As Concurred by the Senate

131st General Assembly

Regular Session **Sub. S. B. No. 129**

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Senators Gardner, Cafaro

Cosponsors: Senators Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner, Tavares, Eklund, Hughes, Jones, Obhof, Patton, Sawyer, Schiavoni, Thomas, Uecker, Faber, Hackett, Hottinger, Jordan

Representatives Bishoff, DeVitis, Henne, Amstutz, Anielski, Antani, Boyd, Brown, Burkley, Conditt, Craig, Cupp, Green, Hambley, Huffman, Lepore-Hagan, McClain, Patterson, Rogers, Schaffer, Sears, Smith, R., Sprague

A BILL

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

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

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

Sec. 340.034. All of the following apply to the recovery

housing required by section 340.033 of the Revised Code to be included in the array of treatment services and recovery support for all levels of opioid and co-occurring drug addiction that 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, 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, 3923.63, 3923.80, 3923.85, 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. 1751.72. (A) As used in this section:

(1) "Chronic condition" means a medical condition that has

persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

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

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

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

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

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

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

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

health care service, device, or drug.

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

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

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

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

(B) If a policy, contract, or agreement issued by a health insuring corporation contains a prior authorization requirement, then all of the following apply:

(1) On or before January 1, 2018, the health insuring corporation shall permit health care practitioners to access the prior authorization form through the applicable electronic software system.

(2)(a) For policies issued on or after January 1, 2018, the health insuring corporation or other payer acting on behalf of the health insuring corporation, shall accept prior authorization requests through a secure electronic transmission.

(b) For policies issued on or after January 1, 2018, the health insuring corporation, a pharmacy benefit manager

responsible for handling prior authorization requests, or other payer acting on behalf of the health insuring corporation shall accept and respond to prior prescription benefit authorization requests through a secure electronic transmission using NCPDP SCRIPT standard ePA transactions, and for prior medical benefit authorization requests through a secure electronic transmission using standards established by the council for affordable quality health care on operating rules for information exchange or its successor.

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

(i) A facsimile;

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

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

(4)(a) For policies issued on or after January 1, 2018, if the health care practitioner submits the request for prior authorization as described in divisions (B)(1) and (2) of this section, the health insuring corporation shall respond to all prior authorization requests within forty-eight hours for urgent

care services, or ten calendar days for any prior approval request that is not for an urgent care service, of the time the request is received by the health insuring corporation with all information necessary to support the prior authorization request. Division (B)(4) of this section does not apply to emergency services.

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

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

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

(b) For policies issued on or after January 1, 2018, if a health insuring corporation requests additional information that is required to process a prior authorization request as described in division (B)(4)(b)(i) of this section, the health care practitioner shall provide an electronic receipt to the

health insuring corporation acknowledging that the request for additional information was received.

(6)(a) For policies issued on or after January 1, 2017, for a prior approval related to a chronic condition, the health insuring corporation shall honor a prior authorization approval for an approved drug for the lesser of the following from the date of the approval:

(i) Twelve months;

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

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

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

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

(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.

(iii) If the health care practitioner does not respond within five calendar days from the date the request was

received, the health insuring corporation may terminate the twelve-month approval.

(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.

(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:

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

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

(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;

(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;

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

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

(7) For policies issued on or after January 1, 2017, a health insuring corporation 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:

(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.

(b) Medications that are controlled substances not included in division (B)(6)(e)(v) of this section.

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.

(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.

(9)(a) For policies issued on or after January 1, 2017, upon written request, a health insuring corporation 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:

(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed.

(ii) The new service was not known to be needed at the time the original prior authorized service was performed.

(iii) The need for the new service was revealed at the time the original authorized service was performed.

(b) Once the written request and all necessary information is received, the health insuring corporation shall review the claim for coverage and medical necessity. The health insuring corporation 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.

(10)(a) For policies issued on or after January 1, 2017, the health insuring corporation 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.

(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 health insuring corporation's web site or, if applicable, the health insuring corporation's portal.

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

(11)(a) For policies issued on or after January 1, 2017, the health insuring corporation shall make available to all

participating health care practitioners on its web site or provider portal a listing of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

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

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

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

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

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

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

(C) For policies issued on or after January 1, 2017,

except in cases of fraudulent or materially incorrect information, a health insuring corporation shall not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met:

(1) The health care practitioner submits a prior authorization request to the health insuring corporation for a health care service, drug, or device.

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

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

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

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

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

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

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

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

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

(5) If the health care practitioner submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the health care practitioner in the approved prior authorization request, upon receiving a denial of services from the health insuring corporation, the health care practitioner may resubmit the claim pursuant to division (C) of this section with the information that matches the information included in the approved prior authorization.

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

(E) For policies issued on or after January 1, 2017, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) For policies issued on or after January 1, 2018, the insurer or plan shall permit health care practitioners to access the prior authorization form through the applicable electronic software system.

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

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

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

(i) A facsimile;

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

(3) For policies issued on or after January 1, 2018, a

health care practitioner and an insurer or plan may enter into a contractual arrangement under which the insurer or plan agrees to process prior authorization requests that are not submitted electronically because of the financial hardship that electronic submission of prior authorization requests would create for the health care practitioner or if internet connectivity is limited or unavailable where the health care practitioner is located.

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

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

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

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

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

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

(i) Twelve months;

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

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

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

(i) The request for information by the insurer or plan and the response by the health care practitioner shall be in an

electronic format, which may be by traditional electronic mail or other electronic communication.

(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.

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

(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.

(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:

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

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

(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;

(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;

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

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

(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:

(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.

(b) Medications that are controlled substances not included in division (B)(6)(e)(v) of this section.

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.

(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.

(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:

(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed.

(ii) The new service was not known to be needed at the time the original prior authorized service was performed.

(iii) The need for the new service was revealed at the time the original authorized service was performed.

(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.

(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.

(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.

(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.

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

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

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

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

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

(c) The appeal shall be between the health care practitioner requesting the service in question and a clinical

peer.

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

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

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

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

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

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

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

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

(4) On the date the health care practitioner renders the prior approved health care service, drug, or device, all of the

following are true:

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

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

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

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

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

(E) For policies issued on or after January 1, 2017, 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.

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

(G) This section does not apply to any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage as described in section 3923.37 of the Revised Code, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance as defined by the superintendent of insurance by rule; coverage under a plan through medicare or the federal employees benefit program; or any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

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

(B) The director of mental health and addiction services may withhold funds otherwise to be allocated to a board of alcohol, drug addiction, and mental health services under

section 5119.23 of the Revised Code if the board denies available service on the basis of race, color, religion, creed, sex, age, national origin, disability as defined in section 4112.01 of the Revised Code, or developmental disability.

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

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

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

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

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

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

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

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

(b) In the opinion of a practitioner with knowledge of the recipient's medical or behavioral condition, would subject the

recipient to adverse health consequences without the care or treatment that is the subject of the request.

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

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

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

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

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

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

(i) A facsimile;

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

(3) On or before January 1, 2018, a health care provider and the department of medicaid or its designee may enter into a contractual arrangement under which the department or its designee agrees to process prior authorization requests that are not submitted electronically because of the financial hardship that electronic submission of prior authorization requests would create for the provider or if internet connectivity is limited or unavailable where the provider is located.

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

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

(ii) For a response that is considered incomplete, the health care provider shall provide the additional information requested under division (B)(4)(b)(i) of this section within

seventy-two hours of the time the request is received by the provider.

(5)(a) On or before January 1, 2018, if a health care provider submits a prior authorization request as described in divisions (B)(1) and (2) of this section, the department or its designee shall provide an electronic receipt to the health care provider acknowledging that the prior authorization request was received.

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

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

(i) Twelve months;

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

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

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

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

(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.

(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.

(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.

(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:

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

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

(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;

(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;

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

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

(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:

(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.

(b) Medications that are controlled substances not included in division (B)(6)(e)(v) of this section.

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.

(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.

(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 question meets all of the following:

(i) The service is directly related to another service for which prior approval has already been obtained and that has already been performed.

(ii) The new service was not known to be needed at the time the original prior authorized service was performed.

(iii) The need for the new service was revealed at the time the original authorized service was performed.

(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.

(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.

(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.

(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.

(11)(a) On or before January 1, 2017, make available to all participating health care providers on its web site or provider portal a listing of its prior authorization requirements, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

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

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

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

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

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

(d) If the appeal does not resolve the disagreement, the appeal procedures shall permit the recipient to further appeal

in accordance with section 5160.31 of the Revised Code.

(C) Beginning January 1, 2017, except in cases of fraudulent or materially incorrect information, the department or its designee shall not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met:

(1) The health care provider submits a prior authorization request to the department or its designee for a health care service, drug, or device.

(2) The department or its designee approves the prior authorization request after determining that all of the following are true:

(a) The recipient is eligible for the health care service, drug, or device under the medical assistance program.

(b) The health care service, drug, or device is covered by the medical assistance program.

(c) The health care service, drug, or device meets the department's standards for medical necessity and prior authorization.

(3) The health care provider renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the health care provider's contract with the department or the department's designee.

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

(a) The recipient is eligible for the medical assistance

program.

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

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

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

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

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

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

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

Sec. 110.12. Sections 110.10 and 110.11 of ~~this act~~ Am.

Sub. H.B. 64 of the 131st General Assembly shall take effect ~~September 15, 2016~~July 1, 2017.

It is the intent of this amendment to delay the taking effect of the amendments to sections 340.01, 340.03, 340.15, and 5119.21 of the Revised Code, as contemplated by the amendment, until July 1, 2017.

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

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

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

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

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

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

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

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

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