(132nd General Assembly)
(Substitute Senate Bill Number 265)

AN ACT

To amend sections 173.12, 341.192, 1739.05, 1751.01, 3702.30, 3712.06, 3712.061, 3963.01, and 5167.12 and to enact sections 1751.91, 3901.83, 3901.831, 3901.832, 3901.833, 3923.89, 5164.14, 5164.7512, 5164.7514, and 5167.121 of the Revised Code to permit certain health insurers to provide payment or reimbursement for services lawfully provided by a pharmacist, to adopt requirements related to step therapy protocols, 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, 3963.01, and 5167.12 be amended and sections 1751.91, 3901.83, 3901.831, 3901.832, 3901.833, 3923.89, 5164.14, 5164.7512, 5164.7514, 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 contributions to the center, but no otherwise eligible person shall be refused services because of inability to make a contribution.

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

(A) Services available within the facility:

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

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

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

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

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

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

(B) Services provided outside the facility:

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

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

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

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

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

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

The department of aging, or the local entity approved by the department under section 173.11 of the Revised Code for the operation of a center, may contract for any or all of the services provided by the center with any other state agency, county, township, municipal corporation, school district, community or technical college district, health district, person, or organization.

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

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

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

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

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

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

(B) If a physician employed by or under contract to a county, municipal corporation, township, the department of youth services, or the department of rehabilitation and correction to provide medical services to persons confined in a jail or state correctional institution determines that a person who is confined in the jail or state correctional institution or who is in the custody of a law enforcement officer prior to the person's confinement in a jail or state correctional institution requires

necessary care that the physician cannot provide, the necessary care shall be provided by a medical provider. The county, municipal corporation, township, the department of youth services, or the department of rehabilitation and correction shall pay a medical provider for necessary care an amount not exceeding the authorized reimbursement rate for the same service established by the department of medicaid under the medicaid program.

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

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

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

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

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 3923.80, 3923.84, 3923.85, 3923.851, 3923.89, 3924.031, 3924.032, and 3924.27 of the Revised Code.

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

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

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

Sec. 1751.01. As used in this chapter:

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

(a) Physician's services, except when such services are supplemental under division (B) of this section;

(b) Inpatient hospital services;

(c) Outpatient medical services;

(d) Emergency health services;

(e) Urgent care services;

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;

(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;

(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.

"Basic health care services" does not include experimental procedures.

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

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.

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

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

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

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

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

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

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

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(a) Services of facilities for intermediate or long-term care, or both;

(b) Dental care services;

(c) Vision care and optometric services including lenses and frames;

(d) Podiatric care or foot care services;

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;

(f) Short-term outpatient evaluative and crisis-intervention mental health services;

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

(h) Home health services;

(i) Prescription drug services;

(j) Nursing services;

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(l) Physical therapy services;

(m) Chiropractic services;

(n) Any other category of services approved by the superintendent of insurance.

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

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

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

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

(F) "Compensation" means remuneration for the provision of health care services, determined

on other than a fee-for-service or discounted-fee-for-service basis.

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

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

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

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

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

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

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

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

(O) "Health insuring corporation" means a corporation, as defined in division (H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

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

(P) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

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

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

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

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

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

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

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

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

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

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

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

(X) "Primary care provider" means a provider that is designated by a health insuring

corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

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

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

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

(BB) "Subscriber" means a person who is responsible for making payments to a health insuring corporation 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 insuring corporation.

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 meaning as in section 4731.65 of the Revised Code.

(4) "Health care facility" means any of the following:

(a) An ambulatory surgical facility;

(b) A freestanding dialysis center;

(c) A freestanding inpatient rehabilitation facility;

(d) A freestanding birthing center;

(e) A freestanding radiation therapy center;

(f) A freestanding or mobile diagnostic imaging center.

(5) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

(B) By rule adopted in accordance with sections 3702.12 and 3702.13 of the Revised Code, the director of health shall establish quality standards for health care facilities. The standards may incorporate accreditation standards or other quality standards established by any entity recognized by the director.

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

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

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

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

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

(3) This division does not create, and shall not be construed as creating, a new cause of action or substantive legal right against a health care facility and in favor of a patient who allegedly sustains harm as a result of the failure of the patient's physician to obtain informed consent from the patient prior to performing a procedure on or otherwise caring for the patient in the health care facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Is reviewed by the patient's attending physician and by the patient's interdisciplinary team immediately prior to or on admission to each session of respite care.

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

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

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

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

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

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

(3) All care, treatment, and services furnished by the contractor are entered into the pediatric respite care patient's medical record;

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

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

Sec. 3901.83. As used in sections 3901.83 to 3901.833 of the Revised Code:

(A) "Clinical practice guidelines" means a systematically developed statement to assist health care provider and patient decisions with regard to appropriate health care for specific clinical circumstances and conditions.

(B) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health plan issuer or utilization review organization to determine whether or not health care services or drugs are appropriate and consistent with medical or scientific evidence.

(C) "Health benefit plan" and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(D) "Medical or scientific evidence" has the same meaning as in section 3922.01 of the Revised Code.

(E) "Step therapy exemption" means an overriding of a step therapy protocol in favor of immediate coverage of the health care provider's selected prescription drug.

(F) "Step therapy protocol" means a protocol or program that establishes a specific sequence in which prescription drugs that are for a specified medical condition and that are consistent with medical or scientific evidence for a particular patient are covered, under either a medical or prescription drug benefit, by a health benefit plan, including both self-administered and physician-administered drugs.

(G) "Urgent care services" has the same meaning as in section 3923.041 of the Revised Code.

(H) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.

Sec. 3901.831. (A) If a health plan issuer or a utilization review organization implements a step therapy protocol, that protocol shall be implemented via clinical review criteria that are based on clinical practice guidelines or medical or scientific evidence.

(B) When establishing a step therapy protocol, a health plan issuer and a utilization review organization shall also take into account the needs of atypical patient populations and diagnoses when establishing clinical review criteria.

(C) This section shall not be construed as requiring either a health plan issuer or the state to set up a new entity to develop clinical review criteria for step therapy protocols.

Sec. 3901.832. (A)(1)(a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a health plan issuer or utilization review organization through the use of a step therapy protocol, the health plan issuer or utilization review organization shall provide the prescribing health care provider access to a clear, easily accessible, and convenient process to request a step therapy exemption on behalf of a covered individual. A health plan issuer or utilization review organization may use its existing medical exceptions process to satisfy this

requirement.

(b) A step therapy exemption request shall include supporting documentation and rationale.

(2)(a) A health plan issuer shall make available, to all health care providers, a list of all drugs covered by the issuer that are subject to a step therapy protocol. If the health plan issuer offers more than one health benefit plan, and the covered drugs subject to a step therapy protocol vary from one plan to another, then the health plan issuer shall issue a separate list for each plan.

(b) Along with the information required under division (A)(2)(a) of this section, a health plan issuer shall indicate what information or documentation must be provided to the issuer or organization for a step therapy exemption request to be considered complete. Such information shall be provided for each drug, if the requirements vary according to the drug, plan, or protocol in question.

(3)(a) The list required under division (A)(2)(a) of this section, along with the required information or documentation described in division (A)(2)(b) of this section, shall be made available on the issuer's web site or provider portal.

(b) A utilization review organization shall, for each health benefit plan it oversees that implements a step therapy protocol, similarly make the list and information required under divisions (A)(2)(a) and (b) of this section available on its web site or provider portal.

(4) From the time a step therapy exemption request is received by a health plan issuer or utilization review organization, the issuer or organization shall either grant or deny the request within the following time frames:

(a) Forty-eight hours for a request related to urgent care services;

(b) Ten calendar days for all other requests.

(5)(a) A provider may, on behalf of the covered individual, appeal any exemption request that is denied.

(b) From the time an appeal is received by a health plan issuer or utilization review organization, the issuer or organization shall either grant or deny the appeal within the following time frames:

(i) Forty-eight hours for appeals related to urgent care services;

(ii) Ten calendar days for all other appeals.

(c) The appeal shall be between the health care provider requesting the service in question and a clinical peer, as defined in section 3923.041 of the Revised Code.

(d)(i) The appeal shall be considered an internal appeal for purposes of section 3922.03 of the Revised Code.

(ii) A health plan issuer shall not impose a step therapy exemption appeal as an additional level of appeal beyond what is required under section 3922.03 of the Revised Code, unless otherwise permitted by law.

(e)(i) If the appeal does not resolve the disagreement, the covered individual, or the covered individual's authorized representative, may request an external review under Chapter 3922. of the Revised Code to the extent Chapter 3922. of the Revised Code is applicable.

(ii) As used in division (A)(5)(e) of this section, "authorized representative" has the same meaning as in section 3922.01 of the Revised Code.

(6) If a health plan issuer or utilization review organization does not either grant or deny an

exemption request or an appeal within the time frames prescribed in division (A)(4) or (5) of this section, then such an exemption request or appeal shall be deemed to be granted.

(B) Pursuant to a step therapy exemption request initiated under division (A)(1) of this section or an appeal made under division (A)(5) of this section, a health plan issuer or utilization review organization shall grant a step therapy exemption if any of the following are met:

(1) The required prescription drug is contraindicated for that specific patient, pursuant to the drug's United States food and drug administration prescribing information.

(2) The patient has tried the required prescription drug while under their current, or a previous, health benefit plan, or another United States food and drug administration approved AB-rated prescription drug, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(3) The patient is stable on a prescription drug selected by the patient's health care provider for the medical condition under consideration, regardless of whether or not the drug was prescribed when the patient was covered under the current or a previous health benefit plan, or has already gone through a step therapy protocol. However, a health benefit plan may require a stable patient to try a pharmaceutical alternative, per the federal food and drug administration's orange book, purple book, or their successors, prior to providing coverage for the prescribed drug.

(C) Upon the granting of a step therapy exemption, the health plan issuer or utilization review organization shall authorize coverage for the prescription drug prescribed by the patient's treating health care provider.

(D) This section shall not be construed to prevent either of the following:

(1) A health plan issuer or utilization review organization from requiring a patient to try any new or existing pharmaceutical alternative, per the federal food and drug administration's orange book, purple book, or their successors, prior to providing or renewing coverage for the prescribed drug;

(2) A health care provider from prescribing a prescription drug, consistent with medical or scientific evidence.

(E) Committing a series of violations of this section that, taken together, constitute a practice or pattern shall be considered an unfair and deceptive practice under sections 3901.19 to 3901.26 of the Revised Code.

Sec. 3901.833. The superintendent of insurance may adopt rules as necessary to enforce sections 3901.83 to 3901.833 of the Revised Code.

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

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

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

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

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

(B) The patient's individual or group policy of sickness and accident insurance or public

employee benefit plan provides for payment or reimbursement of the service.

Sec. 3963.01. As used in this chapter:

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

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

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

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

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

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

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

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

(F) "Electronic claims transport" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States department of health and human services pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator.

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

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

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

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

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

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

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

(J) "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or

adds a new product. A material amendment does not include any of the following:

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

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

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

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

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

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

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

(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 health agency, hospice care program, pediatric respite care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in

health care contracts. ~~"Provider"~~

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

(1) A nursing home~~, or a~~ ;

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

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

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

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

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

(B) Administering immunizations in accordance with section 4729.41 of the Revised Code;

(C) Administering drugs in accordance with section 4729.45 of the Revised Code.

Sec. 5164.7512. (A) As used in sections 5164.7512 to 5164.7514 of the Revised Code:

(1) "Clinical practice guidelines" means a systematically developed statement to assist providers and medicaid recipients in making decisions about appropriate health care for specific clinical circumstances and conditions.

(2) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by the medicaid program to determine whether or not a health care service or drug is appropriate and consistent with medical or scientific evidence.

(3) "Medical or scientific evidence" has the same meaning as in section 3922.01 of the Revised Code.

(4) "Step therapy exemption" means an overriding of a step therapy protocol in favor of immediate coverage of a medicaid provider's selected prescription drug.

(5) "Step therapy protocol" means a protocol under which it is determined through a specific sequence whether the medicaid program, under either a pharmacy or medical benefit, will pay for a prescribed drug that a medicaid provider, consistent with medical or scientific evidence, prescribes for a medicaid recipient's specified medical condition, including both self-administered and physician-administered drugs.

(6) "Urgent care services" has the same meaning as in section 3922.041 of the Revised Code.

(B) If the department of medicaid utilizes a step therapy protocol for the medicaid program under which it is recommended that prescribed drugs be taken in a specific sequence, the department shall do all of the following:

(1) Implement that step therapy protocol using clinical review criteria that are based on clinical practice guidelines or medical or scientific evidence. The department shall take into account

the needs of atypical patient populations and diagnoses when establishing clinical review criteria.

(2) In a manner consistent with section 5164.7514 of the Revised Code, establish and implement a step therapy exemption process under which medicaid recipients and medicaid providers who prescribe prescribed drugs for medicaid recipients may request and receive a step therapy exemption;

(3)(a) Make available, to all medicaid providers, a list of all drugs covered by the medicaid program that are subject to a step therapy protocol;

(b) Along with the information required under division (B)(3)(a) of this section, the department of medicaid shall indicate what information or documentation must be provided to the department for a step therapy exemption request to be considered complete. Such information shall be provided for each drug, if the requirements vary according to the drug or protocol in question.

(c) The list required under division (B)(3)(a) of this section, along with all of the required information or documentation described in division (B)(3)(b) of this section, shall be made available on the department of medicaid's web site or provider portal.

(C) This section shall not be construed as requiring the department to set up a new entity to develop clinical review criteria for step therapy protocols.

Sec. 5164.7514. (A) All of the following shall apply to the step therapy exemption process established and implemented by the department of medicaid pursuant to division (B)(2) of section 5164.7512 of the Revised Code:

(1) The process shall be clear and convenient.

(2) The process shall be easily accessible on the department's web site.

(3) The process shall require that a medicaid provider initiate a step therapy exemption request on behalf of a medicaid recipient.

(4) The process shall require supporting documentation and rationale be submitted with each request for a step therapy exemption.

(5) The process shall, pursuant to a step therapy exemption request made under division (B)(2) of section 5164.7512 of the Revised Code or an appeal made under division (B)(2) of this section, require the department to grant a step therapy exemption if either of the following applies:

(a) Either of the following apply to the prescribed drug that would otherwise have to be used under the step therapy protocol:

(i) The required prescription drug is contraindicated for that specific medicaid recipient, pursuant to the drug's United States food and drug administration prescribing information.

(ii) The medicaid recipient tried the required prescription drug while enrolled in medicaid or other health care coverage, or another United States food and drug administration approved AB-rated prescription drug, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(b) The medicaid recipient is stable on the prescribed drug selected by the recipient's medicaid provider for the medical condition under consideration, regardless of whether or not the drug was prescribed while the individual in question was a medicaid recipient, or has already gone through a step therapy protocol. However, the department may require a stable medicaid recipient to try a pharmaceutical alternative, per the federal food and drug administration's orange book, purple book, or their successors, prior to providing coverage for the prescribed drug.

(6) On granting a step therapy exemption, the department shall authorize payment for the prescribed drug prescribed by the medicaid recipient's medicaid provider.

(B)(1) From the time a step therapy exemption request is received, the department shall either grant or deny the request within the following time frames:

(a) Forty-eight hours for requests related to urgent care services;

(b) Ten calendar days for all other requests.

(2)(a) If an exemption request is denied, a medicaid provider may appeal the denial on behalf of the medicaid recipient.

(b) From the time a step therapy appeal is received, the department shall either grant or deny the appeal within the following time frames:

(i) Forty-eight hours for appeals related to urgent care services;

(ii) Ten calendar days for all other appeals.

(3) The appeal shall be between the medicaid provider making the appeal and a clinical peer appointed by or contracted by the department or the department's designee.

(4) If the department does not either grant or deny an exemption request or an appeal within the time frames prescribed in division (B)(1) or (2) of this section, then such an exemption request or appeal shall be deemed to be granted.

(C) If an appeal is rejected, the medicaid recipient in question may make a further appeal in accordance with section 5160.31 of the Revised Code.

(D) This section shall not be construed to prevent either of the following:

(1) The department from requiring a medicaid recipient to try any new or existing pharmaceutical alternative, per the federal food and drug administration's orange book, purple book, or their successors, before authorizing a medicaid payment for the prescribed drug;

(2) A medicaid provider from prescribing a prescribed drug that is determined to be consistent with medical or scientific evidence.

Sec. 5167.12. (A) When contracting under section 5167.10 of the Revised Code with a managed care organization that is a health insuring corporation, the department of medicaid shall require the health insuring corporation to provide coverage of prescribed drugs for medicaid recipients enrolled in the health insuring corporation. In providing the required coverage, the health insuring corporation may use strategies for the management of drug utilization, but any such strategies are subject to ~~divisions (B) and (E)~~ the limitations and requirements of this section and the department's approval.

(B) The department shall not permit a health insuring corporation to impose a prior authorization requirement in the case of a drug to which all of the following apply:

(1) The drug is an antidepressant or antipsychotic.

(2) The drug is administered or dispensed in a standard tablet or capsule form, except that in the case of an antipsychotic, the drug also may be administered or dispensed in a long-acting injectable form.

(3) The drug is prescribed by any of the following:

(a) A physician who is allowed by the health insuring corporation to provide care as a psychiatrist through its credentialing process, as described in division (C) of section 5167.10 of the Revised Code;

(b) A psychiatrist who is practicing at a location on behalf of a community mental health services provider whose mental health services are certified by the department of mental health and addiction services under section 5119.36 of the Revised Code;

(c) A certified nurse practitioner, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code;

(d) A clinical nurse specialist, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code.

(4) The drug is prescribed for a use that is indicated on the drug's labeling, as approved by the federal food and drug administration.

(C) Subject to division (E) of this section, the department shall authorize a health insuring corporation to develop and implement a pharmacy utilization management program under which prior authorization through the program is established as a condition of obtaining a controlled substance pursuant to a prescription.

(D) The department shall require a health insuring corporation to comply with ~~section~~ sections 5164.091, 5164.7511, 5164.7512, and 5164.7514 of the Revised Code ~~with respect to medication synchronization~~, as if the health insuring corporation were the department.

~~(E) The department shall require a health insuring corporation to comply with section 5164.091 of the Revised Code as if the health insuring corporation were the department.~~

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.

SECTION 2. That existing sections 173.12, 341.192, 1739.05, 1751.01, 3702.30, 3712.06, 3712.061, 3963.01, and 5167.12 of the Revised Code are hereby repealed.

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.

SECTION 4. Sections 3901.83 to 3901.833 of the Revised Code, as enacted by this act, shall apply to health benefit plans, as defined in section 3922.01 of the Revised Code, delivered, issued for delivery, modified, or renewed on or after January 1, 2020. Not later than ninety days after the effective date of this act, the Medicaid Director shall submit to the United States Secretary of Health and Human Services a Medicaid state plan amendment as necessary for the implementation of sections 5164.7512, 5164.7514, and 5167.12 of the Revised Code, as amended or enacted by this act.

SECTION 5. 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 operation, finds that the composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act.

_____

Speaker _____ of the House of Representatives.

_____

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

_____

Secretary of State.

File No. _____ Effective Date _____