

As Reported by the House Insurance Committee

131st General Assembly

Regular Session

2015-2016

Sub. S. B. No. 129

Senators Gardner, Cafaro

Cosponsors: Senators Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner, Tavares, Eklund, Hughes, Jones, Obhof, Patton, Sawyer, Schiavoni, Thomas, Uecker Representatives Bishoff, DeVitis, Henne

A BILL

To amend sections 340.034, 1739.05, and 5119.25, to 1
enact sections 1751.72, 3923.041, and 5160.34 of 2
the Revised Code, and to amend Sections 110.12 3
and 812.40 of Am. Sub. H.B. 64 of the 131st 4
General Assembly, to amend Section 812.40 of Am. 5
Sub. H.B. 483 of the 130th General Assembly to 6
amend the law related to the prior authorization 7
requirements of insurers and to delay the 8
effective date of certain laws regarding 9
community mental health and addiction services. 10

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

Section 1. That sections 340.034, 1739.05, and 5119.25 be 11
amended and sections 1751.72, 3923.041, and 5160.34 of the 12
Revised Code be enacted to read as follows: 13

Sec. 340.034. All of the following apply to the recovery 14
housing required by section 340.033 of the Revised Code to be 15
included in the array of treatment services and recovery support 16
for all levels of opioid and co-occurring drug addiction that 17

are part of the continuum of care established by each board of alcohol, drug addiction, and mental health services pursuant to division (A) (11) of section 340.03 of the Revised Code:

(A) The recovery housing shall not be subject to residential facility licensure by the department of mental health and addiction services under section 5119.34 of the Revised Code. In addition, the recovery housing shall not be owned and operated by a board of alcohol, drug addiction, and mental health services unless any of the following applies:

(1) The board owns and operates the recovery housing on ~~September 15, 2016~~ July 1, 2017.

(2) The board utilizes local funds in the development, purchase, or operation of the recovery housing.

(3) The board determines that there is a need for the board to assume the ownership and operation of the recovery housing such as when an existing owner and operator of the recovery housing goes out of business, and the board considers the assumption of ownership and operation of the recovery housing to be in the best interest of the community.

(B) The recovery housing shall have protocols for all of the following:

(1) Administrative oversight;

(2) Quality standards;

(3) Policies and procedures, including house rules, for its residents to which the residents must agree to adhere.

(C) Family members of the recovery housing's residents may reside in the recovery housing to the extent the recovery housing's protocols permit.

(D) The recovery housing shall not limit a resident's duration of stay to an arbitrary or fixed amount of time. Instead, each resident's duration of stay shall be determined by the resident's needs, progress, and willingness to abide by the recovery housing's protocols, in collaboration with the recovery housing's owner and operator, and, if appropriate, in consultation and integration with a community addiction services provider.

(E) The recovery housing may permit its residents to receive medication-assisted treatment.

(F) A recovery housing resident may receive addiction services that are certified by the department of mental health and addiction services under section 5119.36 of the Revised Code.

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, 75
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 76
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 77
3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 78
3924.031, 3924.032, and 3924.27 of the Revised Code. 79

(C) A multiple employer welfare arrangement created 80
pursuant to sections 1739.01 to 1739.22 of the Revised Code 81
shall solicit enrollments only through agents or solicitors 82
licensed pursuant to Chapter 3905. of the Revised Code to sell 83
or solicit sickness and accident insurance. 84

(D) A multiple employer welfare arrangement created 85
pursuant to sections 1739.01 to 1739.22 of the Revised Code 86
shall provide benefits only to individuals who are members, 87
employees of members, or the dependents of members or employees, 88
or are eligible for continuation of coverage under section 89
1751.53 or 3923.38 of the Revised Code or under Title X of the 90
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100
Stat. 227, 29 U.S.C.A. 1161, as amended. 92

(E) A multiple employer welfare arrangement created 93
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 94
subject to, and shall comply with, sections 3903.81 to 3903.93 95
of the Revised Code in the same manner as other life or health 96
insurers, as defined in section 3903.81 of the Revised Code. 97

Sec. 1751.72. (A) As used in this section: 98

(1) "Chronic condition" means a medical condition that has 99
persisted after reasonable efforts have been made to relieve or 100
cure its cause and has continued, either continuously or 101
episodically, for longer than six continuous months. 102

(2) "Clinical peer" means a health care practitioner in 103

the same, or in a similar, specialty that typically manages the 104
medical condition, procedure, or treatment under review. 105

(3) "Covered person" means a person receiving coverage for 106
health services under a policy, contract, or agreement issued by 107
a health insuring corporation. 108

(4) "Emergency services" has the same meaning as in 109
section 1753.28 of the Revised Code. 110

(5) "Fraudulent or materially incorrect information" means 111
any type of intentional deception or misrepresentation made by a 112
person with the knowledge that the deception could result in 113
some unauthorized benefit to the covered person in question. 114

(6) "Health care practitioner" has the same meaning as in 115
section 3701.74 of the Revised Code. 116

(7) "NCPDP SCRIPT standard" means the national council for 117
prescription drug programs SCRIPT standard version 201310 or the 118
most recent standard adopted by the the United States department 119
of health and human services. 120

(8) "Prior authorization requirement" means any practice 121
implemented by a health insuring corporation in which coverage 122
of a health care service, device, or drug is dependent upon a 123
covered person or a health care practitioner obtaining approval 124
from the health insuring corporation prior to the service, 125
device, or drug being performed, received, or prescribed, as 126
applicable. "Prior authorization" includes prospective or 127
utilization review procedures conducted prior to providing a 128
health care service, device, or drug. 129

(9) "Urgent care services" means a medical care or other 130
service for a condition where application of the timeframe for 131
making routine or non-life threatening care determinations is 132

<u>either of the following:</u>	133
<u>(a) Could seriously jeopardize the life, health, or safety</u>	134
<u>of the patient or others due to the patient's psychological</u>	135
<u>state;</u>	136
<u>(b) In the opinion of a practitioner with knowledge of the</u>	137
<u>patient's medical or behavioral condition, would subject the</u>	138
<u>patient to adverse health consequences without the care or</u>	139
<u>treatment that is the subject of the request.</u>	140
<u>(10) "Utilization review" and "utilization review</u>	141
<u>organization" have the same meanings as in section 1751.77 of</u>	142
<u>the Revised Code.</u>	143
<u>(B) If a policy, contract, or agreement issued by a health</u>	144
<u>insuring corporation contains a prior authorization requirement,</u>	145
<u>then all of the following apply:</u>	146
<u>(1) On or before January 1, 2018, the health insuring</u>	147
<u>corporation shall permit health care practitioners to access the</u>	148
<u>prior authorization form through the applicable electronic</u>	149
<u>software system.</u>	150
<u>(2)(a) For policies issued on or after January 1, 2018,</u>	151
<u>the health insuring corporation or other payer acting on behalf</u>	152
<u>of the health insuring corporation, shall accept prior</u>	153
<u>authorization requests through a secure electronic transmission.</u>	154
<u>(b) For policies issued on or after January 1, 2018, the</u>	155
<u>health insuring corporation, a pharmacy benefit manager</u>	156
<u>responsible for handling prior authorization requests, or other</u>	157
<u>payer acting on behalf of the health insuring corporation shall</u>	158
<u>accept and respond to prior prescription benefit authorization</u>	159
<u>requests through a secure electronic transmission using NCPDP</u>	160
<u>SCRIPT standard ePA transactions, and for prior medical benefit</u>	161

authorization requests through a secure electronic transmission 162
using standards established by the council for affordable 163
quality health care on operating rules for information exchange 164
or its successor. 165

(c) For purposes of division (B)(2) of this section, 166
neither of the following shall be considered a secure electronic 167
transmission: 168

(i) A facsimile; 169

(ii) A proprietary payer portal for prescription drug 170
requests that does not use NCPDP SCRIPT standard. 171

(3) For policies issued on or after January 1, 2018, a 172
health care practitioner and health insuring corporation may 173
enter into a contractual arrangement under which the health 174
insuring corporation agrees to process prior authorization 175
requests that are not submitted electronically because of the 176
financial hardship that electronic submission of prior 177
authorization requests would create for the health care 178
practitioner or if internet connectivity is limited or 179
unavailable where the health care practitioner is located. 180

(4)(a) For policies issued on or after January 1, 2018, if 181
the health care practitioner submits the request for prior 182
authorization as described in divisions (B)(1) and (2) of this 183
section, the health insuring corporation shall respond to all 184
prior authorization requests within forty-eight hours for urgent 185
care services, or ten calendar days for any prior approval 186
request that is not for an urgent care service, of the time the 187
request is received by the health insuring corporation with all 188
information necessary to support the prior authorization 189
request. Division (B)(4) of this section does not apply to 190

emergency services. 191

(b) (i) The response required under division (B) (4) (a) of 192
this section shall indicate whether the request is approved, 193
denied, or incomplete. If the prior authorization is denied, the 194
health insuring corporation shall provide the specific reason 195
for the denial. If the prior authorization request is 196
incomplete, the health insuring corporation shall indicate the 197
specific additional information that is required to process the 198
request. 199

(ii) For a response that is considered incomplete, the 200
health care practitioner shall provide the additional 201
information requested under division (B) (4) (b) (i) of this 202
section within seventy-two hours of the time the request is 203
received by the practitioner. 204

(5) (a) For policies issued on or after January 1, 2018, if 205
a health care practitioner submits a prior authorization request 206
as described in divisions (B) (1) and (2) of this section, the 207
health insuring corporation shall provide an electronic receipt 208
to the health care practitioner acknowledging that the prior 209
authorization request was received. 210

(b) For policies issued on or after January 1, 2018, if a 211
health insuring corporation requests additional information that 212
is required to process a prior authorization request as 213
described in division (B) (4) (b) (i) of this section, the health 214
care practitioner shall provide an electronic receipt to the 215
health insuring corporation acknowledging that the request for 216
additional information was received. 217

(6) (a) For policies issued on or after January 1, 2017, 218
for a prior approval related to a chronic condition, the health 219

insuring corporation shall honor a prior authorization approval 220
for an approved drug for the lesser of the following from the 221
date of the approval: 222

(i) Twelve months; 223

(ii) The last day of the covered person's eligibility 224
under the policy, contract, or agreement. 225

(b) The duration of all other prior authorization 226
approvals shall be dictated by the policy, contract, or 227
agreement issued by the health insuring corporation. 228

(c) A health insuring corporation may, in relation to a 229
prior approval under division (B) (6) (a) of this section, require 230
a health care practitioner to submit information to the health 231
insuring corporation indicating that the patient's chronic 232
condition has not changed. 233

(i) The request for information by the health insuring 234
corporation and the response by the health care practitioner 235
shall be in an electronic format, which may be by electronic 236
mail or other electronic communication. 237

(ii) The frequency of the submission of requested 238
information shall be consistent with medical or scientific 239
evidence as defined in section 3922.01 of the Revised Code, but 240
shall not be required more frequently than quarterly. 241

(iii) If the health care practitioner does not respond 242
within five calendar days from the date the request was 243
received, the health insuring corporation may terminate the 244
twelve-month approval. 245

(d) A year long approval provided under division (B) (6) (a) 246
of this section is no longer valid and automatically terminates 247

if there are changes to federal or state laws or federal 248
regulatory guidance or compliance information prescribing that 249
the drug in question is no longer approved or safe for the 250
intended purpose. 251

(e) A twelve-month approval provided under division (B) (6) 252
(a) of this section does not apply to and is not required for 253
any of the following: 254

(i) Medications that are prescribed for a non-maintenance 255
condition; 256

(ii) Medications that have a typical treatment of less 257
than one year; 258

(iii) Medications that require an initial trial period to 259
determine effectiveness and tolerability, beyond which a one- 260
year, or greater, prior authorization period will be given; 261

(iv) Medications where there is medical or scientific 262
evidence as defined in section 3922.01 of the Revised Code that 263
do not support a twelve-month prior approval; 264

(v) Medications that are a schedule I or II controlled 265
substance or any opioid analgesic or benzodiazepine, as defined 266
in section 3719.01 of the Revised Code; 267

(vi) Medications that are not prescribed by an in-network 268
provider as part of a care management program. 269

(7) For policies issued on or after January 1, 2017, a 270
health insuring corporation may, but is not required to, provide 271
the twelve-month approval prescribed in division (B) (6) (a) of 272
this section for a prescription drug that meets either of the 273
following: 274

(a) The drug is prescribed or administered to treat a rare 275

<u>medical condition and pursuant to medical or scientific evidence</u>	276
<u>as defined in section 3922.01 of the Revised Code.</u>	277
<u>(b) Medications that are controlled substances not</u>	278
<u>included in division (B)(6)(e)(v) of this section.</u>	279
<u>For purposes of division (B)(7) of this section, "rare</u>	280
<u>medical condition" means any disease or condition that affects</u>	281
<u>fewer than two hundred thousand individuals in the United</u>	282
<u>States.</u>	283
<u>(8) Nothing in division (B)(6) or (7) of this section</u>	284
<u>prohibits the substitution of any drug that has received a</u>	285
<u>twelve-month approval under division (B)(6)(a) of this section</u>	286
<u>when there is a release of a United States food and drug</u>	287
<u>administration approved comparable brand product or a generic</u>	288
<u>counterpart of a brand product that is listed as therapeutically</u>	289
<u>equivalent in the United States food and drug administration's</u>	290
<u>publication titled approved drug products with therapeutic</u>	291
<u>equivalence evaluations.</u>	292
<u>(9)(a) For policies issued on or after January 1, 2017,</u>	293
<u>upon written request, a health insuring corporation shall permit</u>	294
<u>a retrospective review for a claim that is submitted for a</u>	295
<u>service where prior authorization was required but not obtained</u>	296
<u>if the service in question meets all of the following:</u>	297
<u>(i) The service is directly related to another service for</u>	298
<u>which prior approval has already been obtained and that has</u>	299
<u>already been performed.</u>	300
<u>(ii) The new service was not known to be needed at the</u>	301
<u>time the original prior authorized service was performed.</u>	302
<u>(iii) The need for the new service was revealed at the</u>	303
<u>time the original authorized service was performed.</u>	304

(b) Once the written request and all necessary information 305
is received, the health insuring corporation shall review the 306
claim for coverage and medical necessity. The health insuring 307
corporation shall not deny a claim for such a new service based 308
solely on the fact that a prior authorization approval was not 309
received for the new service in question. 310

(10) (a) For policies issued on or after January 1, 2017, 311
the health insuring corporation shall disclose to all 312
participating health care practitioners any new prior 313
authorization requirement at least thirty days prior to the 314
effective date of the new requirement. 315

(b) The notice may be sent via electronic mail or standard 316
mail and shall be conspicuously entitled "Notice of Changes to 317
Prior Authorization Requirements." The notice is not required to 318
contain a complete listing of all changes made to the prior 319
authorization requirements, but shall include specific 320
information on where the health care practitioner may locate the 321
information on the health insuring corporation's web site or, if 322
applicable, the health insuring corporation's portal. 323

(c) All participating health care practitioners shall 324
promptly notify the health insuring corporation of any changes 325
to the health care practitioner's electronic mail or standard 326
mail address. 327

(11) (a) For policies issued on or after January 1, 2017, 328
the health insuring corporation shall make available to all 329
participating health care practitioners on its web site or 330
provider portal a listing of its prior authorization 331
requirements, including specific information or documentation 332
that a provider must submit in order for the prior authorization 333
request to be considered complete. 334

(b) The health insuring corporation shall make available 335
on its web site information about the policies, contracts, or 336
agreements offered by the health insuring corporation that 337
clearly identifies specific services, drugs, or devices to which 338
a prior authorization requirement exists. 339

(12) For policies issued on or after January 1, 2018, the 340
health insuring corporation shall establish a streamlined appeal 341
process relating to adverse prior authorization decision 342
determinations that shall include all of the following: 343

(a) For urgent care services, the appeal shall be 344
considered within forty-eight hours after the health insuring 345
corporation receives the appeal. 346

(b) For all other matters, the appeal shall be considered 347
within ten calendar days after the health insuring corporation 348
receives the appeal. 349

(c) The appeal shall be between the health care 350
practitioner requesting the service in question and a clinical 351
peer. 352

(d) If the appeal does not resolve the disagreement, 353
either the covered person or an authorized representative as 354
defined in section 3922.01 of the Revised Code may request an 355
external review under Chapter 3922. of the Revised Code to the 356
extent Chapter 3922. of the Revised Code is applicable. 357

(C) For policies issued on or after January 1, 2017, 358
except in cases of fraudulent or materially incorrect 359
information, a health insuring corporation shall not 360
retroactively deny a prior authorization for a health care 361
service, drug, or device when all of the following are met: 362

(1) The health care practitioner submits a prior 363

authorization request to the health insuring corporation for a 364
health care service, drug, or device. 365

(2) The health insuring corporation approves the prior 366
authorization request after determining that all of the 367
following are true: 368

(a) The patient is eligible under the health benefit plan. 369

(b) The health care service, drug, or device is covered 370
under the patient's health benefit plan. 371

(c) The health care service, drug, or device meets the 372
health insuring corporation's standards for medical necessity 373
and prior authorization. 374

(3) The health care practitioner renders the health care 375
service, drug, or device pursuant to the approved prior 376
authorization request and all of the terms and conditions of the 377
health care practitioner's contract with the health insuring 378
corporation. 379

(4) On the date the health care practitioner renders the 380
prior approved health care service, drug, or device, all of the 381
following are true: 382

(a) The patient is eligible under the health benefit plan. 383

(b) The patient's condition or circumstances related to 384
the patient's care has not changed. 385

(c) The health care practitioner submits an accurate claim 386
that matches the information submitted by the health care 387
practitioner in the approved prior authorization request. 388

(5) If the health care practitioner submits a claim that 389
includes an unintentional error and the error results in a claim 390

that does not match the information originally submitted by the 391
health care practitioner in the approved prior authorization 392
request, upon receiving a denial of services from the health 393
insuring corporation, the health care practitioner may resubmit 394
the claim pursuant to division (C) of this section with the 395
information that matches the information included in the 396
approved prior authorization. 397

(D) Any provision of a contractual arrangement entered 398
into between a health insuring corporation and a health care 399
practitioner or beneficiary that is contrary to divisions (A) to 400
(C) of this section is unenforceable. 401

(E) For policies issued on or after January 1, 2017, 402
committing a series of violations of this section that, taken 403
together, constitute a practice or pattern shall be considered 404
an unfair and deceptive practice under sections 3901.19 to 405
3901.26 of the Revised Code. 406

(F) The superintendent of insurance may adopt rules in 407
accordance with Chapter 119. of the Revised Code as necessary to 408
implement the provisions of this section. 409

(G) This section does not apply to any of the following 410
types of coverage: a policy, contract, certificate, or agreement 411
that covers only a specified accident, accident only, credit, 412
dental, disability income, long-term care, hospital indemnity, 413
supplemental coverage as described in section 3923.37 of the 414
Revised Code, specified disease, or vision care; coverage issued 415
as a supplement to liability insurance; insurance arising out of 416
workers' compensation or similar law; automobile medical payment 417
insurance; insurance under which benefits are payable with or 418
without regard to fault and which is statutorily required to be 419
contained in any liability insurance policy or equivalent self- 420

insurance; a medicare supplement policy of insurance as defined 421
by the superintendent of insurance by rule; coverage under a 422
plan through medicare or the federal employees benefit program; 423
or any coverage issued under Chapter 55 of Title 10 of the 424
United States Code and any coverage issued as a supplement to 425
that coverage. 426

Sec. 3923.041. (A) As used in this section: 427

(1) "Chronic condition" means a medical condition that has 428
persisted after reasonable efforts have been made to relieve or 429
cure its cause and has continued, either continuously or 430
episodically, for longer than six continuous months. 431

(2) "Clinical peer" means a health care practitioner in 432
the same or in a similar, specialty that typically manages the 433
medical condition, procedure, or treatment under review. 434

(3) "Covered person" means a person receiving coverage for 435
health services under a policy of sickness and accident 436
insurance or a public employee benefit plan. 437

(4) "Emergency service" has the same meaning as in section 438
1753.28 of the Revised Code. 439

(5) "Fraudulent or materially incorrect information" means 440
any type of intentional deception or misrepresentation made by a 441
person with the knowledge that the deception could result in 442
some unauthorized benefit to the covered person in question. 443

(6) "Health care practitioner" has the same meaning as in 444
section 3701.74 of the Revised Code. 445

(7) "NCPDP SCRIPT standard" means the national council for 446
prescription drug programs SCRIPT standard version 201310 or the 447
most recent standard adopted by the United States department of 448

health and human services. 449

(8) "Prior authorization requirement" means any practice 450
implemented by either a sickness and accident insurer or a 451
public employee benefit plan in which coverage of a health care 452
service, device, or drug is dependent upon a covered person or a 453
health care practitioner obtaining approval from the insurer or 454
plan prior to the service, device, or drug being performed, 455
received, or prescribed, as applicable. "Prior authorization" 456
includes prospective or utilization review procedures conducted 457
prior to providing a health care service, device, or drug. 458

(9) "Urgent care services" means a medical care or other 459
service for a condition where application of the timeframe for 460
making routine or non-life threatening care determinations is 461
either of the following: 462

(a) Could seriously jeopardize the life, health, or safety 463
of the patient or others due to the patient's psychological 464
state; 465

(b) In the opinion of a practitioner with knowledge of the 466
patient's medical or behavioral condition, would subject the 467
patient to adverse health consequences without the care or 468
treatment that is the subject of the request. 469

(10) "Utilization review" and "utilization review 470
organization" have the same meanings as in section 1751.77 of 471
the Revised Code. 472

(B) If a policy issued by a sickness and accident insurer 473
or a public employee benefit plan contains a prior authorization 474
requirement, then all of the following apply: 475

(1) For policies issued on or after January 1, 2018, the 476
insurer or plan shall permit health care practitioners to access 477

the prior authorization form through the applicable electronic 478
software system. 479

(2) (a) For policies issued on or after January 1, 2018, 480
the insurer or plan, or other payer acting on behalf of the 481
insurer or plan, to accept prior authorization requests through 482
a secure electronic transmission. 483

(b) For policies issued on or after January 1, 2018, the 484
insurer or plan, a pharmacy benefit manager responsible for 485
handling prior authorization requests, or other payer acting on 486
behalf of the insurer or plan shall accept and respond to prior 487
prescription benefit authorization requests through a secure 488
electronic transmission using NCPDP SCRIPT standard ePA 489
transactions, and for prior medical benefit authorization 490
requests through a secure electronic transmission using 491
standards established by the council for affordable quality 492
health care on operating rules for information exchange or its 493
successor. 494

(c) For purposes of division (B) (2) of this section, 495
neither of the following shall be considered a secure electronic 496
transmission: 497

(i) A facsimile; 498

(ii) A proprietary payer portal for prescription drug 499
requests that does not use NCPDP SCRIPT standard. 500

(3) For policies issued on or after January 1, 2018, a 501
health care practitioner and an insurer or plan may enter into a 502
contractual arrangement under which the insurer or plan agrees 503
to process prior authorization requests that are not submitted 504
electronically because of the financial hardship that electronic 505
submission of prior authorization requests would create for the 506

health care practitioner or if internet connectivity is limited 507
or unavailable where the health care practitioner is located. 508

(4) (a) For policies issued on or after January 1, 2018, if 509
the health care practitioner submits the request for prior 510
authorization electronically as described in divisions (B) (1) 511
and (2) of this section, the insurer or plan shall respond to 512
all prior authorization requests within forty-eight hours for 513
urgent care services, or ten calendar days for any prior 514
approval request that is not for an urgent care service, of the 515
time the request is received by the insurer or plan with all 516
information necessary to support the prior authorization 517
request. Division (B) (4) of this section does not apply to 518
emergency services. 519

(b) (i) The response required under division (B) (4) (a) of 520
this section shall indicate whether the request is approved, 521
denied, or incomplete. If the prior authorization is denied, the 522
insurer or plan shall provide the specific reason for the 523
denial. If the prior authorization request is incomplete, the 524
insurer or plan shall indicate the specific additional 525
information that is required to process the request. 526

(ii) For a response that is considered incomplete, the 527
health care practitioner shall provide the additional 528
information requested under division (B) (4) (b) (i) of this 529
section within seventy-two hours of the time the request is 530
received by the practitioner. 531

(5) (a) For policies issued on or after January 1, 2018, if 532
a health care practitioner submits a prior authorization request 533
as described in divisions (B) (1) and (2) of this section, the 534
insurer or plan shall provide an electronic receipt to the 535
health care practitioner acknowledging that the prior 536

authorization request was received. 537

(b) For policies issued on or after January 1, 2018, if an 538
issuer or plan requests additional information that is required 539
to process a prior authorization request as described in 540
division (B) (4) (b) (i) of this section, the health care 541
practitioner shall provide an electronic receipt to the issuer 542
or plan acknowledging that the request for additional 543
information was received. 544

(6) (a) For policies issued on or after January 1, 2017, 545
for a prior approval related to a chronic condition, the insurer 546
or plan shall honor a prior authorization approval for an 547
approved drug for the lesser of the following from the date of 548
the approval: 549

(i) Twelve months; 550

(ii) The last day of the covered person's eligibility 551
under the policy or plan. 552

(b) The duration of all other prior authorization 553
approvals shall be dictated by the policy or plan. 554

(c) An insurer or plan, in relation to prior approval 555
under division (B) (6) (a) of this section, may require a health 556
care practitioner to submit information to the insurer or plan 557
indicating that the patient's chronic condition has not changed. 558

(i) The request for information by the insurer or plan and 559
the response by the health care practitioner shall be in an 560
electronic format, which may be by traditional electronic mail 561
or other electronic communication. 562

(ii) The frequency of the submission of requested 563
information shall be consistent with medical or scientific 564

evidence as defined in section 3922.01 of the Revised Code, but 565
shall not be required more frequently than quarterly. 566

(iii) If the health care practitioner does not respond 567
within five calendar days from the date the request was 568
received, the insurer or plan may terminate the twelve-month 569
approval. 570

(d) A year long approval provided under division (B) (6) (a) 571
of this section is no longer valid and automatically terminates 572
if there are changes to federal or state laws or federal 573
regulatory guidance or compliance information prescribing that 574
the drug in question is no longer approved or safe for the 575
intended purpose. 576

(e) A twelve-month approval provided under division (B) (6) 577
(a) of this section does not apply to and is not required for 578
any of the following: 579

(i) Medications that are prescribed for a non-maintenance 580
condition; 581

(ii) Medications that have a typical treatment of less 582
than one year; 583

(iii) Medications that require an initial trial period to 584
determine effectiveness and tolerability, beyond which a one- 585
year, or greater, prior authorization period will be given; 586

(iv) Medications where there is medical or scientific 587
evidence as defined in section 3922.01 of the Revised Code that 588
do not support a twelve-month prior approval; 589

(v) Medications that are a schedule I or II controlled 590
substance or any opioid analgesic or benzodiazepine, as defined 591
in section 3719.01 of the Revised Code; 592

(vi) Medications that are not prescribed by an in-network provider as part of the care management program. 593
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(7) For policies issued on or after January 1, 2017, an insurer or plan may, but is not required to, provide the twelve-month approval prescribed in division (B)(6)(a) of this section for a prescription drug that meets either of the following: 595
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(a) The drug is prescribed or administered to treat a rare medical condition and pursuant to medical or scientific evidence as defined in section 3922.01 of the Revised Code. 599
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(b) Medications that are controlled substances not included in division (B)(6)(e)(v) of this section. 602
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For purposes of division (B)(7) of this section, "rare medical condition" means any disease or condition that affects fewer than two hundred thousand individuals in the United States. 604
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(8) Nothing in division (B)(6) or (7) of this section prohibits the substitution of any drug that has received a twelve-month approval under division (B)(6)(a) of this section when there is a release of a United States food and drug administration approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent in the United States food and drug administration's publication titled approved drug products with therapeutic equivalence evaluations. 608
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(9)(a) For policies issued on or after January 1, 2017, upon written request, an insurer or plan shall permit a retrospective review for a claim that is submitted for a service where prior authorization was required but not obtained if the service in question meets all of the following: 617
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(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed. 622
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(ii) The new service was not known to be needed at the time the original prior authorized service was performed. 625
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(iii) The need for the new service was revealed at the time the original authorized service was performed. 627
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(b) Once the written request and all necessary information is received, the insurer or plan shall review the claim for coverage and medical necessity. The insurer or plan shall not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question. 629
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(10) (a) For policies issued on or after January 1, 2017, the insurer or plan shall disclose to all participating health care practitioners any new prior authorization requirement at least thirty days prior to the effective date of the new requirement. 635
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(b) The notice may be sent via electronic mail or standard mail and shall be conspicuously entitled "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of all changes made to the prior authorization requirements, but shall include specific information on where the health care practitioner may locate the information on the insurer or plan's web site or, if applicable, the insurer's or plan's portal. 640
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(c) All participating health care practitioners shall promptly notify the insurer or plan of any changes to the health care practitioner's electronic mail or standard mail address. 648
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(11) (a) For policies issued on or after January 1, 2017, 651
the insurer or plan shall make available to all participating 652
health care practitioners on its web site or provider portal a 653
listing of its prior authorization requirements, including 654
specific information or documentation that a provider must 655
submit in order for the prior authorization request to be 656
considered complete. 657

(b) The insurer or plan shall make available on its web 658
site information about the policies, contracts, or agreements 659
offered by the insurer or plan that clearly identifies specific 660
services, drugs, or devices to which a prior authorization 661
requirement exists. 662

(12) For policies issued on or after January 1, 2018, the 663
insurer or plan shall establish a streamlined appeal process 664
relating to adverse prior authorization determinations that 665
shall include all of the following: 666

(a) For urgent care services, the appeal shall be 667
considered within forty-eight hours after the insurer or plan 668
receives the appeal. 669

(b) For all other matters, the appeal shall be considered 670
within ten calendar days after the insurer or plan receives the 671
appeal. 672

(c) The appeal shall be between the health care 673
practitioner requesting the service in question and a clinical 674
peer. 675

(d) If the appeal does not resolve the disagreement, 676
either the covered person or an authorized representative as 677
defined in section 3922.01 of the Revised Code may request an 678
external review under Chapter 3922. of the Revised Code to the 679

extent Chapter 3922. of the Revised Code is applicable. 680

(C) For policies issued on or after January 1, 2017, 681
except in cases of fraudulent or materially incorrect 682
information, an insurer or plan shall not retroactively deny a 683
prior authorization for a health care service, drug, or device 684
when all of the following are met: 685

(1) The health care practitioner submits a prior 686
authorization request to the insurer or plan for a health care 687
service, drug, or device; 688

(2) The insurer or plan approves the prior authorization 689
request after determining that all of the following are true: 690

(a) The patient is eligible under the health benefit plan. 691

(b) The health care service, drug, or device is covered 692
under the patient's health benefit plan. 693

(c) The health care service, drug, or device meets the 694
insurer's or plan's standards for medical necessity and prior 695
authorization. 696

(3) The health care practitioner renders the health care 697
service, drug, or device pursuant to the approved prior 698
authorization request and all of the terms and conditions of the 699
health care practitioner's contract with the insurer or plan; 700

(4) On the date the health care practitioner renders the 701
prior approved health care service, drug, or device, all of the 702
following are true: 703

(a) The patient is eligible under the health benefit plan. 704

(b) The patient's condition or circumstances related to 705
the patient's care has not changed. 706

(c) The health care practitioner submits an accurate claim 707
that matches the information submitted by the health care 708
practitioner in the approved prior authorization request. 709

(5) If the health care practitioner submits a claim that 710
includes an unintentional error and the error results in a claim 711
that does not match the information originally submitted by the 712
health care practitioner in the approved prior authorization 713
request, upon receiving a denial of services from the insurer or 714
plan, the health care practitioner may resubmit the claim 715
pursuant to division (C) of this section with the information 716
that matches the information included in the approved prior 717
authorization. 718

(D) Any provision of a contractual arrangement entered 719
into between an insurer or plan and a health care practitioner 720
or beneficiary that is contrary to divisions (A) to (C) of this 721
section is unenforceable. 722

(E) For policies issued on or after January 1, 2017, 723
committing a series of violations of this section that, taken 724
together, constitute a practice or pattern shall be considered 725
an unfair and deceptive practice under sections 3901.19 to 726
3901.26 of the Revised Code. 727

(F) The superintendent of insurance may adopt rules in 728
accordance with Chapter 119. of the Revised Code as necessary to 729
implement the provisions of this section. 730

(G) This section does not apply to any of the following 731
types of coverage: a policy, contract, certificate, or agreement 732
that covers only a specified accident, accident only, credit, 733
dental, disability income, long-term care, hospital indemnity, 734
supplemental coverage as described in section 3923.37 of the 735

Revised Code, specified disease, or vision care; coverage issued 736
as a supplement to liability insurance; insurance arising out of 737
workers' compensation or similar law; automobile medical payment 738
insurance; insurance under which benefits are payable with or 739
without regard to fault and which is statutorily required to be 740
contained in any liability insurance policy or equivalent self- 741
insurance; a medicare supplement policy of insurance as defined 742
by the superintendent of insurance by rule; coverage under a 743
plan through medicare or the federal employees benefit program; 744
or any coverage issued under Chapter 55 of Title 10 of the 745
United States Code and any coverage issued as a supplement to 746
that coverage. 747

Sec. 5119.25. (A) The director of mental health and 748
addiction services, in whole or in part, may withhold funds 749
otherwise to be allocated to a board of alcohol, drug addiction, 750
and mental health services under section 5119.23 of the Revised 751
Code if the board fails to comply with Chapter 340. or 5119. of 752
the Revised Code or rules of the department of mental health and 753
addiction services. However, beginning ~~September 15, 2016~~ July 1, 754
2017, the director shall withhold all such funds from the board 755
when required to do so under division (A)(4) of section 340.08 756
of the Revised Code or division (G)(1) of section 5119.22 of the 757
Revised Code. 758

(B) The director of mental health and addiction services 759
may withhold funds otherwise to be allocated to a board of 760
alcohol, drug addiction, and mental health services under 761
section 5119.23 of the Revised Code if the board denies 762
available service on the basis of race, color, religion, creed, 763
sex, age, national origin, disability as defined in section 764
4112.01 of the Revised Code, or developmental disability. 765

(C) The director shall issue a notice identifying the 766
areas of noncompliance and the action necessary to achieve 767
compliance. The director may offer technical assistance to the 768
board to achieve compliance. The board shall have thirty days 769
from receipt of the notice of noncompliance to present its 770
position that it is in compliance or to submit to the director 771
evidence of corrective action the board took to achieve 772
compliance. Before withholding funds, the director or the 773
director's designee shall hold a hearing within thirty days of 774
receipt of the board's position or evidence to determine if 775
there are continuing violations and that either assistance is 776
rejected or the board is unable, or has failed, to achieve 777
compliance. The director may appoint a representative from 778
another board of alcohol, drug addiction, and mental health 779
services to serve as a mentor for the board in developing and 780
executing a plan of corrective action to achieve compliance. Any 781
such representative shall be from a board that is in compliance 782
with Chapter 340. of the Revised Code, this chapter, and the 783
department's rules. Subsequent to the hearing process, if it is 784
determined that compliance has not been achieved, the director 785
may allocate all or part of the withheld funds to one or more 786
community mental health services providers or community 787
addiction services providers to provide the mental health 788
service or addiction service for which the board is not in 789
compliance until the time that there is compliance. The director 790
shall adopt rules in accordance with Chapter 119. of the Revised 791
Code to implement this section. 792

Sec. 5160.34. (A) As used in this section: 793

(1) "Chronic condition" means a medical condition that has 794
persisted after reasonable efforts have been made to relieve or 795
cure its cause and has continued, either continuously or 796

episodically, for longer than six continuous months. 797

(2) "Clinical peer" means a medical provider in the same, 798
or in a similar, specialty that typically manages the medical 799
condition, procedure, or treatment under review. 800

(3) "Emergency services" has the same meaning as in 801
section 1753.28 of the Revised Code. 802

(4) "Prior authorization requirement" means any practice 803
implemented by a medical assistance program in which coverage of 804
a health care service, device, or drug is dependent upon a 805
medical assistance recipient or a health care provider, 806
receiving approval from the department of medicaid or its 807
designee, including a medicaid managed care organization, prior 808
to the service, device, or drug being performed, received, or 809
prescribed, as applicable. "Prior authorization" includes 810
prospective or utilization review procedures conducted prior to 811
providing a health care service, device, or drug. 812

(5) "Urgent care services" means a medical care or other 813
service for a condition where application of the timeframe for 814
making routine or non-life threatening care determinations is 815
either of the following: 816

(a) Could seriously jeopardize the life, health, or safety 817
of the recipient or others due to the recipient's psychological 818
state; 819

(b) In the opinion of a practitioner with knowledge of the 820
recipient's medical or behavioral condition, would subject the 821
recipient to adverse health consequences without the care or 822
treatment that is the subject of the request. 823

(6) "Utilization review" and "utilization review 824
organization" have the same meanings as in section 1751.77 of 825

the Revised Code. 826

(B) If a medical assistance program has a prior 827
authorization requirement, the department of medicaid or its 828
designee, including a medicaid managed care organization, shall 829
do all of the following: 830

(1) On or before January 1, 2018, permit a health care 831
provider to access the prior authorization form through the 832
applicable electronic software system. 833

(2) (a) On or before January 1, 2018, permit the department 834
or its designee to accept and respond to prior prescription 835
benefit authorization requests through a secure electronic 836
transmission. 837

(b) On or before January 1, 2018, the department or its 838
designee shall accept and respond to prior prescription benefit 839
authorization requests through a secure electronic transmission 840
using NCPDP SCRIPT standard ePA transactions, and for prior 841
medical benefit authorization requests through a secure 842
electronic transmission using standards established by the 843
council for affordable quality health care on operating rules 844
for information exchange or its successor. 845

(c) For purposes of division (B) (2) of this section, 846
neither of the following shall be considered a secure electronic 847
transmission: 848

(i) A facsimile; 849

(ii) A proprietary payer portal for prescription drug 850
requests that does not use NCPDP SCRIPT standard. 851

(3) On or before January 1, 2018, a health care provider 852
and the department of medicaid or its designee may enter into a 853

contractual arrangement under which the department or its 854
designee agrees to process prior authorization requests that are 855
not submitted electronically because of the financial hardship 856
that electronic submission of prior authorization requests would 857
create for the provider or if internet connectivity is limited 858
or unavailable where the provider is located. 859

(4) (a) On or before January 1, 2018, if the health care 860
provider submits the request for prior authorization 861
electronically as described in divisions (B) (1) and (2) of this 862
section, respond to all prior authorization requests within 863
forty-eight hours for urgent care services, or ten calendar days 864
for any prior approval request that is not for an urgent care 865
service, of the time the request is received by the department 866
or its designee with all information necessary to support the 867
prior authorization request. Division (B) (5) of this section 868
does not apply to emergency services. 869

(b) (i) The response required under division (B) (4) (a) of 870
this section shall indicate whether the request is approved, 871
denied, or incomplete. If the prior authorization is denied, the 872
department or its designee shall provide the specific reason for 873
the denial. If the prior authorization request is incomplete, 874
the department or its designee shall indicate the specific 875
additional information that is required to process the request. 876

(ii) For a response that is considered incomplete, the 877
health care provider shall provide the additional information 878
requested under division (B) (4) (b) (i) of this section within 879
seventy-two hours of the time the request is received by the 880
provider. 881

(5) (a) On or before January 1, 2018, if a health care 882
provider submits a prior authorization request as described in 883

divisions (B) (1) and (2) of this section, the department or its 884
designee shall provide an electronic receipt to the health care 885
provider acknowledging that the prior authorization request was 886
received. 887

(b) On or before January 1, 2018, if the department or its 888
designee requests additional information that is required to 889
process a prior authorization request as described in division 890
(B) (4) (b) (i) of this section, the health care provider shall 891
provide an electronic receipt to the department or its designee 892
acknowledging that the request for additional information was 893
received. 894

(6) (a) On or before January 1, 2017, honor a prior 895
authorization approval for an approved drug for the lesser of 896
the following from the date of approval: 897

(i) Twelve months; 898

(ii) The last day of the medical assistance recipient's 899
eligibility for the medical assistance program. 900

(b) The duration of all other prior authorization 901
approvals shall be dictated by the medical assistance program. 902

(c) The department or its designee, in relation to prior 903
approval under division (B) (6) (a) of this section, may require a 904
health care provider to submit information to the department or 905
its designee indicating that the patient's chronic condition has 906
not changed. 907

(i) The request for information by the department or its 908
designee and the response by the health care provider shall be 909
in an electronic format, which may be by traditional electronic 910
mail or other electronic communication. 911

(ii) The frequency of the submission of requested information shall be consistent with medical or scientific evidence as defined in section 3922.01 of the Revised Code, but shall not be required more frequently than quarterly. 912
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(iii) If the health care provider does not respond within five calendar days from the date the request was received, the insurer or plan may terminate the twelve-month approval. 916
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(d) A year long approval provided under division (B) (6) (a) of this section is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance or compliance information prescribing that the drug in question is no longer approved or safe for the intended purpose. 919
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(e) A twelve-month approval provided under division (B) (6) (a) of this section does not apply to and is not required for any of the following: 925
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(i) Medications that are prescribed for a non-maintenance condition; 928
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(ii) Medications that have a typical treatment of less than one year; 930
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(iii) Medications that require an initial trial period to determine effectiveness and tolerability, beyond which a one-year, or greater, prior authorization period will be given; 932
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(iv) Medications where there is medical or scientific evidence as defined in section 3922.01 of the Revised Code that do not support a twelve-month prior approval; 935
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(v) Medications that are a schedule I or II controlled substance or any opioid analgesic or benzodiazepine, as defined 938
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<u>in section 3719.01 of the Revised Code;</u>	940
<u>(vi) Medications that are not prescribed by an in-network provider as part of a care management program.</u>	941 942
<u>(7) On or before January 1, 2017, the department or its designee may, but is not required to, provide the twelve-month approval prescribed in division (B) (6) (a) of this section for a prescription drug that meets either of the following:</u>	943 944 945 946
<u>(a) The drug is prescribed or administered to treat a rare medical condition and pursuant to medical or scientific evidence as defined in section 3922.01 of the Revised Code.</u>	947 948 949
<u>(b) Medications that are controlled substances not included in division (B) (6) (e) (v) of this section.</u>	950 951
<u>For purposes of division (B) (7) of this section, "rare medical condition" means any disease or condition that affects fewer than two-hundred thousand individuals in the United States.</u>	952 953 954 955
<u>(8) Nothing in division (B) (6) or (7) of this section prohibits the substitution of any drug that has received a twelve-month approval under division (B) (6) (a) of this section when there is a release of a United States food and drug administration approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent in the United States food and drug administration's publication titled approved drug products with therapeutic equivalence evaluations.</u>	956 957 958 959 960 961 962 963 964
<u>(9) (a) On or after January 1, 2017, upon written request, the department or its designee shall permit a retrospective review for a claim that is submitted for a service where prior authorization was required, but not obtained if the service in</u>	965 966 967 968

question meets all of the following: 969

(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed. 970
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(ii) The new service was not known to be needed at the time the original prior authorized service was performed. 973
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(iii) The need for the new service was revealed at the time the original authorized service was performed. 975
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(b) Once the written request and all necessary information is received, the department or its designee shall review the claim for coverage and medical necessity. The department or its designee shall not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question. 977
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(10) (a) On or before January 1, 2017, disclose to all participating health care providers any new prior authorization requirement at least thirty days prior to the effective date of the new requirement. 983
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(b) The notice may be sent via electronic mail or standard mail and shall be conspicuously entitled "Notice of Changes to Prior Authorization Requirements." The notice is not required to contain a complete listing of all changes made to the prior authorization requirements, but shall include specific information on where the health care practitioner may locate the information on the department's or its designee's web site or, if applicable, the department's or its designee's portal. 987
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(c) All participating health care providers shall promptly notify the department or its designee of any changes to the health care provider's electronic mail or standard mail address. 995
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(11) (a) On or before January 1, 2017, make available to 998
all participating health care providers on its web site or 999
provider portal a listing of its prior authorization 1000
requirements, including specific information or documentation 1001
that a provider must submit in order for the prior authorization 1002
request to be considered complete. 1003

(b) Make available on its web site information about the 1004
medical assistance programs offered in this state that clearly 1005
identifies specific services, drugs, or devices to which a prior 1006
authorization requirement exists. 1007

(12) On or before January 1, 2018, establish a streamlined 1008
appeal process relating to adverse prior authorization 1009
determinations that shall include all of the following: 1010

(a) For urgent care services, the appeal shall be 1011
considered within forty-eight hours after the department or its 1012
designee receives the appeal. 1013

(b) For all other matters, the appeal shall be considered 1014
within ten calendar days after the department or its designee 1015
receives the appeal. 1016

(c) The appeal shall be between the health care provider 1017
requesting the service in question and a clinical peer appointed 1018
by or contracted by the department or the department's designee. 1019

(d) If the appeal does not resolve the disagreement, the 1020
appeal procedures shall permit the recipient to further appeal 1021
in accordance with section 5160.31 of the Revised Code. 1022

(C) Beginning January 1, 2017, except in cases of 1023
fraudulent or materially incorrect information, the department 1024
or its designee shall not retroactively deny a prior 1025
authorization for a health care service, drug, or device when 1026

<u>all of the following are met:</u>	1027
<u>(1) The health care provider submits a prior authorization</u>	1028
<u>request to the department or its designee for a health care</u>	1029
<u>service, drug, or device.</u>	1030
<u>(2) The department or its designee approves the prior</u>	1031
<u>authorization request after determining that all of the</u>	1032
<u>following are true:</u>	1033
<u>(a) The recipient is eligible for the health care service,</u>	1034
<u>drug, or device under the medical assistance program.</u>	1035
<u>(b) The health care service, drug, or device is covered by</u>	1036
<u>the medical assistance program.</u>	1037
<u>(c) The health care service, drug, or device meets the</u>	1038
<u>department's standards for medical necessity and prior</u>	1039
<u>authorization.</u>	1040
<u>(3) The health care provider renders the health care</u>	1041
<u>service, drug, or device pursuant to the approved prior</u>	1042
<u>authorization request and all of the terms and conditions of the</u>	1043
<u>health care provider's contract with the department or the</u>	1044
<u>department's designee.</u>	1045
<u>(4) On the date the health care provider renders the prior</u>	1046
<u>approved health care service, drug, or device, all of the</u>	1047
<u>following are true:</u>	1048
<u>(a) The recipient is eligible for the medical assistance</u>	1049
<u>program.</u>	1050
<u>(b) The recipient's condition or circumstances related to</u>	1051
<u>the recipient's care has not changed.</u>	1052
<u>(c) The health care provider submits an accurate claim</u>	1053

that matches the information submitted by the health care 1054
provider in the approved prior authorization request. 1055

(5) If the health care provider submits a claim that 1056
includes an unintentional error and the error results in a claim 1057
that does not match the information originally submitted by the 1058
health care provider in the approved prior authorization 1059
request, upon receiving a denial of services from the department 1060
or its designee, the health care practitioner may resubmit the 1061
claim pursuant to division (C) of this section with the 1062
information that matches the information included in the 1063
approved prior authorization. 1064

(D) Any provision of a contractual arrangement entered 1065
into between the department or its designee and a health care 1066
provider or recipient that is contrary to divisions (A) to (C) 1067
of this section is unenforceable. 1068

(E) The director of medicaid may adopt rules in accordance 1069
with Chapter 119. of the Revised Code as necessary to implement 1070
the provisions of this section. 1071

Section 2. That existing sections 340.034, 1739.05, and 1072
5119.25 of the Revised Code are hereby repealed. 1073

Section 3. That sections 110.12 and 812.40 of Am. Sub. 1074
H.B. 64 of the 131st General Assembly be amended to read as 1075
follows: 1076

Sec. 110.12. Sections 110.10 and 110.11 of ~~this act~~ Am. 1077
Sub. H.B. 64 of the 131st General Assembly shall take effect 1078
September 15, 2016~~July 1, 2017.~~ 1079

It is the intent of this amendment to delay the taking 1080
effect of the amendments to sections 340.01, 340.03, 340.15, and 1081
5119.21 of the Revised Code, as contemplated by the amendment, 1082

until July 1, 2017. 1083

Sec. 812.40. Section 340.034 of the Revised Code takes 1084
effect ~~September 15, 2016~~July 1, 2017. 1085

Section 4. That existing Sections 110.12 and 812.40 of Am. 1086
Sub. H.B. 64 of the 131st General Assembly are hereby repealed. 1087

Section 5. That Section 812.40 of Am. Sub. H.B. 483 of the 1088
130th General Assembly be amended to read as follows: 1089

Sec. 812.40. (A) The following take effect ~~two years after~~ 1090
~~the effective date of this act~~July 1, 2017: 1091

(1) The amendments by ~~this act~~Am. Sub. H.B. 483 of the 1092
130th General Assembly to sections 340.01, 340.03, 340.08, 1093
340.09, 340.15, 5119.21, and 5119.22 of the Revised Code; 1094

(2) The enactment by ~~this act~~Am. Sub. H.B. 483 of the 1095
130th General Assembly of sections 340.033, 340.034, 340.20, 1096
5119.362, 5119.363, and 5119.364 of the Revised Code. 1097

(B) The amendments by ~~this act~~Am. Sub. H.B. 483 of the 1098
130th General Assembly to division (A) of section 5119.25 of the 1099
Revised Code take effect ~~two years after the effective date of~~ 1100
~~this section~~July 1, 2017. The amendments by ~~this act~~Am. Sub. 1101
H.B. 483 of the 130th General Assembly to division (C) of that 1102
section take effect at the earliest time permitted by law. 1103

Section 6. That existing Section 812.40 of Am. Sub. H.B. 1104
483 of the 130th General Assembly is hereby repealed. 1105

Section 7. Sections 340.034 and 5119.25 of the Revised 1106
Code, as amended by this act, take effect on September 15, 2016. 1107