider has a cross-coverage arrangement; (ii) a physician assistant or advance practice registered nurse with whom the telehealth provider has a supervision agreement or standard care agreement, respectively; (iii) in the case of a physician assistant, a physician with whom the physician assistant has a supervision agreement; and (iv) a provider requested by the patient.

The most problematic of these limitations is subsection (a)(i)’s restriction that the telehealth provider can only refer to another provider with whom the telehealth provider has a cross coverage agreement. This limitation is particularly concerning in rural communities, where access to care is already a significant concern. For example, a provider in Meigs County that is providing telehealth services to a patient in that region of the state would have to have a cross-coverage agreement with virtually every type of specialist in order to meet this requirement. That is an unreasonable requirement, especially in an area that is already underserved and in which telemedicine is intended to expand access. For example, if the Meigs County provider determines during a telehealth visit that the “immediate/non-emergent” patient needs to see a neurologist, but the Meigs County provider does not have a cross-coverage agreement with a neurologist, subsection (a)(i) would effectively not allow the Meigs County provider to refer the patient to anyone for an in-person visit. OHA is very confused regarding this limitation and does not believe it furthers the statutory intent of the legislature or enhances access to care, particularly in rural areas.

We strongly encourage the removal of subsection (a) because of the confusion it will cause and the inability of providers to operationalize this provision. In summary, subsection (a): (1) introduces a classification of patients (“immediate/non-emergent”) that is not defined, is not commonly used in the provider lexicon, is not necessary given the remainder of subsection (B)(4), and will create significant confusion regarding the patients to which the Medical Board intends this section to apply; and (2) overly restricts the ability of telehealth providers to refer patients for in-person care, even if it is possible to adequately discern which patients meet the “immediate/non-emergent” category.

We understand the mission of the Common Sense Initiative is to ensure Ohio’s regulatory policies help make Ohio a jobs and business-friendly state. One of CSI’s stated goals is that “compliance should be easy and inexpensive.” OHA is concerned that subsection (B)(4)(a) does not create a well-defined standard that invites compliance and undermines the utility of telehealth services by unnecessarily restricting the universe of providers to whom a patient could be referred.
Again, OHA appreciates the Medical Board’s process in developing these rules and the opportunity to raise the issues identified above to CSI. Please feel free to contact me with any questions or for additional information.

Sincerely,

Sean McGlone
Sr. V.P. & General Counsel

cc: Executive Director Stephanie Loucka (via email)
Kim Anderson (via email)
Jill Reardon (via email)
Nathan Smith (via email)
May 31, 2022

Common Sense Initiative
Governor’s Office
Riffe Tower 30th Floor
77 South High Street
Columbus, Ohio 43215

RE: State Medical Board Telehealth Rule OAC 4731-37-01: Definitions

The Ohio Society for Respiratory Care would like to comment on this rule which addresses the regulation of telehealth for Respiratory Care Professionals (RCPs) licensed under the State Medical Board of Ohio.

Section (B) A health care professional may provide telehealth services to a patient located in this state. This statement is very confusing and problematic as many Ohio hospitals and physicians provide care for patients in bordering states and beyond. Statewide, our academic medical centers offer tertiary specialty services, such as transplant programs, complex surgeries, and rare disease management programs that attract regional, national, and even, international patients. Specialty teams of multi-disciplinary health care professionals support these programs, including RCPs, dietitians, and genetic counselors, to provide comprehensive assessment, treatment, and continuing care.

It is common practice for RCPs to follow-up with their chronic pulmonary or post-transplant patients on a regular basis via telehealth to assess their pulmonary status. For example, in the case of a post-lung transplant patient, RCPs use telehealth to directly observe the patient perform lung spirometry to obtain valid pulmonary function results which can detect early signs of lung rejection. These results are shared with the physician for prompt intervention.

We believe that RCPs and other health care professionals licensed under the medical board need to use telehealth to access their patients with whom that have an established relationship, whether the patient resides in Ohio or outside the State, or if the patient is on vacation or, for example, wintering in Florida. We believe section (B) could limit valuable access to patients under our care, diminish patient safety monitoring, and require a regular unnecessary travel inconvenience for the patient and their families.

We believe that this rule should state: 4731-37-01 (B) “A healthcare professional may provide telehealth services to patients located within this state and to patients with whom the healthcare professional has an established provider/patient relationship and are located outside of Ohio. The healthcare professional is subject to all applicable laws and rules of the state where the patient is located and shall comply with all the following requirements:"

Thank you for your consideration of our concern. If you have any questions, please feel free to contact me at: susanciar@outlook.com or 937-239-2458.

Sincerely,

Sue Ciarlariello, OSRC Legislative Chair
Recent activity:

To require an occupational licensing authority to issue a license or government certification to an applicant who holds a license, government certification, or private certification or has satisfactory work experience in another state under certain circumstances.

**Of Note:**
- Requires automatic licensure of out of state applicants that meet certain criteria.


**SB 131 – Occupational Licensing (Reciprocity) (Sen. Roegner and Sen. McColley) (companion HB 203)**
To require an occupational licensing authority to issue a license or government certification to an applicant who holds a license, government certification, or private certification or has satisfactory work experience in another state under certain circumstances.

**Of note:**
- Requires automatic licensure of out of state applicants that meet certain criteria.
- Allows for the licensing authority to take disciplinary action against an applicant, deny an application and determine fitness to practice of an applicant.
- Amended – A person who holds a license issued through an interstate licensure compact to which Ohio is a party is not required to obtain a license through reciprocity.
- Amended – Delays the bill’s effective date to 270 days after the bill’s effective date


**Of Note:**
- Creates a new license type for surgical assistants to be overseen by the Medical Board.
- Amended – Revises the bill’s provision allowing an applicant who is not credentialed by a national organization as a surgical assistant to be eligible for licensure if the applicant has instead practiced as a surgical assistant at an Ohio hospital or facility during any part of the 6 month period that precedes the bill’s effective date by increasing that period to 18 months


**Of note:**
- Change current law to no longer limit “massage therapy” to the treatment of disorders of the human body
- Standardizes, for purposes of regulation by the State Medical Board, townships, and municipal corporations, terminology regarding massage therapy and individuals authorized to perform massage therapy
- Eliminates township authority to issue licenses to individuals who perform massage therapy
- Requires that if a township opts to regulate massage establishments, the regulations must require all massage therapy to be performed only by specified state-licensed professionals or massage therapy students


**Of Note:**
- Requires that all schedule II drugs be prescribed electronically.
- Exceptions a prescriber may issue a written rather than electronic prescriptions for a schedule II controlled substance: temporary technical, electrical, or broadband failure; prescription is issued for a nursing home resident or hospice care patient; the prescriber is employed by or under contract with the same entity that operates the pharmacy; the prescriber determines that an electronic prescription cannot be issued in a timely manner and the patient’s medical condition is at risk; the prescriber issues per year not more than 50 prescriptions for schedule II controlled substances; prescription issued from a health care facility or emergency department and the prescriber determines an electronic prescription would be impractical
• Amended – Modifies a provision of existing law, which allows a physician licensed in another state or territory, but unlicensed in Ohio, to provide consultation to physician licensed in Ohio, by requiring that the Ohio-licensed physician who receives the consultation from the out-of-state physician must have an established physician-patient relationship with the patient who is the subject of the consultation


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**Actively Monitoring**

**SB 322 – Sex Offenses**
Regarding sex offenses and individuals regulated by the State Medical Board

**Of Note:**
• Modifies the law governing sex offenses and medical professionals
• Increasing reporting requirements of suspected sexual activity by medical professionals; Allowing the board to suspend a license upon an indictment, as well as permitting an automatic 90 day suspension of a license of an individual whose license was suspended, revoked or surrendered in another jurisdiction; Requiring licensees to provide notification of their probationary status to their patients; Allowing the board to share the confidential investigation status of a licensee with the complainant; Adding a public member of the board to the internal investigatory process, to allow additional board insight into the handling of sexual misconduct

**Status:** Introduced in the Senate 4/12/2022. Referred to Senate Health committee 5/18/2022

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**SB 261- Changes to Medical Marijuana law (Sen. S. Huffman)**

**Of Note:**
• Transfers portions of the Medical Marijuana Program from the Board of Pharmacy to the Department of Commerce; Expands the types of qualifying medical conditions; Adds a telehealth provision; Modifies the requirement that a CTR applicant demonstrate they don’t have ownership or investment interest with an entity licensed as a dispensary; Allows the medical director of a dispensary who is a licensed CTR to recommend medical marijuana.


Of Note:
- Allows Autism Spectrum Disorder to be included in qualifying conditions.

Status: Passed House 3/2/2022. 1st Senate Health Hearing 3/30/2022

HB 286 – Court of Common Pleas (Rep. Bill Seitz) (companion SB 189)
To generally change the venue in which appeal from an agency order is proper to the local court of common pleas.

Of note:
- Modifies the current Administrative Procedure Act by generally providing that a party adversely affected by an order of an agency may appeal from the order to the court of common pleas of the county in which the place of business of the party is located or the county in which the party is a resident.
- Removes the current provision that any party adversely affected by an order of an agency issued pursuant to any other adjudication may appeal, with certain exceptions, to the Franklin County Court of Common Pleas.
- Amended – requires that appeals of orders of specified agencies must be to the Franklin County Court of Common Pleas, or the county in which the licensee is a resident.
- Amended - Requires appeals from an administrative order by any party who is not a resident of Ohio must be to the Franklin County Court of Common Pleas.


SB 189 – Change venue for appeal from an agency order (Sen. Lang and Sen. McColley) (companion SB 286)

Of Note:
- To generally change the venue in which appeal from an agency order is proper to the local court of common pleas.
- Modifies the current Administrative Procedure Act by generally providing that a party adversely affected by an order of an agency may appeal from the order to the court of common pleas of the county in which the place of business of the party is located or the county in which the party is a resident.
- Removes the current provision that any party adversely affected by an order of an agency issued pursuant to any other adjudication may appeal, with certain exceptions, to the Franklin County Court of Common Pleas.


To revise the law governing the practice of anesthesiologist assistants.
Of Note:
- Adds anesthesiologist assistants to the list of individuals authorized to prescribe drugs or dangerous drugs or drug therapy related devices during professional practice.
- Adds anesthesiologist assistant list of practitioners from which a respiratory care therapist may receive orders or prescriptions.


Of Note:
- Requires each occupational licensing board to prepare a report including fee structure for each license issued by the board, whether the fee structure can competitively align with neighboring states, whether the fee structure is a financial barrier for license holders.
- Requires the report be submitted to the Senate President, Speaker of the House and chairpersons of committees responsible for reviewing occupational licensing boards


SB 55 – Massage Therapy (Sen. Brenner) (companion bill HB 81)
To make changes to the laws governing massage establishments and massage therapy.

Of Note:
- Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.


Regarding drug offenses and treatment.

Of Note:
- Proposes to reduce the abuse of prescription opioids, establish addiction treatment facilities, increase penalties for drug trafficking violations, modify penalties for drug possession, require an offender convicted of a drug possession or drug trafficking offense involving certain drugs to be subject to ten years of post-release control, allow a criminal defendant who has a severe substance use disorder involving certain drugs to be confined by a state detoxification provider while awaiting trial, create restitution work programs, and make an appropriation.
- Limits opioid prescriptions for acute pain to three days. Then, re-examination of the patient is required, and the prescriber may issue a new prescription for more than 3 days.
• Allows health related licensing board to adopt rules specifying circumstances under which a prescriber may issue an initial prescription for an opioid to treat acute pain in an amount that exceeds three days.


Establish a Parkinson’s disease registry and to change the observance of “Parkinson’s Disease Awareness Month” from September to April

**Of Note:**
• Requires that each individual case of Parkinson’s disease be reported to the registry by the physician, physician assistant, group practice, hospital or health care facility that employs the professional who diagnosed or treated the patients Parkinson’s disease
• A health care provider may be disciplined by the provider’s licensing board for failure to comply with the bill’s reporting requirements

**Status:** Passed out of the House 4/6/2022. Referred to Senate Health committee 5/18/2022

To protect the health care professional-patient relationship, to promote alternative drugs and therapies for the treatment of SARS-CoV-2, including its variants, and COVID-19.

**Of Note:**
• Allows for off label drug use for patients diagnosed with COVID-19 or its variants
• Requires each health board and department to promote and increase distribution of these drugs
• Denies the department of health, state medical board or board of nursing from suppressing the promotion or access to these drugs
• Denies reprimand of health care professionals for prescribing or promoting these drugs

**Status:** Introduced in House 4/21/2022. Referred to House Civil Justice committee 5/17/2022

**SB 296 – Narcotics (Sen. Manning and Sen. S. Huffman)**
Regards access to naloxone and certain narcotics testing products

**Of Note:**
• Adds physician assistants and advanced practice registered nurses to those who may authorize a pharmacist or pharmacy intern to dispense naloxone without a prescription.

**Status:** Introduced in the Senate 2/15/2022. 1st Senate Health hearing 3/16/2022. 2nd Senate Health hearing 3/23/22. 3rd Senate Health hearing 3/30/2022. 4th Senate Health hearing 4/6/2022
SB 311 – Coroners and Death Certificates (Sen. S. Huffman and Sen. Johnson)
Revise the law governing coroners and death certificates

Of Note:
- Requires that collaboration agreements between APRN’s and collaborating physicians, and supervision agreements between physician assistants and supervising physicians, contain an agreement that the physician must complete and sign the medical certificate of death, regardless or coroner jurisdiction

Status: Introduced in the Senate 3/10/2022. 1st Senate Health hearing 3/30/2022. 2nd Senate Health hearing 4/6/2022

HB 64 – Regards fraudulent assisted reproduction (Rep. Powell)
To create the crime of fraudulent assisted reproduction and civil actions for an assisted reproduction procedure without consent.

Of Note:
- Prohibits a health care professional from purposely or knowingly using human reproductive material from a donor while performing an assisted reproduction procedure if the person receiving the procedure has not expressly consented to the use of that donor’s material.
- Creates the crime of fraudulent assisted reproduction, making it a third-degree felony and allows for civil action against a fertility doctor within ten years of the offense.


To amend the law related to physician-administered drugs

Of Note:
- Prohibits a health benefit plan from requiring that physician-administered drugs be dispensed by a pharmacy, limiting coverage when such drugs are not dispensed by a pharmacy or affiliated pharmacy, or covering such drugs with higher cost-sharing if dispensed in a setting other than a pharmacy


HB 50 – Medical Devices (Rep. Miranda)
Enact Paige’s Law re: medical identifying devices

Of Note:
- Modifies the law governing the use of medical identifying devices, including by recognizing devices containing bar or quick response codes that may be scanned to obtain medical information in an emergency

Regarding pretreatment notice about the possibility of reversing a mifepristone abortion.

**Of Note:**
- Prohibits a physician from performing a mifepristone abortion without both informing the patient of the possibility to reverse the mifepristone abortion if she changes her mind and providing information from the Department of Health website on assistance with reversing the effects of the mifepristone abortion
- Criminalizes violations of the previous requirements as a misdemeanor of the first degree.
- Allows a patient who a mifepristone abortion is performed on to file a wrongful death suit against an individual who fails to inform the patient of the possibility of reversal.


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**Closely monitoring**

To exempt certain mental health care providers’ residential and familial information from disclosure under the Public Records Law.

**Of Note:**
- Adds forensic mental health providers, mental health evaluation providers, and regional psychiatric hospital employees to the list of professions, consolidated in continuing law into the term “designated public service worker,” whose residential and familial information is exempted from disclosure under the Public Records Law.

**Status:** Passed out the House 2/4/2021. 1st Senate Health hearing 3/24/2021. 2nd Senate Health hearing 10/6/2021

To extend certain timelines for qualified civil immunity and expand immunity to include hearing aid dealers and hearing aid fitters; to authorize emergency medical technicians to administer COVID-19 tests; to expressly cover COVID-19 vaccine injuries under the workers' compensation system.
Of Note:
- Sunsets June 30, 2023
- Provides vaccine mandate exemption for vaccines that have not received an FDA biologics license.
- Most public and private sector would be able to receive exemptions:
  a) Medical contraindications; - shall provide a written statement from primary care provider
  b) Natural immunity: - responsible for any costs or fees associated with demonstrating natural immunity to the employer.
  c) Reasons of conscience, including religious convictions. -shall provide a written statement


SB 150 – Physician Contracts (Sen. Johnson and Sen. Williams)
To prohibit the use of noncompete provisions in physician employment contracts.

Of Note:
- Would prohibit the use of noncompete provisions in physician employment contracts.


SB 151 – Infant Medical Treatment (Sen. Johnson)
To establish standards for the medical treatment of certain infants and to name the act Emery and Elliot's Law.

Of Note:
- Outlines medical treatment for mothers and infants in emergency situations or infants with a disability.


SB 48 – Cultural Competency (Sen. Maharath and Sen. Antonio)
To require certain health care professionals to complete instruction in cultural competency.

Of Note:
- Requires certain health care professionals to complete instruction in cultural competency and provide proof of completion at initial application for licensure and at renewal.
- Includes: dentists, nurses, pharmacists, physicians, psychologists, and social workers.


HB 160 – Health Estimates (Health care price transparency) (Rep. Holmes)
Regarding the provision of health care cost estimates.

Of Note:
- Authorizes the relevant regulatory boards to impose administrative remedies on a health plan issuer or health care provider who fails to comply with the bill’s health care price transparency provisions.


HB 43– Authorize public bodies to meet via video- and teleconference (Rep. Sobecki and Rep. Hoops)

To authorize public bodies to meet via teleconference and video conference.

Of Note:
- Allows public bodies to meet and hold hearings via teleconference or video conference.
- Requires public bodies to provide the public with access to meetings and hearings commensurate with the method in which the meeting is being conducted.


SB 123 – Abortion (Sen. Roegner and Sen. O’Brien) (companion HB 598)

To enact the Human Life Protection Act to prohibit abortions based upon a condition precedent.

Of Note:
- Prohibits, as the crime of criminal abortion, a person from purposely causing or inducing an abortion by using a drug or substance or an instrument or other means.
- Provides that criminal abortion is a felony of the fourth degree.
- Provides an affirmative defense to a criminal abortion charge if the physician performed or induced the abortion, or attempted to do so, under the determination that it was necessary to prevent the woman’s death or a serious risk of the substantial and irreversible impairment of a major bodily function.
- Requires the State Medical Board to revoke a physician’s license to practice if the physician is guilty of abortion manslaughter, criminal abortion, or promoting abortion.


HB 598 – Abortion (Rep. Schmidt) (companion SB 123)

To enact the Human Life Protection Act to prohibit abortions based upon a condition precedent

Of Note:
- Prohibits, as the crime of criminal abortion, a person from purposely causing or inducing an abortion by using a drug or substance or an instrument or other means.
- Provides that criminal abortion is a felony of the fourth degree.
- Provides an affirmative defense to a criminal abortion charge if the physician performed or induced the abortion, or attempted to do so, under the determination that it was
necessary to prevent the woman’s death or a serious risk of the substantial and irreversible impairment of a major bodily function.

- Requires the State Medical Board to revoke a physician’s license to practice if the physician is guilty of abortion manslaughter, criminal abortion, or promoting abortion.


**SB 161 – Surgical Smoke (Sen. Brenner)**

Regards surgical smoke.

**Of Note:**

- Requires that not later than one year after the effective date of enactment, each ambulatory surgical facility shall adopt and implement a policy designed to prevent human exposure to surgical smoke during any planned surgical procedure that is likely to generate surgical smoke.
- The policy shall include the use of a surgical smoke evacuation system.


To license and regulate art therapists and music therapists.

**Of Note:**

- Creates a new license type for music therapists to be regulated under the Medical Board

**Status:** Introduced in the Senate 7/1/2021. Assigned to Senate Health 9/8/2021. 1st Senate Health hearing 5/18/2022


To license and regulate art therapists and music therapists.

**Of Note:**

- Creates a new license type for music therapists to be regulated under the Medical Board


To modify the laws governing the practice of advanced practice registered nurses and to designate these provisions as the Better Access, Better Care Act.

**Of Note:**

- Would allow an APRN who has completed 2,000 clinical practice hours under a standard care arrangement the option to practice without a collaboration agreement.
• Allows an APRN who has not completed the required hours to enter into a standard care arrangement with an APRN who has completed 2,000 clinical practice hours.


To authorize a pregnant minor to consent to receive health care to maintain or improve her life or the life of the unborn child she is carrying.

**Of Note:**
- Allows a pregnant minor to consent to receive health care, such as prenatal health care, health care during delivery, post-delivery health care, and family planning services, to maintain or improve her life or the life of the unborn child she is carrying.
- States that the bill does not remove or limit any person’s responsibility under Ohio law to report child abuse or neglect.

**Status:** Introduced in the House 5/19/2021. Referred to House Families, Aging and Human Services 6/24/2021.

**HB 388 – Vaccine Refusal (Rep. Jordan)**
To prohibit taking certain actions against an individual because the individual refuses to be vaccinated against a disease.

**Of Note:**
- Prohibits certain discriminatory actions against unvaccinated people

**Status:** Introduced in the House 8/12/2021.

To regulate the practice of certified professional midwives and to name this act the Ohio Midwife Practice Act.

**Of Note:**
- Regulates the practice of certified professional midwives

**Status:** Introduced in the House 8/12/2021. Referred to House Families, Aging and Human Services 9/21/2021.

**HB 495- Create Patient Protection Act (Representative Gross)**

**Of Note:**
- Requires specified health care professionals (including physicians, PA’s, anesthesiology assistants, limited branch licensees, acupuncturists and genetic counselors) to offer patients medical chaperones and to establish certain mandatory reporting requirements for health care professionals.
- The health care professional may refuse to conduct an exam if the patient or patient’s representative declines to have a medical chaperone present during the exam
**Status:** Introduced in the House 11/23/2021. Referred to the House Families Aging and Human Services 12/7/2021

**HB 496 – Regulate the Practice of Certified Midwives (Rep. Koehler)**  
To regulate the practice of certified nurse-midwives, certified midwives, and certified professional midwives

**Of Note:**  
- Regulates the practice of certified professional midwives


To authorize the operation of remote dispensing pharmacies

**Of Note:**  
- Authorized the operation of remote dispensing pharmacies and charges the State Board of Pharmacy with their regulations  
- Requires a remote dispensing pharmacy to be staffed by two or more pharmacy interns or certified pharmacy technicians and overseen and operated by both a supervising pharmacy and pharmacist through the use of a telepharmacy system.


To revise the law governing the review of patient information in the Ohio Automated Rx Reporting System, to establish requirements on the dispensing of opioid analgesics, to provide for a cash transfer.

**Of Note:**  
- Requires health related licensing boards to adopt guidelines regarding patient counseling and education to be provided by a health care professional when prescribing an opioid analgesic for five or more days  
- Revises the law requiring prescribers to review patient information in OARRS, by eliminating an exception for an opioid analgesic prescribed or personally furnished for seven days

**Status:** Introduced in the House 5/12/2022. Referred to House Health committee 5/17/2022. 1st House Health hearing 5/24/2022

Regards certain off-label use of drugs, products, and devices approved or authorized by the USFDA

**Of Note:**
- Allows for off-label drug treatment for patients at risk of having another qualifying condition
- Other qualifying condition means a preventable, acute or chronic health condition caused by a contagion that has resulted in the death of at least one person in this state

**Status:** Introduced in the House 5/16/2022. Referred to House Health committee 5/18/2022

Enact the Save Adolescents from Experimentation (SAFE) Act

**Of Note:**
- Bans physicians, mental health providers, or other medical health care professionals from preforming gender transition procedures or referring to a medical health care professional for gender transition procedures if the individual is under 18 years old
- Any violation will be considered unprofessional conduct and subject to disciplinary action from the licensing body

Operationalizing

**SB 6 – Join Interstate Medical Licensure Compact (Sen. Roegner and Sen. Steve Huffman)**

**Of Note:**
- Actively working through implementation

**Status:** Passed out of the legislature 6/24/2021. Signed by Governor DeWine 7/1/2021. Required to be operational by 9/28/2022.

**HB 110 – State Operating Budget (Rep. Oelslager)**
Creates appropriations for FY 2022-2023.

**Of Note:**
- The Medical Board budget request was granted in the first version of the bill and remained in the final version.


**Sub HB 51- Valuation determinations for property damage from natural events with language to reauthorize remote hearing authority for Ohio public entities. Contains emergency clause.**

**Of Note:**
- Public bodies could choose to meet remotely through June 30 under legislation passed by the Senate on Wednesday with an emergency clause. House concurred in Senate Amendments 2/9/2022. Signed by Governor DeWine (2/17/2022). Effective date 2/17/2022

**SB 9 – Regulations (Sen. McColley and Sen. Roegner)**
To reduce regulatory restrictions in administrative rules.

**Of Note:**
- Requires certain agencies to reduce the number of regulatory restrictions in their administrative rules.
- Changes the criteria that all agencies must use when conducting a five-year review of an existing rule to match the act’s criteria for elimination of regulatory restrictions

Enacted but no operational changes needed

HB 6 – Modify laws governing certain professions due to COVID-19 (Rep. Roemer)
To modify the laws governing certain health professionals and educator preparation programs due to COVID-19.

Of Note:
- Allows pharmacists to administer immunization for influenza, COVID-19, and any other disease but only pursuant to prescription for persons seven or older.
- Allows pharmacists to administer immunizations for a disease to those 13 and older.
- Allows podiatrists to administer vaccinations for individuals seven and older for influenza and COVID-19.


To revise the law governing the practice of athletic training.

Of note:
- Makes changes to the law governing the practice of athletic training, including by requiring an athletic trainer to practice under a collaboration agreement with a physician or podiatrist.
- Amendment was included in the final version to prohibit an athletic trainer from administering intratendinous and intra-articular injections.


Regards emergency prescription refills.

Of Note:
- Increases from one to three the number of times that a pharmacist may dispense, without a prescription, certain drugs (dangerous drugs, other than a schedule II controlled substance) to a specific patient within a 12-month period.


HB 138 – Emergency Medical Services (Rep. Baldridge)
Regarding the scope of emergency medical services provided by emergency medical service personnel.
Of Note:
- Eliminates the enumeration of specific services that may be provided by emergency medical services (EMS) personnel.
- Requires the State Board of Emergency Medical, Fire, and Transportation Services to establish the scope of practice for EMS personnel through rulemaking.
- Permits EMS personnel to comply with a do-not-resuscitate order issued by a physician assistant or advanced practice registered nurse.
- Requires the medical director or cooperating physician advisory board of each EMS organization to establish protocols for EMS personnel to follow when providing services at all times.