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Tenacity, Creativity and Results are the three words that best describe Shaheen & Gordon's approach to addressing complex legal issues. Our health care team closely monitors the rapidly changing legal environment so that our clients are prepared to meet the challenges of today as well as tomorrow. Relying on a wealth of experience, we offer practical advice and assist in implementing recommendations tailored specifically to meet the needs of both large and small health care clients.

FEDERAL DEVELOPMENTS***OIG: Improper Hospital Reporting Resulted In Overpayments for Recalled Cardiac Medical Devices***

In a recent report titled "Hospitals Did Not Comply With Medicare Requirements for Reporting Certain Cardiac Device Credits," the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG") reported that every single payment it reviewed for a recent recalled cardiac medical device failed to comply with Medicare requirements for reporting manufacturer credits. Following the manufacturers issuing reportable credits to hospitals, the hospitals failed to adjust the claims with the proper condition codes, value codes, or modifiers to reduce the payment, resulting in potential overpayments from Medicare of \$4.4 million.

OIG recommended to the Centers for Medicare and Medicaid Services ("CMS") that it notify the hospitals associated with the overpayments in order to trigger repayment obligations in accordance with the 60-day rule. OIG also recommended that CMS provide education to providers about proper reporting of device recalls.

OIG's report is available at:
<https://oig.hhs.gov/oas/reports/region5/51600059.pdf>

CMS Issues Proposed Rule Providing Flexibility For Managed Care Access Monitoring Requirements

On March 22, 2018, the Centers for Medicare & Medicaid Services ("CMS") issued a notice of proposed rulemaking ("NPRM") that would give states flexibility from certain Medicaid access to care requirements. Under the NPRM, when the majority of a State's covered lives (85% or more) receive services through managed care plans (currently 17 States meet this threshold), the State would be exempted from the requirements to analyze certain data and to monitor access. Additionally, the proposed rule would provide states with flexibility in performing a specific access analysis when making nominal reductions to fee-for-service rates (less than 4% in a State fiscal year and 6% over two consecutive years). According to a press release from CMS, the NPRM is partly in response to State concerns over the undue administrative burdens of meeting the requirements as well as to President's Trump commitment to "cut the red tape" and help States focus resources and time on patient outcomes. According to the CMS press release, "These efforts are instead designed to support CMS efforts to move away from micromanaging state programs and instead focus on measuring program outcomes and holding states accountable for achieving result." Comments on the NPRM are due May 22, 2018.

The NPRM can be read in full at: <https://www.gpo.gov/fdsys/pkg/FR-2018-03-23/pdf/2018-05898.pdf>

Next Generation Sequencing Tests Receive Expanded Coverage

On March 16, the Centers for Medicare & Medicaid Services (“CMS”) finalized a National Coverage Determination that covers diagnostic laboratory tests using Next Generation Sequencing (“NGS”) for patients with advanced cancer (recurrent, metastatic, relapsed, refractory, or stages III or IV cancer, for example). In a press release, CMS stated that it “believes when these tests are used as a companion diagnostic to identify patients with certain genetic mutations that may benefit from U.S. Food and Drug Administration (FDA)-approved treatments, these tests can assist patients and their oncologists in making more informed treatment decisions.” CMS also suggested that using NGS could help determine whether a patient is a good candidate for certain clinical trials. Tests that gain FDA approval or clearance as an in vitro companion diagnostic will automatically receive full coverage, provided coverage criteria are also met. For other tests using NGS for Medicare patients with advanced cancer, coverage determinations will be made by local Medicare Administrative Contractors.

The CMS Decision Memo about NGS can be accessed here: <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=290>

OIG: Noncompliance with Medicare Requirements Resulted in \$367 Million Overpayment for Physical Therapy Services

In a recent report titled “Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements,” the U.S. Department of Health and Human Services, Office of the Inspector General (“OIG”) noted that 61% of the claims for outpatient physical therapy it reviewed recently did not comply with Medicare medical necessity, coding, or documentation requirements. Based on the results of the claims it sampled, OIG estimates that Medicare paid \$367 million during the six-month audit period for claims that did not comply with Medicare requirements.

OIG identified Medicare’s ineffective controls as a factor that led to the overpayments. OIG made three recommendations to the Centers for Medicare & Medicaid Services (“CMS”): 1) notify providers of identified overpayments to trigger the look-back and repayment obligation; 2) establish more effective mechanisms for monitoring compliance; and 3) educate providers about Medicare requirements for outpatient physical therapy claims. OIG reports that CMS does not agree with its findings and all of its recommendations.

OIG’s report is available at: <https://oig.hhs.gov/oas/reports/region5/51400041.pdf>

HRSA Seeks Delay of Final Rule on 340B Civil Monetary Penalties

By way of a recent notice submitted to the Office of Management and Budget, the Health Resources and Services Administration (“HRSA”) is seeking a delay to the implementation of a Final Rule imposing civil monetary penalties on drug manufacturers who overcharge providers for drugs under the 340B drug discount program. The Final Rule imposed penalties of up to \$5,000 where a manufacturer “knowingly and intentionally” charges a provider more than the ceiling price for a discounted drug. The Final Rule also set forth the calculation for the ceiling price.

This is not the first time that HRSA has sought to delay the Final Rule. The Trump administration has delayed the Final Rule several times, citing the need for additional rulemaking.

The Final Rule is available at: <https://www.gpo.gov/fdsys/pkg/FR-2017-01-05/pdf/2016-31935.pdf>

Federal Court Refuses to Dismiss FCA Claim Involving Alleged False Certifications of Homebound Status

On March 22, 2018, the U.S. District Court for the Northern District of Illinois denied a motion to dismiss a False Claims Act lawsuit brought by a relator alleging that the defendant provider of home physician services had falsely certified that some patients were homebound. The defendant – America’s Disabled Homebound, Inc. – had argued in its motion to dismiss that the relator had failed to provide any document or bill that was allegedly submitted to the government and had failed to sufficiently allege that the certifications were false. The District Court held that the relator need not present a specific document that was submitted to the government. The Court also held that sufficiently alleged false certifications with particularity identifying specific patients that were allegedly not homebound.

NJ Medical Group Agrees to \$417,816 Settlement and Corrective Plan After Vendor Data Breach

On April 4, 2018, the New Jersey Attorney General announced that New Jersey-based Virtue Medical Group, PA (“VMG”) had agreed to pay \$417,816 and enter into a corrective action plan stemming from a data breach involving patient records of up 1,654 individuals treated at one of several VMG specialty practices. The patient data was made publicly available through online searches after Best Medical Transcription (“BMT”), a Georgia-based vendor hired to transcribe dictations of medical notes, letters, and reports, failed to properly secure a File Transfer Protocol (“FTP”) website where the data was being stored. The AG’s investigation discovered that even after the vendor secured the website when they discovered the breach, Google and other search engines had already created cached indexes of the data which remained publicly available. The AG’s office identified the following specific violations of the HIPAA Security and Privacy Rules:

- Failing to implement a security awareness and training program for all members of its workforce, including management.
- Being delayed in identifying and responding to the security incident; mitigating its harmful effects; and documenting the incident and its outcome.
- Failing to establish and implement procedures to create and maintain retrievable exact copies of ePHI maintained on the FTP Site.
- Improperly disclosing the PHI of its patients.
- Failing to maintain a written or electronic log of the number of times the FTP Site was accessed.

“Although it was a third-party vendor that caused this data breach, VMG is being held accountable because it was their patient data and it was their responsibility to protect it,” said Sharon M. Joyce, Acting Director of the Division of Consumer Affairs. “This enforcement action sends a message to medical practices that having a good handle on your own cybersecurity is not enough. You must fully vet your vendors for their security as well.”

The NJ Attorney General’s press release is available at:

<http://nj.gov/oag/newsreleases18/pr20180404b.html>.

STATE DEVELOPMENTS***NH Department of Insurance Proposed New Network Adequacy Rules***

On March 21, 2018, the NH Department of Insurance announced it had submitted a proposed rule to the Joint Legislative Committee on Administrative Rules governing the network adequacy requirements for insurers. Under the law, insurance companies must maintain provider networks sufficient to ensure members have reasonable access to covered health care services including behavioral health services. The

current network adequacy rules were drafted over 20 years ago. The Insurance Department stated that under the new rule, “the Department will be able to compare companies’ networks on an apples-to-apples basis, allowing the Department to identify gaps in network access to behavioral health care providers, and assisting insurance companies in identifying non-contracted providers that can supply a needed service to allow them to meet the network adequacy standard.” The Department will hold a public hearing on the proposed rule on Monday, April 23, 2018 at 2pm at the NH Insurance Department, Walker Building, 21 S. Fruit St., Concord.

The proposed rule may be accessed at <https://www.nh.gov/insurance/legal/documents/ins2701ip.pdf>

First Circuit Court of Appeals Rules in Favor of NH Hospitals in Dispute Over Medicaid Payment Rules

On April 4, 2018, the First Circuit Court of Appeals upheld the lower court’s decision in a suit brought by the New Hampshire Hospital Association challenging the state’s adoption of a policy in 2010 reinterpreting the way Medicaid payments made to hospitals were calculated. In its decision the First Circuit Court stated that the change in policy was one that could not be adopted without providing the public notice and time to comment. The policy in dispute has since been adopted after a notice and comment period but it applies only to fiscal years after its adoption in June 2017. That rule is also the subject of court challenges.

2018 LEGISLATIVE UPDATES

HB 1102-FN This bill authorizes the commissioner of the department of health and human services to contract with a physician certified by the Academy Society of Addiction Medicine to review medication assisted treatment in New Hampshire. Passed by the House with Amendment. The amendment allows the HHS Commissioner to contract with multiple physicians, permits the physician(s) to be certified from one of multiple accrediting bodies, and describes the consultant’s role in more general terms. **The bill is before the Senate HHS Committee.**

HB 1362: This bill authorizes individuals and certain businesses to purchase health insurance from out-of-state companies. The bill grants rulemaking authority to the insurance commissioner for the purposes of the bill. **Introduced and referred to House Commerce Committee. Referred to interim study.**

HB 1418-FN This bill requires the commissioner of the department of health and human services, in consultation with the insurance commissioner, to develop a list of certain critical prescription drugs for purposes of cost control and transparency. Under this bill, the commissioner shall make an annual report on prescription drugs and their role in overall health care spending in New Hampshire. Passed with Amendment by the House. The amendment provides for the creation of a Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs. **Introduced and referred to the Senate HHS Committee.**

HB 1462-FN: This bill requires employers who offer health or dental benefits, or both, to its employees to maintain that coverage for an employee who has filed a compensable claim under the workers’ compensation law for 24 months or until the employee has returned to work, whichever is shorter. **Voted Inexpedient to Legislate by the House.**

HB 1465: This bill requires Medicare supplemental insurance policies to provide coverage for hearing aids. **Introduced and referred to House Commerce Committee. Referred for interim study by the House.**

HB 1468: This bill establishes a commission to study legislative oversight activities related to the department of health and human services. Introduced and referred to House HHS Committee. Voted Ought to Pass by the House. The amendment extends the date for the study committee to report by one year to November 1, 2019 and repeals the study committee on the same date. **Introduced and referred to Senate HHS Committee which voted Ought to Pass with Amendment. The Amendment requires an interim report by the study commission by November 1, 2019 and a final report by November 1, 2020 and repeal the study commission on November 1, 2020.**

HB 1471: This bill clarifies the law relating to telemedicine services. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and by the full House. Referred to House Commerce and Consumer Affairs Committee. The amendment clarified that the reimbursement rates will be the same as for services provided in the provider's office or facility, "provided that such rates do not exceed rate for in-person consultation at the originating site." The House passed the bill with another amendment **The amended bill eliminates the proposed provision regarding reimbursement rates. The bill instead establishes a committee to study health care reimbursement for telemedicine and telehealth. Introduced in the Senate and referred to the Senate HHS Committee.**

HB 1506-FN This bill: I. Establishes the regulation and licensure of assistant physicians by the board of medicine. II. Regulates their practice through assistant physician collaborative practice arrangements. III. Establishes a grant program in the department of health and human services to provide matching funds for primary care clinics in medically underserved areas utilizing assistant physicians. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment replaces "assistant physicians" with "graduate physicians." **Introduced and referred to the Senate HHS Committee which voted Ought to Pass with Amendment. The Amendment completely eliminates the text of the original bill and replaces it with language amending RSA 126-T, a statute related to the Commission on Primary Care Workforce Issues. It expands the membership of the commission, changes the scope of the review and extends the due dates for a report.**

HB 1530: This bill adds a requirement for submission of criminal history records prior to licensure or certification by an allied health professional governing board. Introduced, referred to House Executive Departments and Administration Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment permits applicants for licensure to be employed in an allied health profession on a conditional basis for up to 90 days while awaiting the results of a criminal history record check, subject to certain requirements. **Introduced and referred to the Senate Committee on Executive Departments and Administration.**

HB 1571: This bill authorizes the board of nursing to operate or contract for an alternative recovery monitoring program for nurses impaired by substance use disorders or mental or physical illness. Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment reconfigures the proposed statutory language and adds a provision for the board of nursing to promulgate rules to implement the statute. **Introduced and referred to Senate Committee, Executive Departments and Administration. Voted Ought to Pass by Committee.**

HB 1577: This bill provides for the regulation of the use of general anesthesia, deep sedation, or moderate anesthesia by dentists and the reporting of adverse events. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment adds a provision for dental insurance coverage for children under 13 years of age for dental procedures requiring anesthesia. **Introduced and referred to Senate HHS Committee.**

HB 1606: This bill makes various changes to the regulation of doctors of naturopathic medicine including the scope of practice of naturopaths and the procedures of the naturopathic board of examiners. Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment provides for the election of a chairperson of the board of examiners, changes the quorum for the board from four members to three, and increases the frequency of submission by the licensee of proof of continuing education. **Voted Ought to Pass by the Senate.**

HB1654: This bill prohibits holding an injured driver or passenger responsible for medical costs determined to not be reasonable. Introduced and referred to House Commerce Committee. Voted Ought to Pass by the Committee and the full House. **Introduced and referred to Senate Commerce Committee.**

HB1664: This bill clarifies the eligibility to reappoint a member of a governing board of an allied health profession to an additional full term. Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass by the Committee and the full House. **Introduced and referred to Senate Executive Departments and Administration. Voted Ought to Pass by Committee.**

HB1665: This bill clarifies the authority of the governing boards of allied health professionals concerning individuals who are certified by such boards. Introduced and referred to House Executive Departments and Administration Committee. Voted Ought to Pass by the Committee and the full House. **Introduced and referred to Senate Executive Departments and Administration. Voted Ought to Pass by Committee.**

HB 1672-FN: This bill requires a search warrant issued by a judge based upon probable cause for any federal request for information relative to users of therapeutic cannabis created by the registry. Introduced and referred to House Judiciary Committee. Voted Ought to Pass by the Committee. **Introduced and referred to Senate Judiciary Committee.**

HB 1707-FN: This bill requires the physician who performs an abortion, or the referring physician, to provide a pregnant woman with certain information at least 24 hours prior to the abortion, and to obtain her consent that she has received such information. **Introduced and referred to House HHS Committee, which voted to refer the bill for interim study.**

HB 1740: This bill repeals the provision relating to the costs of blood testing orders when certain individuals have been exposed to another person's bodily fluids. Introduced and referred to House Commerce Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment does not repeal the current statute but rather eliminates the requirement that private health or automobile insurance be responsible for payment when there is no workers' compensation coverage. **Introduced and referred to Senate Commerce Committee.**

HB 1741: This bill allows an insured to pay the least amount for covered prescription medication under the managed care law. Introduced and referred to House Commerce Committee. Voted Ought to Pass with

Amendment by the Committee and the full House. The amendment deletes the entire bill and provides only for a new definition for “contracted copayment.” **Introduced and referred to Senate HHS Committee. Voted Ought to Pass by Committee. Bill subsequently Laid on Table.**

HB 1743: This bill increases the percentage of money distributed to the alcohol abuse prevention and treatment fund. This bill also repeals the ability of the commissioner to get fiscal committee approval to use certain funds to pay for the operational costs of the Sununu Youth Services Center. Introduced and referred to House Finance Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment requires funding transfer out of or within the Sununu Youth Services Center to get the prior approval of the Fiscal Committee, clarifies the procedure for filling unfunded positions within the Department of Health and Human Services, and requires the Commissioner to make a monthly report to the Fiscal Committee. **Introduced and referred to Senate Finance Committee.**

HB 1746: This bill prohibits certain practices of pharmacy benefit managers. Introduced, referred to House Commerce Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment adds a repeal of the prohibition to take effect on June 30, 2020. **Introduced and referred to Senate HHS Committee.**

HB 1751: This bill requires insurance coverage for treatment for pediatric autoimmune neuropsychiatric disorders. **Introduced, referred to House Commerce Committee and sent to subcommittee. Referred for interim study by the full House.**

HB 1769-FN: This bill prohibits discrimination against physicians based on maintenance of certification. Introduced and referred to House HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment makes a small change to those entities that are prohibited from differentiating between physicians based on a physician’s maintenance of certification. **Introduced and referred to Senate HHS.**

HB 1787-FN: This bill prohibits discrimination against health care providers who conscientiously object to participating in certain medical procedures. Introduced and referred to House HHS Committee where it was vacated and referred to House Judiciary Committee. Voted Inexpedient to Legislate by the Committee. **Voted Inexpedient to Legislate by the House.**

HB 1791-FN: This bill declares that a contract between an insurance carrier or pharmacy benefit manager and a contracted pharmacy shall not contain a provision prohibiting the pharmacist from providing certain information to an insured. Introduced and referred to House Commerce Committee. Voted Ought to Pass by Committee. Voted Ought to Pass by the Committee and the full House. **Introduced and referred to Senate HHS Committee.**

HB 1809-FN: This bill prohibits balance billing under the managed care law. This bill is the result of the committee established in 2017. Introduced, referred to House Commerce Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee and the full House. The amendment moves the new statutory language to a different chapter and updates internal references. **Introduced and referred to Senate HHS Committee.**

HB 1811-FN-A: This bill: I. Extends the New Hampshire Health Protection Program. II. Requires the commissioner of the department of health and human services to apply to the Centers for Medicare and

Medicaid Services for a waiver to develop a screening process for medically complex persons who are enrolled in the New Hampshire health protection program. III. Allows the use of general funds to fund the New Hampshire health protection program. **Introduced and referred to House HHS Committee. Voted by Committee and House to refer to Interim Study.**

HB 1816-FN: This bill requires the commissioner of the department of health and human services to adjust the Medicaid managed care program by requesting a certain waiver from the Centers for Medicare and Medicaid Services, implementing enhanced eligibility screening, and requiring managed care organizations to meet the federal medical loss ratio provision with any surplus to be deposited into the general fund. This bill also eliminates certain provisions under step 2 of the program. Introduced, referred to House HHS Committee and sent to subcommittee. Voted Ought to Pass with Amendment by the Committee. The bill as amended declares that the remaining unimplemented phases of step 2 of the program shall not be implemented and requires the commissioner to implement enhanced eligibility screening and require managed care organizations to meet the Federal medical loss ratio provision with any nonfederal surplus to be deposited into the general fund. **Introduced and referred to Senate HHS Committee.**

HB 1822-FN: This bill allows pharmacists to dispense hormonal contraceptives pursuant to a standing order entered into by health care providers. This bill is the result of the commission established pursuant to 2017, 23. Introduced and referred to House HHS Committee where it was Voted Inexpedient to Legislate. The full House rejected the Committee's vote and instead voted Ought to Pass. It was then sent to the House Commerce Committee to assess its economic impact. **Committee and House voted Ought to Pass with Amendment. The amendment changes the language related to contraceptive coverage to reference payment for an initial screening performed by the pharmacist rather than medication therapy management services. Introduced and referred to Senate HHS Committee which voted Ought to Pass.**

SB 313-FN: This bill establishes the New Hampshire Granite Advantage Health Care Program which shall replace the current New Hampshire health protection program. Under this program, those individuals eligible to receive benefits under the Medicaid program and newly eligible adults shall choose coverage offered by one of the managed care organizations contracted as vendors under the Medicaid program. Introduced and referred to Senate Finance Committee. Voted Ought to Pass with Amendment by the Committee and the full House. The bill as amended provides for the establishment of the Granite Workforce Pilot Program and increases the amount of liquor revenues to be deposited into the Alcohol Abuse Prevention and Treatment fund and provides that moneys deposited into the fund shall be transferred to the Granite Advantage Health Care Trust Fund for substance use disorder prevention, treatment, and recovery. **Introduced and referred to House HHS Committee. Voted Ought to Pass by the Committee. The Amendments primarily address the funding to the Granite Advantage Health Care Trust Fund. Referred to Finance Committee.**

SB 327: This bill removes the requirement that a member of the medical review subcommittee be from the Board of Medicine and reduces the time limitation for allegations of professional misconduct enforced by the Board of Medicine. This bill is a request of the Board of Medicine. Introduced and referred to Senate Executive Departments and Administration. Voted Ought to Pass by the Committee and the full Senate. **Introduced and referred to House Executive Departments and Administration.**

SB 332: This bill requires insurers offering health insurance policies with prescription drug coverage to allow covered persons to synchronize the dispensing dates of their prescription drugs. Introduced and referred to

Senate HHS Committee. Voted Ought to Pass with Amendment by the Committee and the full Senate. The amendment revises the bill by adding specificity to the circumstances under which the synchronization is available. **Introduced and referred to House Commerce Committee.**

SB 354: This bill prohibits a pharmacy benefits manager or insurer from charging or holding a pharmacy responsible for a fee related to a claim under certain circumstances. This bill also prohibits a pharmacy benefits manager or insurer from charging higher copayments and or inserting gag clauses in contracts. Introduced and referred to the Senate Commerce Committee. **Voted Ought to Pass by Senate. Introduced and referred to House Commerce Committee.**

SB 374: This bill exempts the adoption of emergency medical and trauma services protocols from the rulemaking process under RSA 541-A. Introduced and referred to Senate Executive Departments and Administration. **Voted Ought to Pass by the Committee and the full Senate. Introduced and referred to House Executive Departments and Administration.**

SB 377: This bill makes various changes to the regulation of dentists and dental hygienists, including requiring criminal history records checks for new applicants and establishing a professionals' health program for impaired dentists. This bill is a request of the board of dental examiners. Introduced and referred to Senate HHS Committee. Voted Ought to Pass by the Committee and the full Senate. **Introduced and referred to House Executive Departments and Administration.**

SB 378-FN: This bill exempts certain health care facilities from the requirement of employing registered medical technicians. Introduced and referred to Senate HHS Committee. Voted Ought to Pass by the Committee and the full Senate. **Introduced and referred to House Executive Departments and Administration.**

SB 379: This bill changes the time frame for insurance companies and managed care organizations to recover payments from a health care provider for services completed. As introduced, the bill would have reduced the time period for retroactive denials from 18 months to 6 months. The amended bill changes the time frame to 12 months. **Voted Ought to Pass by the Senate. Introduced and referred to House Commerce Committee.**

SB 383: This bill establishes a commission to study the benefits and costs of a "health care for all" program for New Hampshire. Introduced and referred to Senate HHS Committee. **Voted Ought to Pass with Amendment by the Senate. The amendment changes the purpose of the study commission to one which will recommend policies that will enhance access to affordable health care for all New Hampshire residents. Introduced in the House Commerce Committee.**

SB 421: This bill clarifies insurance coverage for prescription contraceptive drugs and prescription contraceptive devices and for contraceptive services. **Introduced and referred to Senate Commerce Committee. Voted Ought to Pass by the Senate; Introduced and referred to House Commerce Committee.**

SB 475: This bill requires health care providers to provide certain information to persons being tested for Lyme disease. **Voted Ought to Pass with Amendment by the Senate. The amendment changes the notice to be provided to patient who are screened for Lyme disease and adds a repeal of the newly-added chapter effective July 1, 2023. Introduced and referred to the House HHS Committee.**

SB 502-FN: This bill clarifies the standards for acquisition transactions involving health care charitable trusts and the review required by the director of charitable trusts. Voted Ought to Pass by the Senate. **Introduced and referred to House Commerce Committee.**

SB 531-FN: This bill provides for the office of professional licensure and certification to establish by rule and collect the fees for boards and commissions administered by the office, and to deposit the fees collected in the office of professional licensure and certification fund for payment of the costs and salaries of the office. This bill is a request of the office of professional licensure and certification. Senate voted Ought to Pass. **Introduced to House Executive Departments and Administration Committee. Voted Ought to Pass with Amendment by the Committee.** The Amendment requires the establishment of fees by the office of professional licensure to be done on a biennial basis in conjunction with the preparation of the biennial budget. It also makes clear that current board, commission and council rules addressing fees shall remain in effect until they expire or new rules are adopted.

SB 573-FN-A: This bill allows the chief medical examiner and designees to register and access the controlled drug prescription health and safety program. This bill also makes an appropriation to the controlled drug prescription health and safety program. This bill is a request of the controlled drug prescription health and safety program, established in RSA 318-B:32. Introduced and referred to Senate HHS Committee which voted Ought to Pass with Amendment. **Senate voted Ought to Pass with Amendment.** The amendment clarifies the access by the Chief Medical Examiner and delegates. House voted Ought to Pass. Referred to House Finance Committee.

SB 576-FN: This bill repeals the provision suspending home health services rate setting established in 2017, 156. **After being laid on the table and removed, Senate voted Ought to Pass with Amendment. The amended bill requires the Department of Health and Human Services to review Medicaid reimbursement for home health services. Introduced and referred to House Finance Committee.**

SB 578-FN: This bill clarifies the terms of appointment and salary for the following positions in the department of health and human services: deputy commissioner, associate commissioner of human services and behavioral health, associate commissioner of operations, and associate commissioner for population health. The bill is a request of the department of health and human services. **Senate voted Ought to Pass. Introduced and referred to House Executive Departments and Administration.**

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Cinde Warmington, Kara J. Dowal, and Alexander W. Campbell contributed to this month's [Legal Update](#).

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