

As Passed by the Senate

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Am. S. B. No. 265

Senator Dolan

Cosponsors: Senators Beagle, Brown, Coley, Eklund, Gardner, Hackett, Hoagland, Hottinger, Huffman, Kunze, Lehner, Manning, Obhof, O'Brien, Schiavoni, Thomas, Uecker, Wilson, Yuko

A BILL

To amend sections 173.12, 341.192, 1739.05, 1751.01, 3702.30, 3712.06, 3712.061, and 3963.01 and to enact sections 1751.91, 3923.89, 5164.14, and 5167.121 of the Revised Code to permit certain health insurers to provide payment or reimbursement for services lawfully provided by a pharmacist and to recognize pharmacist services in certain other laws.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 173.12, 341.192, 1739.05, 1751.01, 3702.30, 3712.06, 3712.061, and 3963.01 be amended and sections 1751.91, 3923.89, 5164.14, and 5167.121 of the Revised Code be enacted to read as follows:

Sec. 173.12. The services provided by a multipurpose senior center shall be available to all residents of the area served by the center who are sixty years of age or older, except where legal requirements for the use of funds available for a component program specify other age limits. Persons who receive

services from the center may be encouraged to make voluntary 18
contributions to the center, but no otherwise eligible person 19
shall be refused services because of inability to make a 20
contribution. 21

Services provided by the center may include, but are not 22
limited to, the following: 23

(A) Services available within the facility: 24

(1) Preventive medical services, diagnostic and treatment 25
services, emergency health services, and counseling on health 26
matters, which are provided on a regular basis by a licensed 27
physician, pharmacist, or ~~by a~~ registered nurse or other 28
qualified health professional; 29

(2) A program to locate full- or part-time employment 30
opportunities; 31

(3) Information and counseling by professional or other 32
persons specially trained or qualified to enable older adults to 33
make decisions on personal matters, including income, health, 34
housing, transportation, and social relationships; 35

(4) A listing of services available in the community for 36
older adults to assist in identifying the type of assistance 37
needed, to place them in contact with appropriate services, and 38
to determine whether services have been received and identified 39
needs met; 40

(5) Legal advice and assistance by an attorney or a legal 41
assistant acting under the supervision of an attorney; 42

(6) Recreation, social activities, and educational 43
activities. 44

(B) Services provided outside the facility: 45

(1) Routine health services necessary to help functionally 46
impaired older adults to maintain an appropriate standard of 47
personal health, provided to them in their homes by licensed 48
physicians, registered nurses, or other qualified health service 49
personnel; 50

(2) Household services, such as light housekeeping, 51
laundrying, meal preparation, personal and grocery shopping, 52
check cashing and bill paying, friendly visiting, minor 53
household repairs, and yard chores, that are necessary to help 54
functionally impaired older adults meet the normal demands of 55
daily living; 56

(3) The delivery, on a regular schedule, of hot or cold 57
nourishing meals to functionally impaired older adults and the 58
determination of the nutritional needs of such persons; 59

(4) Door-to-door vehicular transportation for functionally 60
impaired or other older adults. 61

Other services, including social and recreational 62
services, adult education courses, reassurance by telephone, 63
escort services, and housing assistance may be added to the 64
center's program as appropriate, to the extent that resources 65
are available. 66

Services may be furnished by public agencies or private 67
persons or organizations, but all services shall be coordinated 68
by a single management unit, operating within the center, that 69
is established, staffed, and equipped for this purpose. 70

The department of aging, or the local entity approved by 71
the department under section 173.11 of the Revised Code for the 72
operation of a center, may contract for any or all of the 73
services provided by the center with any other state agency, 74

county, township, municipal corporation, school district, 75
community or technical college district, health district, 76
person, or organization. 77

The department shall provide for the necessary insurance 78
coverage to protect all volunteers from the normal risks of 79
personal liability while they are acting within the scope of 80
their volunteer assignments for the provision of services under 81
this section. 82

As used in this section, "functionally impaired older 83
adult" means an individual sixty years of age or older who 84
requires help from others in order to cope with the normal 85
demands of daily living. 86

Sec. 341.192. (A) As used in this section: 87

(1) "Jail" means a county jail, or a multicounty, 88
municipal-county, or multicounty-municipal correctional center. 89

(2) "Medical provider" means a physician, hospital, 90
laboratory, pharmacist, pharmacy, or other health care provider 91
that is not employed by or under contract to a county, municipal 92
corporation, township, the department of youth services, or the 93
department of rehabilitation and correction to provide medical 94
services to persons confined in a jail or state correctional 95
institution, or is in the custody of a law enforcement officer. 96

(3) "Necessary care" means medical care of a nonelective 97
nature that cannot be postponed until after the period of 98
confinement of a person who is confined in a jail or state 99
correctional institution, or is in the custody of a law 100
enforcement officer without endangering the life or health of 101
the person. 102

(B) If a physician employed by or under contract to a 103

county, municipal corporation, township, the department of youth 104
services, or the department of rehabilitation and correction to 105
provide medical services to persons confined in a jail or state 106
correctional institution determines that a person who is 107
confined in the jail or state correctional institution or who is 108
in the custody of a law enforcement officer prior to the 109
person's confinement in a jail or state correctional institution 110
requires necessary care that the physician cannot provide, the 111
necessary care shall be provided by a medical provider. The 112
county, municipal corporation, township, the department of youth 113
services, or the department of rehabilitation and correction 114
shall pay a medical provider for necessary care an amount not 115
exceeding the authorized reimbursement rate for the same service 116
established by the department of medicaid under the medicaid 117
program. 118

Sec. 1739.05. (A) A multiple employer welfare arrangement 119
that is created pursuant to sections 1739.01 to 1739.22 of the 120
Revised Code and that operates a group self-insurance program 121
may be established only if any of the following applies: 122

(1) The arrangement has and maintains a minimum enrollment 123
of three hundred employees of two or more employers. 124

(2) The arrangement has and maintains a minimum enrollment 125
of three hundred self-employed individuals. 126

(3) The arrangement has and maintains a minimum enrollment 127
of three hundred employees or self-employed individuals in any 128
combination of divisions (A) (1) and (2) of this section. 129

(B) A multiple employer welfare arrangement that is 130
created pursuant to sections 1739.01 to 1739.22 of the Revised 131
Code and that operates a group self-insurance program shall 132

comply with all laws applicable to self-funded programs in this 133
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 134
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 135
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 136
3923.30, 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 137
3923.80, 3923.84, 3923.85, 3923.851, 3923.89, 3924.031, 138
3924.032, and 3924.27 of the Revised Code. 139

(C) A multiple employer welfare arrangement created 140
pursuant to sections 1739.01 to 1739.22 of the Revised Code 141
shall solicit enrollments only through agents or solicitors 142
licensed pursuant to Chapter 3905. of the Revised Code to sell 143
or solicit sickness and accident insurance. 144

(D) A multiple employer welfare arrangement created 145
pursuant to sections 1739.01 to 1739.22 of the Revised Code 146
shall provide benefits only to individuals who are members, 147
employees of members, or the dependents of members or employees, 148
or are eligible for continuation of coverage under section 149
1751.53 or 3923.38 of the Revised Code or under Title X of the 150
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 151
Stat. 227, 29 U.S.C.A. 1161, as amended. 152

(E) A multiple employer welfare arrangement created 153
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 154
subject to, and shall comply with, sections 3903.81 to 3903.93 155
of the Revised Code in the same manner as other life or health 156
insurers, as defined in section 3903.81 of the Revised Code. 157

Sec. 1751.01. As used in this chapter: 158

(A) (1) "Basic health care services" means the following 159
services when medically necessary: 160

(a) Physician's services, except when such services are 161

supplemental under division (B) of this section;	162
(b) Inpatient hospital services;	163
(c) Outpatient medical services;	164
(d) Emergency health services;	165
(e) Urgent care services;	166
(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;	167 168
(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;	169 170 171
(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;	172 173 174 175
(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.	176 177 178
"Basic health care services" does not include experimental procedures.	179 180
Except as provided by divisions (A) (2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in	181 182 183 184 185 186 187 188

medicare pursuant to a medicare contract, or to the coverage of 189
beneficiaries enrolled in the federal employee health benefits 190
program pursuant to 5 U.S.C.A. 8905, or to the coverage of 191
medicaid recipients, or to the coverage of beneficiaries under 192
any federal health care program regulated by a federal 193
regulatory body, or to the coverage of beneficiaries under any 194
contract covering officers or employees of the state that has 195
been entered into by the department of administrative services. 196

(2) A health insuring corporation may offer coverage for 197
diagnostic and treatment services for biologically based mental 198
illnesses without offering coverage for all other basic health 199
care services. A health insuring corporation may offer coverage 200
for diagnostic and treatment services for biologically based 201
mental illnesses alone or in combination with one or more 202
supplemental health care services. However, a health insuring 203
corporation that offers coverage for any other basic health care 204
service shall offer coverage for diagnostic and treatment 205
services for biologically based mental illnesses in combination 206
with the offer of coverage for all other listed basic health 207
care services. 208

(3) A health insuring corporation that offers coverage for 209
basic health care services is not required to offer coverage for 210
diagnostic and treatment services for biologically based mental 211
illnesses in combination with the offer of coverage for all 212
other listed basic health care services if all of the following 213
apply: 214

(a) The health insuring corporation submits documentation 215
certified by an independent member of the American academy of 216
actuaries to the superintendent of insurance showing that 217
incurred claims for diagnostic and treatment services for 218

biologically based mental illnesses for a period of at least six 219
months independently caused the health insuring corporation's 220
costs for claims and administrative expenses for the coverage of 221
basic health care services to increase by more than one per cent 222
per year. 223

(b) The health insuring corporation submits a signed 224
letter from an independent member of the American academy of 225
actuaries to the superintendent of insurance opining that the 226
increase in costs described in division (A) (3) (a) of this 227
section could reasonably justify an increase of more than one 228
per cent in the annual premiums or rates charged by the health 229
insuring corporation for the coverage of basic health care 230
services. 231

(c) The superintendent of insurance makes the following 232
determinations from the documentation and opinion submitted 233
pursuant to divisions (A) (3) (a) and (b) of this section: 234

(i) Incurred claims for diagnostic and treatment services 235
for biologically based mental illnesses for a period of at least 236
six months independently caused the health insuring 237
corporation's costs for claims and administrative expenses for 238
the coverage of basic health care services to increase by more 239
than one per cent per year. 240

(ii) The increase in costs reasonably justifies an 241
increase of more than one per cent in the annual premiums or 242
rates charged by the health insuring corporation for the 243
coverage of basic health care services. 244

Any determination made by the superintendent under this 245
division is subject to Chapter 119. of the Revised Code. 246

(B) (1) "Supplemental health care services" means any 247

health care services other than basic health care services that	248
a health insuring corporation may offer, alone or in combination	249
with either basic health care services or other supplemental	250
health care services, and includes:	251
(a) Services of facilities for intermediate or long-term	252
care, or both;	253
(b) Dental care services;	254
(c) Vision care and optometric services including lenses	255
and frames;	256
(d) Podiatric care or foot care services;	257
(e) Mental health services, excluding diagnostic and	258
treatment services for biologically based mental illnesses;	259
(f) Short-term outpatient evaluative and crisis-	260
intervention mental health services;	261
(g) Medical or psychological treatment and referral	262
services for alcohol and drug abuse or addiction;	263
(h) Home health services;	264
(i) Prescription drug services;	265
(j) Nursing services;	266
(k) Services of a dietitian licensed under Chapter 4759.	267
of the Revised Code;	268
(l) Physical therapy services;	269
(m) Chiropractic services;	270
(n) Any other category of services approved by the	271
superintendent of insurance.	272

(2) If a health insuring corporation offers prescription 273
drug services under this division, the coverage shall include 274
prescription drug services for the treatment of biologically 275
based mental illnesses on the same terms and conditions as other 276
physical diseases and disorders. 277

(C) "Specialty health care services" means one of the 278
supplemental health care services listed in division (B) of this 279
section, when provided by a health insuring corporation on an 280
outpatient-only basis and not in combination with other 281
supplemental health care services. 282

(D) "Biologically based mental illnesses" means 283
schizophrenia, schizoaffective disorder, major depressive 284
disorder, bipolar disorder, paranoia and other psychotic 285
disorders, obsessive-compulsive disorder, and panic disorder, as 286
these terms are defined in the most recent edition of the 287
diagnostic and statistical manual of mental disorders published 288
by the American psychiatric association. 289

(E) "Closed panel plan" means a health care plan that 290
requires enrollees to use participating providers. 291

(F) "Compensation" means remuneration for the provision of 292
health care services, determined on other than a fee-for-service 293
or discounted-fee-for-service basis. 294

(G) "Contractual periodic prepayment" means the formula 295
for determining the premium rate for all subscribers of a health 296
insuring corporation. 297

(H) "Corporation" means a corporation formed under Chapter 298
1701. or 1702. of the Revised Code or the similar laws of 299
another state. 300

(I) "Emergency health services" means those health care 301

services that must be available on a seven-days-per-week, 302
twenty-four-hours-per-day basis in order to prevent jeopardy to 303
an enrollee's health status that would occur if such services 304
were not received as soon as possible, and includes, where 305
appropriate, provisions for transportation and indemnity 306
payments or service agreements for out-of-area coverage. 307

(J) "Enrollee" means any natural person who is entitled to 308
receive health care benefits provided by a health insuring 309
corporation. 310

(K) "Evidence of coverage" means any certificate, 311
agreement, policy, or contract issued to a subscriber that sets 312
out the coverage and other rights to which such person is 313
entitled under a health care plan. 314

(L) "Health care facility" means any facility, except a 315
health care practitioner's office, that provides preventive, 316
diagnostic, therapeutic, acute convalescent, rehabilitation, 317
mental health, intellectual disability, intermediate care, or 318
skilled nursing services. 319

(M) "Health care services" means basic, supplemental, and 320
specialty health care services. 321

(N) "Health delivery network" means any group of providers 322
or health care facilities, or both, or any representative 323
thereof, that have entered into an agreement to offer health 324
care services in a panel rather than on an individual basis. 325

(O) "Health insuring corporation" means a corporation, as 326
defined in division (H) of this section, that, pursuant to a 327
policy, contract, certificate, or agreement, pays for, 328
reimburses, or provides, delivers, arranges for, or otherwise 329
makes available, basic health care services, supplemental health 330

care services, or specialty health care services, or a 331
combination of basic health care services and either 332
supplemental health care services or specialty health care 333
services, through either an open panel plan or a closed panel 334
plan. 335

"Health insuring corporation" does not include a limited 336
liability company formed pursuant to Chapter 1705. of the 337
Revised Code, an insurer licensed under Title XXXIX of the 338
Revised Code if that insurer offers only open panel plans under 339
which all providers and health care facilities participating 340
receive their compensation directly from the insurer, a 341
corporation formed by or on behalf of a political subdivision or 342
a department, office, or institution of the state, or a public 343
entity formed by or on behalf of a board of county 344
commissioners, a county board of developmental disabilities, an 345
alcohol and drug addiction services board, a board of alcohol, 346
drug addiction, and mental health services, or a community 347
mental health board, as those terms are used in Chapters 340. 348
and 5126. of the Revised Code. Except as provided by division 349
(D) of section 1751.02 of the Revised Code, or as otherwise 350
provided by law, no board, commission, agency, or other entity 351
under the control of a political subdivision may accept 352
insurance risk in providing for health care services. However, 353
nothing in this division shall be construed as prohibiting such 354
entities from purchasing the services of a health insuring 355
corporation or a third-party administrator licensed under 356
Chapter 3959. of the Revised Code. 357

(P) "Intermediary organization" means a health delivery 358
network or other entity that contracts with licensed health 359
insuring corporations or self-insured employers, or both, to 360
provide health care services, and that enters into contractual 361

arrangements with other entities for the provision of health 362
care services for the purpose of fulfilling the terms of its 363
contracts with the health insuring corporations and self-insured 364
employers. 365

(Q) "Intermediate care" means residential care above the 366
level of room and board for patients who require personal 367
assistance and health-related services, but who do not require 368
skilled nursing care. 369

(R) "Medical record" means the personal information that 370
relates to an individual's physical or mental condition, medical 371
history, or medical treatment. 372

(S) (1) "Open panel plan" means a health care plan that 373
provides incentives for enrollees to use participating providers 374
and that also allows enrollees to use providers that are not 375
participating providers. 376

(2) No health insuring corporation may offer an open panel 377
plan, unless the health insuring corporation is also licensed as 378
an insurer under Title XXXIX of the Revised Code, the health 379
insuring corporation, on June 4, 1997, holds a certificate of 380
authority or license to operate under Chapter 1736. or 1740. of 381
the Revised Code, or an insurer licensed under Title XXXIX of 382
the Revised Code is responsible for the out-of-network risk as 383
evidenced by both an evidence of coverage filing under section 384
1751.11 of the Revised Code and a policy and certificate filing 385
under section 3923.02 of the Revised Code. 386

(T) "Osteopathic hospital" means a hospital registered 387
under section 3701.07 of the Revised Code that advocates 388
osteopathic principles and the practice and perpetuation of 389
osteopathic medicine by doing any of the following: 390

(1) Maintaining a department or service of osteopathic 391
medicine or a committee on the utilization of osteopathic 392
principles and methods, under the supervision of an osteopathic 393
physician; 394

(2) Maintaining an active medical staff, the majority of 395
which is comprised of osteopathic physicians; 396

(3) Maintaining a medical staff executive committee that 397
has osteopathic physicians as a majority of its members. 398

(U) "Panel" means a group of providers or health care 399
facilities that have joined together to deliver health care 400
services through a contractual arrangement with a health 401
insuring corporation, employer group, or other payor. 402

(V) "Person" has the same meaning as in section 1.59 of 403
the Revised Code, and, unless the context otherwise requires, 404
includes any insurance company holding a certificate of 405
authority under Title XXXIX of the Revised Code, any subsidiary 406
and affiliate of an insurance company, and any government 407
agency. 408

(W) "Premium rate" means any set fee regularly paid by a 409
subscriber to a health insuring corporation. A "premium rate" 410
does not include a one-time membership fee, an annual 411
administrative fee, or a nominal access fee, paid to a managed 412
health care system under which the recipient of health care 413
services remains solely responsible for any charges accessed for 414
those services by the provider or health care facility. 415

(X) "Primary care provider" means a provider that is 416
designated by a health insuring corporation to supervise, 417
coordinate, or provide initial care or continuing care to an 418
enrollee, and that may be required by the health insuring 419

corporation to initiate a referral for specialty care and to 420
maintain supervision of the health care services rendered to the 421
enrollee. 422

(Y) "Provider" means any natural person or partnership of 423
natural persons who are licensed, certified, accredited, or 424
otherwise authorized in this state to furnish health care 425
services, or any professional association organized under 426
Chapter 1785. of the Revised Code, provided that nothing in this 427
chapter or other provisions of law shall be construed to 428
preclude a health insuring corporation, health care 429
practitioner, or organized health care group associated with a 430
health insuring corporation from employing certified nurse 431
practitioners, certified nurse anesthetists, clinical nurse 432
specialists, certified nurse-midwives, pharmacists, dietitians, 433
physician assistants, dental assistants, dental hygienists, 434
optometric technicians, or other allied health personnel who are 435
licensed, certified, accredited, or otherwise authorized in this 436
state to furnish health care services. 437

(Z) "Provider sponsored organization" means a corporation, 438
as defined in division (H) of this section, that is at least 439
eighty per cent owned or controlled by one or more hospitals, as 440
defined in section 3727.01 of the Revised Code, or one or more 441
physicians licensed to practice medicine or surgery or 442
osteopathic medicine and surgery under Chapter 4731. of the 443
Revised Code, or any combination of such physicians and 444
hospitals. Such control is presumed to exist if at least eighty 445
per cent of the voting rights or governance rights of a provider 446
sponsored organization are directly or indirectly owned, 447
controlled, or otherwise held by any combination of the 448
physicians and hospitals described in this division. 449

(AA) "Solicitation document" means the written materials 450
provided to prospective subscribers or enrollees, or both, and 451
used for advertising and marketing to induce enrollment in the 452
health care plans of a health insuring corporation. 453

(BB) "Subscriber" means a person who is responsible for 454
making payments to a health insuring corporation for 455
participation in a health care plan, or an enrollee whose 456
employment or other status is the basis of eligibility for 457
enrollment in a health insuring corporation. 458

(CC) "Urgent care services" means those health care 459
services that are appropriately provided for an unforeseen 460
condition of a kind that usually requires medical attention 461
without delay but that does not pose a threat to the life, limb, 462
or permanent health of the injured or ill person, and may 463
include such health care services provided out of the health 464
insuring corporation's approved service area pursuant to 465
indemnity payments or service agreements. 466

Sec. 1751.91. A health insuring corporation may provide 467
payment or reimbursement to a pharmacist for providing a health 468
care service to a patient if both of the following are the case: 469

(A) The pharmacist provided the health care service to the 470
patient in accordance with Chapter 4729. of the Revised Code, 471
including any of the following services: 472

(1) Managing drug therapy under a consult agreement with a 473
physician pursuant to section 4729.39 of the Revised Code; 474

(2) Administering immunizations in accordance with section 475
4729.41 of the Revised Code; 476

(3) Administering drugs in accordance with section 4729.45 477
of the Revised Code. 478

(B) The patient's individual or group health insuring 479
corporation policy, contract, or agreement provides for payment 480
or reimbursement of the service. 481

Sec. 3702.30. (A) As used in this section: 482

(1) "Ambulatory surgical facility" means a facility, 483
whether or not part of the same organization as a hospital, that 484
is located in a building distinct from another in which 485
inpatient care is provided, and to which any of the following 486
apply: 487

(a) Outpatient surgery is routinely performed in the 488
facility, and the facility functions separately from a 489
hospital's inpatient surgical service and from the offices of 490
private physicians, podiatrists, and dentists. 491

(b) Anesthesia is administered in the facility by an 492
anesthesiologist or certified registered nurse anesthetist, and 493
the facility functions separately from a hospital's inpatient 494
surgical service and from the offices of private physicians, 495
podiatrists, and dentists. 496

(c) The facility applies to be certified by the United 497
States centers for medicare and medicaid services as an 498
ambulatory surgical center for purposes of reimbursement under 499
Part B of the medicare program, Part B of Title XVIII of the 500
"Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1395, as 501
amended. 502

(d) The facility applies to be certified by a national 503
accrediting body approved by the centers for medicare and 504
medicaid services for purposes of deemed compliance with the 505
conditions for participating in the medicare program as an 506
ambulatory surgical center. 507

(e) The facility bills or receives from any third-party payer, governmental health care program, or other person or government entity any ambulatory surgical facility fee that is billed or paid in addition to any fee for professional services.

(f) The facility is held out to any person or government entity as an ambulatory surgical facility or similar facility by means of signage, advertising, or other promotional efforts.

"Ambulatory surgical facility" does not include a hospital emergency department.

(2) "Ambulatory surgical facility fee" means a fee for certain overhead costs associated with providing surgical services in an outpatient setting. A fee is an ambulatory surgical facility fee only if it directly or indirectly pays for costs associated with any of the following:

(a) Use of operating and recovery rooms, preparation areas, and waiting rooms and lounges for patients and relatives;

(b) Administrative functions, record keeping, housekeeping, utilities, and rent;

(c) Services provided by nurses, pharmacists, orderlies, technical personnel, and others involved in patient care related to providing surgery.

"Ambulatory surgical facility fee" does not include any additional payment in excess of a professional fee that is provided to encourage physicians, podiatrists, and dentists to perform certain surgical procedures in their office or their group practice's office rather than a health care facility, if the purpose of the additional fee is to compensate for additional cost incurred in performing office-based surgery.

(3) "Governmental health care program" has the same	536
meaning as in section 4731.65 of the Revised Code.	537
(4) "Health care facility" means any of the following:	538
(a) An ambulatory surgical facility;	539
(b) A freestanding dialysis center;	540
(c) A freestanding inpatient rehabilitation facility;	541
(d) A freestanding birthing center;	542
(e) A freestanding radiation therapy center;	543
(f) A freestanding or mobile diagnostic imaging center.	544
(5) "Third-party payer" has the same meaning as in section	545
3901.38 of the Revised Code.	546
(B) By rule adopted in accordance with sections 3702.12	547
and 3702.13 of the Revised Code, the director of health shall	548
establish quality standards for health care facilities. The	549
standards may incorporate accreditation standards or other	550
quality standards established by any entity recognized by the	551
director.	552
In the case of an ambulatory surgical facility, the	553
standards shall require the ambulatory surgical facility to	554
maintain an infection control program. The purposes of the	555
program are to minimize infections and communicable diseases and	556
facilitate a functional and sanitary environment consistent with	557
standards of professional practice. To achieve these purposes,	558
ambulatory surgical facility staff managing the program shall	559
create and administer a plan designed to prevent, identify, and	560
manage infections and communicable diseases; ensure that the	561
program is directed by a qualified professional trained in	562

infection control; ensure that the program is an integral part 563
of the ambulatory surgical facility's quality assessment and 564
performance improvement program; and implement in an expeditious 565
manner corrective and preventive measures that result in 566
improvement. 567

(C) Every ambulatory surgical facility shall require that 568
each physician who practices at the facility comply with all 569
relevant provisions in the Revised Code that relate to the 570
obtaining of informed consent from a patient. 571

(D) The director shall issue a license to each health care 572
facility that makes application for a license and demonstrates 573
to the director that it meets the quality standards established 574
by the rules adopted under division (B) of this section and 575
satisfies the informed consent compliance requirements specified 576
in division (C) of this section. 577

(E) (1) Except as provided in division (H) of this section 578
and in section 3702.301 of the Revised Code, no health care 579
facility shall operate without a license issued under this 580
section. 581

(2) If the department of health finds that a physician who 582
practices at a health care facility is not complying with any 583
provision of the Revised Code related to the obtaining of 584
informed consent from a patient, the department shall report its 585
finding to the state medical board, the physician, and the 586
health care facility. 587

(3) This division does not create, and shall not be 588
construed as creating, a new cause of action or substantive 589
legal right against a health care facility and in favor of a 590
patient who allegedly sustains harm as a result of the failure 591

of the patient's physician to obtain informed consent from the 592
patient prior to performing a procedure on or otherwise caring 593
for the patient in the health care facility. 594

(F) The rules adopted under division (B) of this section 595
shall include all of the following: 596

(1) Provisions governing application for, renewal, 597
suspension, and revocation of a license under this section; 598

(2) Provisions governing orders issued pursuant to section 599
3702.32 of the Revised Code for a health care facility to cease 600
its operations or to prohibit certain types of services provided 601
by a health care facility; 602

(3) Provisions governing the imposition under section 603
3702.32 of the Revised Code of civil penalties for violations of 604
this section or the rules adopted under this section, including 605
a scale for determining the amount of the penalties; 606

(4) Provisions specifying the form inspectors must use 607
when conducting inspections of ambulatory surgical facilities. 608

(G) An ambulatory surgical facility that performs or 609
induces abortions shall comply with section 3701.791 of the 610
Revised Code. 611

(H) The following entities are not required to obtain a 612
license as a freestanding diagnostic imaging center issued under 613
this section: 614

(1) A hospital registered under section 3701.07 of the 615
Revised Code that provides diagnostic imaging; 616

(2) An entity that is reviewed as part of a hospital 617
accreditation or certification program and that provides 618
diagnostic imaging; 619

(3) An ambulatory surgical facility that provides 620
diagnostic imaging in conjunction with or during any portion of 621
a surgical procedure. 622

Sec. 3712.06. Any person or public agency licensed under 623
section 3712.04 of the Revised Code to provide a hospice care 624
program shall: 625

(A) Provide a planned and continuous hospice care program, 626
the medical components of which shall be under the direction of 627
a physician; 628

(B) Ensure that care is available twenty-four hours a day 629
and seven days a week; 630

(C) Establish an interdisciplinary plan of care for each 631
hospice patient and ~~his~~ the patient's family that: 632

(1) Is coordinated by one designated individual who shall 633
ensure that all components of the plan of care are addressed and 634
implemented; 635

(2) Addresses maintenance of patient-family participation 636
in decision making; and 637

(3) Is periodically reviewed by the patient's attending 638
physician and by the patient's interdisciplinary team. 639

(D) Have an interdisciplinary team or teams that provide 640
or supervise the provision of care and establish the policies 641
governing the provision of the care; 642

(E) Provide bereavement counseling for hospice patients' 643
families; 644

(F) Not discontinue care because of a hospice patient's 645
inability to pay for the care; 646

(G) Maintain central clinical records on all hospice 647
patients under its care; and 648

(H) Provide care in individuals' homes, on an outpatient 649
basis, and on a short-term inpatient basis. 650

A provider of a hospice care program may include 651
pharmacist services among the other services that are made 652
available to its hospice patients. 653

A provider of a hospice care program may arrange for 654
another person or public agency to furnish a component or 655
components of the hospice care program pursuant to a written 656
contract. When a provider of a hospice care program arranges for 657
a hospital, a home providing nursing care, or home health agency 658
to furnish a component or components of the hospice care program 659
to its patient, the care shall be provided by a licensed, 660
certified, or accredited hospital, home providing nursing care, 661
or home health agency pursuant to a written contract under 662
which: 663

(1) The provider of a hospice care program furnishes to 664
the contractor a copy of the hospice patient's interdisciplinary 665
plan of care that is established under division (C) of this 666
section and specifies the care that is to be furnished by the 667
contractor; 668

(2) The regimen described in the established plan of care 669
is continued while the hospice patient receives care from the 670
contractor, subject to the patient's needs, and with approval of 671
the coordinator of the interdisciplinary team designated 672
pursuant to division (C) (1) of this section; 673

(3) All care, treatment, and services furnished by the 674
contractor are entered into the hospice patient's medical 675

record; 676

(4) The designated coordinator of the interdisciplinary 677
team ensures conformance with the established plan of care; and 678

(5) A copy of the contractor's medical record and 679
discharge summary is retained as part of the hospice patient's 680
medical record. 681

Any hospital contracting for inpatient care shall be 682
encouraged to offer temporary limited privileges to the hospice 683
patient's attending physician while the hospice patient is 684
receiving inpatient care from the hospital. 685

Sec. 3712.061. (A) Any person or public agency licensed 686
under section 3712.041 of the Revised Code to provide a 687
pediatric respite care program shall do all of the following: 688

(1) Provide a planned and continuous pediatric respite 689
care program, the medical components of which shall be under the 690
direction of a physician; 691

(2) Ensure that care is available twenty-four hours a day 692
and seven days a week; 693

(3) Establish an interdisciplinary plan of care for each 694
pediatric respite care patient and the patient's family that: 695

(a) Is coordinated by one designated individual who shall 696
ensure that all components of the plan of care are addressed and 697
implemented; 698

(b) Addresses maintenance of patient-family participation 699
in decision making; and 700

(c) Is reviewed by the patient's attending physician and 701
by the patient's interdisciplinary team immediately prior to or 702

on admission to each session of respite care. 703

(4) Have an interdisciplinary team or teams that provide 704
or supervise the provision of pediatric respite care program 705
services and establish the policies governing the provision of 706
the services; 707

(5) Maintain central clinical records on all pediatric 708
respite care patients under its care. 709

(B) A provider of a pediatric respite care program may 710
include pharmacist services among the other services that are 711
made available to its pediatric respite care patients. 712

(C) A provider of a pediatric respite care program may 713
arrange for another person or public agency to furnish a 714
component or components of the pediatric respite care program 715
pursuant to a written contract. When a provider of a pediatric 716
respite care program arranges for a home health agency to 717
furnish a component or components of the pediatric respite care 718
program to its patient, the care shall be provided by a home 719
health agency pursuant to a written contract under which: 720

(1) The provider of a pediatric respite care program 721
furnishes to the contractor a copy of the pediatric respite care 722
patient's interdisciplinary plan of care that is established 723
under division (A) (3) of this section and specifies the care 724
that is to be furnished by the contractor; 725

(2) The regimen described in the established plan of care 726
is continued while the pediatric respite care patient receives 727
care from the contractor, subject to the patient's needs, and 728
with approval of the coordinator of the interdisciplinary team 729
designated pursuant to division (A) (3) (a) of this section; 730

(3) All care, treatment, and services furnished by the 731

contractor are entered into the pediatric respite care patient's 732
medical record; 733

(4) The designated coordinator of the interdisciplinary 734
team ensures conformance with the established plan of care; and 735

(5) A copy of the contractor's medical record and 736
discharge summary is retained as part of the pediatric respite 737
care patient's medical record. 738

Sec. 3923.89. A sickness and accident insurer or public 739
employee benefit plan may provide payment or reimbursement to a 740
pharmacist for providing a health care service to a patient if 741
both of the following are the case: 742

(A) The pharmacist provided the health care service to the 743
patient in accordance with Chapter 4729. of the Revised Code, 744
including any of the following services: 745

(1) Managing drug therapy under a consult agreement with a 746
physician pursuant to section 4729.39 of the Revised Code; 747

(2) Administering immunizations in accordance with section 748
4729.41 of the Revised Code; 749

(3) Administering drugs in accordance with section 4729.45 750
of the Revised Code. 751

(B) The patient's individual or group policy of sickness 752
and accident insurance or public employee benefit plan provides 753
for payment or reimbursement of the service. 754

Sec. 3963.01. As used in this chapter: 755

(A) "Affiliate" means any person or entity that has 756
ownership or control of a contracting entity, is owned or 757
controlled by a contracting entity, or is under common ownership 758

or control with a contracting entity. 759

(B) "Basic health care services" has the same meaning as 760
in division (A) of section 1751.01 of the Revised Code, except 761
that it does not include any services listed in that division 762
that are provided by a pharmacist or nursing home. 763

(C) "Contracting entity" means any person that has a 764
primary business purpose of contracting with participating 765
providers for the delivery of health care services. 766

(D) "Credentialing" means the process of assessing and 767
validating the qualifications of a provider applying to be 768
approved by a contracting entity to provide basic health care 769
services, specialty health care services, or supplemental health 770
care services to enrollees. 771

(E) "Edit" means adjusting one or more procedure codes 772
billed by a participating provider on a claim for payment or a 773
practice that results in any of the following: 774

(1) Payment for some, but not all of the procedure codes 775
originally billed by a participating provider; 776

(2) Payment for a different procedure code than the 777
procedure code originally billed by a participating provider; 778

(3) A reduced payment as a result of services provided to 779
an enrollee that are claimed under more than one procedure code 780
on the same service date. 781

(F) "Electronic claims transport" means to accept and 782
digitize claims or to accept claims already digitized, to place 783
those claims into a format that complies with the electronic 784
transaction standards issued by the United States department of 785
health and human services pursuant to the "Health Insurance 786

Portability and Accountability Act of 1996," 110 Stat. 1955, 42 787
U.S.C. 1320d, et seq., as those electronic standards are 788
applicable to the parties and as those electronic standards are 789
updated from time to time, and to electronically transmit those 790
claims to the appropriate contracting entity, payer, or third- 791
party administrator. 792

(G) "Enrollee" means any person eligible for health care 793
benefits under a health benefit plan, including an eligible 794
recipient of medicaid, and includes all of the following terms: 795

(1) "Enrollee" and "subscriber" as defined by section 796
1751.01 of the Revised Code; 797

(2) "Member" as defined by section 1739.01 of the Revised 798
Code; 799

(3) "Insured" and "plan member" pursuant to Chapter 3923. 800
of the Revised Code; 801

(4) "Beneficiary" as defined by section 3901.38 of the 802
Revised Code. 803

(H) "Health care contract" means a contract entered into, 804
materially amended, or renewed between a contracting entity and 805
a participating provider for the delivery of basic health care 806
services, specialty health care services, or supplemental health 807
care services to enrollees. 808

(I) "Health care services" means basic health care 809
services, specialty health care services, and supplemental 810
health care services. 811

(J) "Material amendment" means an amendment to a health 812
care contract that decreases the participating provider's 813
payment or compensation, changes the administrative procedures 814

in a way that may reasonably be expected to significantly 815
increase the provider's administrative expenses, or adds a new 816
product. A material amendment does not include any of the 817
following: 818

(1) A decrease in payment or compensation resulting solely 819
from a change in a published fee schedule upon which the payment 820
or compensation is based and the date of applicability is 821
clearly identified in the contract; 822

(2) A decrease in payment or compensation that was 823
anticipated under the terms of the contract, if the amount and 824
date of applicability of the decrease is clearly identified in 825
the contract; 826

(3) An administrative change that may significantly 827
increase the provider's administrative expense, the specific 828
applicability of which is clearly identified in the contract; 829

(4) Changes to an existing prior authorization, 830
precertification, notification, or referral program that do not 831
substantially increase the provider's administrative expense; 832

(5) Changes to an edit program or to specific edits if the 833
participating provider is provided notice of the changes 834
pursuant to division (A) (1) of section 3963.04 of the Revised 835
Code and the notice includes information sufficient for the 836
provider to determine the effect of the change; 837

(6) Changes to a health care contract described in 838
division (B) of section 3963.04 of the Revised Code. 839

(K) "Participating provider" means a provider that has a 840
health care contract with a contracting entity and is entitled 841
to reimbursement for health care services rendered to an 842
enrollee under the health care contract. 843

(L) "Payer" means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health care contract.

(M) "Primary enrollee" means a person who is responsible for making payments for participation in a health care plan or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health care plan.

(N) "Procedure codes" includes the American medical association's current procedural terminology code, the American dental association's current dental terminology, and the centers for medicare and medicaid services health care common procedure coding system.

(O) "Product" means one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

(1) A health maintenance organization or other product provided by a health insuring corporation;

(2) A preferred provider organization;

(3) Medicare;

(4) Medicaid;

(5) Workers' compensation.

(P) "Provider" means a physician, podiatrist, pharmacist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice registered nurse, occupational therapist, massage therapist, physical therapist, licensed professional counselor, licensed professional clinical

counselor, hearing aid dealer, orthotist, prosthetist, home 872
health agency, hospice care program, pediatric respite care 873
program, or hospital, or a provider organization or physician- 874
hospital organization that is acting exclusively as an 875
administrator on behalf of a provider to facilitate the 876
provider's participation in health care contracts. ~~"Provider"~~ 877

"Provider" does not mean ~~a pharmacist, pharmacy, either of~~ 878
the following: 879

(1) A nursing home, or a ; 880

(2) A provider organization or physician-hospital 881
organization that leases the provider organization's or 882
physician-hospital organization's network to a third party or 883
contracts directly with employers or health and welfare funds. 884

(Q) "Specialty health care services" has the same meaning 885
as in section 1751.01 of the Revised Code, except that it does 886
not include any services listed in division (B) of section 887
1751.01 of the Revised Code that are provided by a pharmacist or 888
a nursing home. 889

(R) "Supplemental health care services" has the same 890
meaning as in division (B) of section 1751.01 of the Revised 891
Code, except that it does not include any services listed in 892
that division that are provided by a pharmacist or nursing home. 893

Sec. 5164.14. The medicaid program may cover a health care 894
service that a pharmacist provides to a medicaid recipient in 895
accordance with Chapter 4729. of the Revised Code, including any 896
of the following services: 897

(A) Managing drug therapy under a consult agreement with a 898
physician pursuant to section 4729.39 of the Revised Code; 899

(B) Administering immunizations in accordance with section 4729.41 of the Revised Code; 900
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(C) Administering drugs in accordance with section 4729.45 of the Revised Code. 902
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Sec. 5167.121. If the medicaid program covers the pharmacist services described in section 5164.14 of the Revised Code, the department of medicaid may require a medicaid managed care organization to provide coverage of the pharmacist services to the same extent when the services are provided to a medicaid recipient who is enrolled in the organization as a part of the care management system established under section 5167.03 of the Revised Code. 904
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Section 2. That existing sections 173.12, 341.192, 1739.05, 1751.01, 3702.30, 3712.06, 3712.061, and 3963.01 of the Revised Code are hereby repealed. 912
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Section 3. Sections 1739.05, 1751.01, and 3923.89 of the Revised Code, as amended or enacted by this act, apply to health benefit plans that are delivered, issued for delivery, or renewed in this state on or after the effective date of this act. Section 3963.01 of the Revised Code, as amended by this act, applies to health care contracts that are entered into, materially amended, or renewed on or after the effective date of this act. 915
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Section 4. Section 1739.05 of the Revised Code is presented in this act as a composite of the section as amended by both Sub. H.B. 463 and Sub. S.B. 319 of the 131st General Assembly. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous 923
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operation, finds that the composite is the resulting version of	929
the section in effect prior to the effective date of the section	930
as presented in this act.	931