

**As Introduced**

**134th General Assembly  
Regular Session  
2021-2022**

**H. B. No. 336**

**Representatives Lipps, West**

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**A BILL**

To amend sections 3901.81, 3901.811, 3902.50, 1  
3902.60, and 3902.70 and to enact sections 2  
3902.72, 3902.73, 3902.74, 3902.75, 3902.76, 3  
3902.77, 4729.66, 5167.124, 5167.125, 5167.126, 4  
5167.127, and 5167.128 of the Revised Code to 5  
impose requirements relating to health plan 6  
issuers, Medicaid, pharmacies, and cancer drugs. 7

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

**Section 1.** That sections 3901.81, 3901.811, 3902.50, 8  
3902.60, and 3902.70 be amended and sections 3902.72, 3902.73, 9  
3902.74, 3902.75, 3902.76, 3902.77, 4729.66, 5167.124, 5167.125, 10  
5167.126, 5167.127, and 5167.128 of the Revised Code be enacted 11  
to read as follows: 12

**Sec. 3901.81.** As used in this section and sections 13  
3901.811 to 3901.815 of the Revised Code: 14

(A) "Auditing entity" means any person or government 15  
entity that performs a pharmacy audit, including a payer, a 16  
pharmacy benefit manager, or a third-party administrator 17  
licensed under Chapter 3959. of the Revised Code. 18

(B) "Business day" means any day of the week excluding 19

Saturday, Sunday, and a legal holiday, as defined in section 20  
1.14 of the Revised Code. 21

(C) "Concurrent review" means a claims review within five 22  
business days of submission of claims for payment for the 23  
provision of dangerous drugs for which the payer or the auditing 24  
entity does not impose a penalty or demand to recoup money from 25  
the pharmacy in any amount. 26

(D) "Dangerous drug," "pharmacy," "practice of pharmacy," 27  
and "prescription" have the same meanings as in section 4729.01 28  
of the Revised Code. 29

(E) "Fraud" means knowingly engaging in deception with the 30  
intent of personal enrichment or gain. 31

(F) "Payer" means any of the following that pays for or 32  
processes a claim for payment for the provision of dangerous 33  
drugs or pharmacy services: 34

(1) A health insuring corporation, as defined in section 35  
1751.01 of the Revised Code; 36

(2) A person authorized to engage in the business of 37  
sickness and accident insurance under Title XXXIX of the Revised 38  
Code; 39

(3) A person or government entity providing coverage of 40  
dangerous drugs or pharmacy services to individuals on a self- 41  
insurance basis; 42

(4) A group health plan, as defined in 29 U.S.C. 1167; 43

(5) A service benefit plan, as referenced in 42 U.S.C. 44  
1396a(a) (25); 45

(6) A medicaid managed care organization that has entered 46

into a contract with the department of medicaid pursuant to 47  
section 5167.10 of the Revised Code; 48

(7) Any other person or government entity that is, by law, 49  
contract, or agreement, responsible for paying for or processing 50  
a claim for payment for the provision of dangerous drugs or 51  
pharmacy services. 52

~~(F)~~ (G) "Pharmacy audit" means a review of one or more 53  
pharmacy records conducted by an auditing entity, one purpose of 54  
which is to identify discrepancies in claims for payment for the 55  
provision of dangerous drugs or pharmacy services. "Pharmacy 56  
audit" does not include concurrent review. 57

~~(G)~~ (H) "Pharmacy benefit manager" means a person that 58  
provides administrative services related to the processing of 59  
claims for payment for the provision of dangerous drugs or 60  
pharmacy services, including performing pharmacy audit 61  
compliance, negotiating pharmaceutical rebate agreements, 62  
developing and managing drug formularies and preferred drug 63  
lists, and administering programs for payers' prior 64  
authorization of claims for payment for the provision of 65  
dangerous drugs or pharmacy services. 66

~~(H)~~ (I) "Pharmacy record" means any record stored 67  
electronically or as a hard copy by a pharmacy that relates to 68  
the provision of dangerous drugs or pharmacy services or any 69  
other component of pharmacist care that is included in the 70  
practice of pharmacy. 71

**Sec. 3901.811.** (A) Except as provided in division (B) of 72  
this section, an auditing entity is subject to all of the 73  
following conditions when performing a pharmacy audit in this 74  
state: 75

(1) If it is necessary that the pharmacy audit be 76  
performed on the premises of a pharmacy, the auditing entity 77  
shall give the pharmacy that is the subject of the audit written 78  
notice of the date or dates on which the audit will be performed 79  
and the range of prescription numbers from which the auditing 80  
entity will select pharmacy records to audit. Notice of the date 81  
or dates on which the audit will be performed shall be given not 82  
less than ten business days before the date the audit is to 83  
commence. Notice of the range of prescription numbers from which 84  
the auditing entity will select pharmacy records to audit shall 85  
be received by the pharmacy not less than seven business days 86  
before the date the audit is to commence. 87

(2) The auditing entity shall not include in the pharmacy 88  
audit a review of a claim for payment for the provision of 89  
dangerous drugs or pharmacy services if the date of the 90  
pharmacy's initial submission of the claim for payment occurred 91  
more than twenty-four months before the date the audit 92  
commences. 93

(3) Absent an indication that there was an error in the 94  
dispensing of a drug, the auditing entity or payer shall not 95  
seek to recoup from the pharmacy that is the subject of the 96  
audit any amount that the pharmacy audit identifies as being the 97  
result of clerical or recordkeeping errors in the absence of 98  
financial harm. For purposes of this provision, an error in the 99  
dispensing of a drug is any of the following: selecting an 100  
incorrect drug, issuing materially incorrect directions, or 101  
dispensing a drug to the incorrect patient. 102

(4) The auditing entity shall not use the accounting 103  
practice of extrapolation when calculating a monetary penalty to 104  
be imposed or amount to be recouped as the result of the 105

pharmacy audit. 106

(5) (a) An auditing entity shall not penalize a pharmacy 107  
based solely on the fact that all materials requested by the 108  
auditing entity are not available during an onsite audit; 109

(b) A pharmacy shall have the opportunity to provide 110  
supplemental materials to an auditing entity after the 111  
completion of an onsite audit. Such materials shall be subject 112  
to the same documentation standards as materials reviewed during 113  
the onsite audit. An auditing entity shall not reject a document 114  
merely on the basis that the document is not an original and 115  
shall accept documents sent via electronic or telephonic means. 116

(6) An audit shall be limited to the lesser of the 117  
following: 118

(a) Two hundred fifty prescriptions; 119

(b) The number of prescriptions dispensed by a pharmacy in 120  
the twenty-four month period prior to the audit. 121

(B) (1) The condition in division (A) (1) of this section 122  
does not apply if, prior to the audit, the auditing entity has 123  
evidence, from its review of claims data, statements, or 124  
physical evidence or its use of other investigative methods, 125  
indicating that fraud or other intentional or willful 126  
misrepresentation exists. 127

(2) The condition in division (A) (3) of this section does 128  
not apply if the auditing entity has evidence, from its review 129  
of claims data, statements, or physical evidence or its use of 130  
other investigative methods, indicating that fraud or other 131  
intentional or willful misrepresentation exists. 132

(3) Division (A) (4) of this section does not apply when 133

the accounting practice of extrapolation is required by state or 134  
federal law. 135

(C) An auditing entity shall not be compensated based on 136  
the level or amounts of recoupments. 137

(D) A pharmacy shall not be required to pay any disputed 138  
recoupments resulting from an audit until after the final 139  
disposition of the audit, including the conclusion of any 140  
relevant appeals or dispute processes. 141

(E) A pharmacy may seek injunctive relief against a payer 142  
or its contracted pharmacy benefit manager for a violation of 143  
this section by an auditing entity. 144

**Sec. 3902.50.** As used in sections 3902.50 to ~~3902.54~~ 145  
3902.77 of the Revised Code: 146

(A) "Ambulance" has the same meaning as in section 4765.01 147  
of the Revised Code. 148

(B) "Clinical laboratory services" has the same meaning as 149  
in section 4731.65 of the Revised Code. 150

(C) "Cost sharing" means the cost to a covered person 151  
under a health benefit plan according to any copayment, 152  
coinsurance, deductible, or other out-of-pocket expense 153  
requirement. 154

(D) "Covered person," "health benefit plan," "health care 155  
services," and "health plan issuer" have the same meanings as in 156  
section 3922.01 of the Revised Code. 157

(E) "Emergency facility" has the same meaning as in 158  
section 3701.74 of the Revised Code. 159

(F) "Emergency services" means all of the following as 160

described in 42 U.S.C. 1395dd:	161
(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;	162 163
(2) Treatment necessary to stabilize an emergency medical condition;	164 165
(3) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.	166 167
(G) <u>Except as in division (I) of this section and in sections 3902.51 to 3902.54 of the Revised Code, "health care provider" or "provider" has the same meaning as in section 3922.01 of the Revised Code.</u>	168 169 170 171
(H) <u>"Pharmacy" has the same meaning as in section 4729.01 of the Revised Code and also includes a dispensing physician.</u>	172 173
(I) <u>"Unanticipated out-of-network care" means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when either of the following conditions applies:</u>	174 175 176 177 178
(1) The covered person did not have the ability to request such services from an in-network provider.	179 180
(2) The services provided were emergency services.	181
<b>Sec. 3902.60.</b> As used in sections 3902.60 and 3902.61 of the Revised Code:	182 183
(A) "Associated conditions" means the symptoms or side effects of stage four advanced metastatic cancer, or the treatment thereof, which would, in the judgment of the health care practitioner in question, jeopardize the health of a	184 185 186 187

covered individual if left untreated. 188

~~(B) "Covered person," "health benefit plan," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.~~ 189  
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~~(C) "Stage four advanced metastatic cancer" means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.~~ 192  
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**Sec. 3902.70.** As used in this section and section 3902.71 of the Revised Code: 196  
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(A) "340B covered entity" and "third-party administrator" have the same meanings as in section 5167.01 of the Revised Code. 198  
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~~(B) "Health plan issuer" has the same meaning as in section 3922.01 of the Revised Code.~~ 201  
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~~(C) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.~~ 203  
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**Sec. 3902.72.** As used in sections 3902.72 to 3902.77 of the Revised Code: 205  
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(A) "Affiliated pharmacy" means a pharmacy in which a health plan issuer, either directly or indirectly through one or more intermediaries, has an investment or ownership interest or with which it shares common ownership. 207  
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(B) "Dispensing physician" means a physician who dispenses a "dangerous drug" as that term is defined in section 4729.01 of the Revised Code. 211  
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(C) Notwithstanding section 3902.50 of the Revised Code, 214



"health plan issuer" has the same meaning as in section 3922.01 215  
of the Revised Code, but also includes an auditing entity, as 216  
defined in section 3901.81 of the Revised Code. 217

(D) "Prior authorization" means any practice implemented 218  
by a health plan issuer in which coverage of a prescription drug 219  
is dependent upon a covered person or a physician obtaining 220  
approval from the health plan issuer prior to the drug being 221  
covered. "Prior authorization" includes prospective or 222  
utilization review procedures conducted prior to providing a 223  
drug. 224

**Sec. 3902.73.** (A) A health plan issuer that offers, 225  
issues, or administers a health benefit plan that covers 226  
pharmacy services, including prescription drug coverage, shall 227  
not do any of the following: 228

(1) Order or direct a covered person to fill a 229  
prescription at or obtain services from an affiliated pharmacy; 230

(2) Restrict a covered person's ability to select a 231  
pharmacy if the selected pharmacy is in the health plan issuer's 232  
pharmacy provider network; 233

(3) Impose a cost-sharing requirement on the covered 234  
person that differs depending on which in-network pharmacy the 235  
covered person uses; 236

(4) Impose any other condition on a covered person or 237  
pharmacy that restricts a covered person's ability to use an in- 238  
network pharmacy of the covered person's choosing; 239

(5) Prevent a pharmacy from participating in the health 240  
plan issuer's network if the pharmacy does both of the 241  
following: 242

<u>(a) Agrees to the reasonable and relevant terms and</u>	243
<u>conditions of the health plan issuer's pharmacy provider</u>	244
<u>contract;</u>	245
<u>(b) Provides pharmacy services in accordance with all</u>	246
<u>applicable state and federal laws.</u>	247
<u>(6) Require a pharmacy, as a condition of participation in</u>	248
<u>the health plan issuer's network, to meet accreditation</u>	249
<u>standards or certification requirements that are inconsistent</u>	250
<u>with or in addition to those of the state board of pharmacy.</u>	251
<u>(7) Transfer or share records relating to prescription</u>	252
<u>information containing patient-identifiable or prescriber-</u>	253
<u>identifiable data to an affiliated pharmacy for any commercial</u>	254
<u>purpose. Division (A) (7) of this section shall not be construed</u>	255
<u>to prohibit the exchange of prescription information between a</u>	256
<u>health plan issuer and an affiliated pharmacy for the limited</u>	257
<u>purposes of pharmacy reimbursement, formulary compliance,</u>	258
<u>pharmacy care, or utilization review.</u>	259
<u>(8) Knowingly make a misrepresentation to a covered</u>	260
<u>person, pharmacist, pharmacy, or dispensing physician.</u>	261
<u>(B) This section does not apply to either of the</u>	262
<u>following:</u>	263
<u>(1) A health benefit plan offered by a health insuring</u>	264
<u>corporation under which a majority of covered services are</u>	265
<u>provided by physicians employed by the health plan issuer or by</u>	266
<u>a single contracted medical group;</u>	267
<u>(2) Pharmacy services provided to an individual receiving</u>	268
<u>inpatient or emergency services at a health care facility that</u>	269
<u>provides medical services on an inpatient or resident basis.</u>	270

<u>Sec. 3902.74. (A) As used in this section:</u>	271
<u>(1) "Incentive payments and adjustments" means price</u>	272
<u>concessions, rebates, discounts, fees, reconciliation</u>	273
<u>adjustments, bonuses, performance payments, incentives, and any</u>	274
<u>other payment adjustment determined through the use of</u>	275
<u>performance criteria, regardless of when such adjustments are</u>	276
<u>applied.</u>	277
<u>(2) "Incentive payment and adjustment system" means a</u>	278
<u>system established by a health plan issuer for determining the</u>	279
<u>amount of payments to participating pharmacies that uses</u>	280
<u>incentive payments and adjustments to determine such payment</u>	281
<u>amounts.</u>	282
<u>(B) If a health plan issuer uses an incentive payment and</u>	283
<u>adjustment system to determine pharmacy reimbursement payments</u>	284
<u>for prescription drugs, the issuer and system shall meet all of</u>	285
<u>the following requirements:</u>	286
<u>(1) The process for determining the incentive payments and</u>	287
<u>adjustments, including performance criteria, shall be described</u>	288
<u>in an express contract between the health plan issuer and the</u>	289
<u>pharmacy entered into not less than six months prior to the</u>	290
<u>start of the period in which the pharmacy's performance is to be</u>	291
<u>measured.</u>	292
<u>(2) The incentive payments and adjustments shall be based</u>	293
<u>on the individual pharmacy's actual performance metrics under</u>	294
<u>the performance criteria.</u>	295
<u>(3) The pharmacy's evaluation shall be based on actual</u>	296
<u>data received from the pharmacy and not extrapolated from a</u>	297
<u>sample of data.</u>	298
<u>(4) The pharmacy's evaluation shall be based on objective</u>	299

performance standards, not on its performance relative to other 300  
pharmacies. 301

(5) The pharmacy's performance shall be evaluated using 302  
only performance criteria over which a pharmacy has meaningful 303  
control and that appropriately correspond to the types of 304  
services offered by the pharmacy, including the dispensing of 305  
specialty drugs. 306

(6) The incentive payments and adjustments shall not favor 307  
the health plan issuer's affiliated pharmacies or discriminate 308  
against nonaffiliated pharmacies. 309

(7) For each claim for which a pharmacy receives decreased 310  
reimbursement, the health plan issuer shall provide the pharmacy 311  
a written explanation detailing how the pharmacy failed to meet 312  
the applicable performance criteria and describing the steps it 313  
must take to improve its performance. The written explanation 314  
shall be provided at the time the incentive payments and 315  
adjustments are applied or as soon as practicable thereafter. 316

(8) Any potential decrease in reimbursement to a pharmacy 317  
is, at a minimum, matched by an equal potential increase in 318  
reimbursement. 319

**Sec. 3902.75.** Each contract between a health plan issuer 320  
and a pharmacy shall include a system by which the pharmacy can 321  
inform a covered person when a drug is available at a lower cost 322  
if purchased outside of the health benefit plan. 323

**Sec. 3902.76.** (A) As used in this section, "clean claim" 324  
means a claim that can be processed without obtaining additional 325  
information from the prescribing provider or a third party, is 326  
not for a recipient who receives financial assistance for the 327  
drug, and is not for a prescribed drug that is associated with a 328

national drug shortage that has been reported to the United States food and drug administration. 329  
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(B) A health plan issuer shall ensure that a covered person can obtain a covered orally administered prescription drug used to treat cancer within seventy-two hours following submission of a clean claim or prior authorization request to the health plan issuer, notwithstanding the prior authorization time limits established in section 1751.72 or 3923.041 of the Revised Code. If the health plan issuer is unable to do so by requiring the covered person to use a pharmacy in the issuer's pharmacy provider network or a dispensing physician in the issuer's physician provider network, the issuer shall cover the drug if purchased from an out-of-network pharmacy or out-of-network dispensing physician to the same extent as it would if the drug were dispensed by an in-network pharmacy or dispensing physician. 331  
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(C) Within twenty-four hours of submission to a health plan issuer of a clean claim or prior authorization request for the drug, the health plan issuer shall confirm receipt of the claim and notify the prescribing provider in writing of both of the following: 345  
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(1) Whether the drug is covered; 350

(2) If the drug is covered, any delay in authorization or coverage that would likely result in the covered person not being able to receive the drug within seventy-two hours following the initial submission of the claim. 351  
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(D) If it is likely that the drug will not be available to a covered person within seventy-two hours of the initial submission, the health plan issuer shall notify the covered 355  
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person that the covered person can use another pharmacy or 358  
dispensing physician to obtain the drug, including a pharmacy or 359  
dispensing physician that is not part of the health plan 360  
issuer's pharmacy provider or physician provider network. The 361  
notification shall be written in a clear, concise, and 362  
intelligible manner. 363

Sec. 3902.77. Any covered person or pharmacy affected by a 364  
violation of sections 3902.73 to 3902.76 of the Revised Code by 365  
a health plan issuer or one or more of its intermediaries may 366  
bring a civil action against the health plan issuer or the 367  
intermediary for compensatory damages and injunctive or other 368  
equitable relief. 369

Sec. 4729.66. No pharmacy shall mail a dangerous drug to a 370  
patient when the patient's prescriber has indicated that the 371  
patient needs an in-person consultation at the time the original 372  
or refill prescription is dispensed; provided, however, that a 373  
patient may voluntarily waive in writing the in-person 374  
consultation and elect to receive the dangerous drug via mail 375  
order. 376

Sec. 5167.124. (A) As used in this section and section 377  
5167.124 of the Revised Code: 378

(1) "Affiliated pharmacy" means a pharmacy in which a 379  
medicaid managed care organization, or a pharmacy benefit 380  
manager under contract with the medicaid director or a medicaid 381  
managed care organization to administer its prescribed drugs 382  
benefit, either directly or indirectly through one or more 383  
intermediaries, has an investment or ownership interest or with 384  
which it shares common ownership. 385

(2) "Dispensing physician" has the same meaning as in 386

<u>section 3902.72 of the Revised Code.</u>	387
<u>(3) "Pharmacy" has the same meaning as in section 3902.50</u>	388
<u>of the Revised Code.</u>	389
<u>(B) A medicaid managed care organization, or a pharmacy</u>	390
<u>benefit manager under contract with the medicaid director or a</u>	391
<u>medicaid managed care organization to administer its prescribed</u>	392
<u>drugs benefit, shall not do any of the following:</u>	393
<u>(1) Order or direct an enrollee to fill a prescription at</u>	394
<u>or obtain services from an affiliated pharmacy;</u>	395
<u>(2) Restrict an enrollee's ability to use a pharmacy if</u>	396
<u>the pharmacy is in the organization's pharmacy provider network;</u>	397
<u>(3) Impose a cost-sharing requirement on an enrollee that</u>	398
<u>differs depending on which participating in-network pharmacy the</u>	399
<u>enrollee uses;</u>	400
<u>(4) Impose any other condition on an enrollee or a</u>	401
<u>pharmacy that restricts the enrollee's ability to use an in-</u>	402
<u>network pharmacy of the enrollee's choosing;</u>	403
<u>(5) Prevent a pharmacy from becoming a participating</u>	404
<u>pharmacy if the pharmacy does both of the following:</u>	405
<u>(a) Agrees to the reasonable and relevant terms and</u>	406
<u>conditions of the medicaid managed care organization's pharmacy</u>	407
<u>provider contract;</u>	408
<u>(b) Provides pharmacy services in accordance with state</u>	409
<u>and federal law.</u>	410
<u>(6) Require a pharmacy, as a condition of participating in</u>	411
<u>the organization's network, to meet accreditation standards or</u>	412
<u>certification requirements that are inconsistent with or in</u>	413

addition to those of the state board of pharmacy; 414

(7) Transfer or share records relating to prescription 415  
information containing patient-identifiable or prescriber- 416  
identifiable data to an affiliated pharmacy for any commercial 417  
purpose. This division shall not be construed to prohibit the 418  
exchange of prescription information between a medicaid managed 419  
care organization and an affiliated pharmacy for the limited 420  
purposes of pharmacy reimbursement, formulary compliance, 421  
pharmacy care, or utilization review. 422

(8) Knowingly make a misrepresentation to an enrollee, 423  
pharmacist, pharmacy, or dispensing physician. 424

(C) This section does not apply to either of the 425  
following: 426

(1) A health benefit plan that is offered under the care 427  
management system and under which a majority of covered services 428  
are provided by physicians employed by the medicaid managed care 429  
organization or by a single contracted medical group; 430

(2) Pharmacy services provided to an individual receiving 431  
inpatient or emergency services at a health care facility that 432  
provides medical services on an inpatient or resident basis. 433

**Sec. 5167.125. (A) As used in this section, "incentive** 434  
**payments and adjustments" and "incentive payment and adjustment** 435  
**system" have the same meanings as in section 3902.74 of the** 436  
**Revised Code.** 437

(B) If a medicaid managed care organization uses an 438  
incentive payment and adjustment system to determine the payment 439  
owed to a pharmacy for dispensing a prescribed drug to an 440  
enrollee, the system shall meet all of the following 441  
requirements: 442



(1) The process for determining the incentive payments and adjustments, including any performance criteria, shall be described in an express contract between the medicaid managed care organization and the pharmacy entered into not less than six months prior to the start of the period when the pharmacy's performance will be measured. 443  
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(2) The incentive payments and adjustments shall be based on the individual pharmacy's actual performance metrics under the performance criteria. 449  
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(3) The pharmacy's evaluation shall be based on actual data received from the pharmacy and not extrapolated from a sample of data. 452  
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(4) The pharmacy's evaluation shall be based on objective performance standards, not on its performance relative to other pharmacies. 455  
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(5) The pharmacy's performance shall be evaluated using only performance criteria over which the pharmacy has meaningful control and that appropriately correspond to the types of services offered by the pharmacy, including the dispensing of specialty drugs. 458  
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(6) The incentive payments and adjustments shall not favor the medicaid managed care organization's affiliated pharmacies or discriminate against nonaffiliated pharmacies. 463  
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(7) For each claim for which a pharmacy receives a decreased payment, the medicaid managed care organization shall provide to the pharmacy a written explanation detailing how the pharmacy failed to meet the applicable performance criteria and describing the steps it must take to improve its performance. The written explanation shall be provided at the time the 466  
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incentive payments or adjustments are applied, or as soon as 472  
practicable thereafter. 473

(8) Any potential decrease in payment to a pharmacy from 474  
incentive payments and adjustments shall be matched, at minimum, 475  
by a potential increase in payment to the pharmacy. 476

**Sec. 5167.126.** Each contract between a medicaid managed 477  
care organization and a pharmacy shall include a system by which 478  
the pharmacy can inform an enrollee whenever a prescribed drug 479  
is available at a lower cost outside of coverage under the 480  
medicaid managed care organization's plan. 481

**Sec. 5167.127.** (A) As used in this section: 482

(1) "Clean claim" has the same meaning as in section 483  
3902.76 of the Revised Code. 484

(2) "Dispensing physician" has the same meaning as in 485  
section 3902.72 of the Revised Code. 486

(B) A medicaid managed care organization shall ensure that 487  
an enrollee can obtain an orally administered prescribed drug 488  
used to treat cancer within seventy-two hours following 489  
submission of a clean claim or prior authorization request to 490  
the medicaid managed care organization, notwithstanding the 491  
prior authorization requirement time limits established in 492  
section 5160.34 of the Revised Code. If the medicaid managed 493  
care organization is unable to do so through a pharmacy in the 494  
organization's pharmacy network or a dispensing physician in the 495  
organization's provider network, it shall cover the drug if 496  
purchased from an out-of-network pharmacy to the same extent as 497  
if the drug were dispensed by an in-network pharmacy or 498  
dispensing physician. 499

(C) Within twenty-four hours of submission to a medicaid 500

managed care organization of a clean claim or prior 501  
authorization request for the drug, the medicaid managed care 502  
organization shall confirm receipt of the claim or request and 503  
notify the prescribing provider in writing of both of the 504  
following: 505

(1) Whether the drug is covered; 506

(2) If the drug is covered, any delay in authorization or 507  
coverage that would likely result in the enrollee not being able 508  
to receive the drug within seventy-two hours from the initial 509  
submission of the claim. 510

(D) If it is likely that the drug will not be available to 511  
an enrollee within seventy-two hours from the initial 512  
submission, the medicaid managed care organization shall notify 513  
the enrollee that the medicaid recipient enrollee can use 514  
another pharmacy or dispensing physician to obtain the drug, 515  
including a pharmacy or dispensing physician that is not part of 516  
the organization's pharmacy or physician provider network. The 517  
notification shall be written in a clear, concise, and 518  
intelligible manner. 519

**Sec. 5167.128.** Any enrollee or pharmacy affected by a 520  
violation of sections 5167.123 to 5167.126 of the Revised Code 521  
by a medicaid managed care organization or one or more of the 522  
organization's intermediaries, including a pharmacy benefit 523  
manager, may bring a civil action against the organization or 524  
the intermediary for compensatory damages and injunctive or 525  
other equitable relief. 526

**Section 2.** That existing sections 3901.81, 3901.811, 527  
3902.50, 3902.60, and 3902.70 of the Revised Code are hereby 528  
repealed. 529

**Section 3.** Sections 3901.81, 3901.811, 3902.50, 3902.60, 530  
and 3902.70 of the Revised Code, as amended in this act, and 531  
sections 3902.72, 3902.73, 3902.74, 3902.75, 3902.76, and 532  
3902.77 of the Revised Code, as enacted in this act, apply to 533  
health benefit plans, as defined in section 3922.01 of the 534  
Revised Code, delivered, issued for delivery, modified, or 535  
renewed on or after the effective date of those sections. 536

**Section 4.** Sections 3901.81, 3901.811, 3902.50, 3902.60, 537  
and 3902.70 of the Revised Code, as amended in this act, and 538  
sections 3902.72, 3902.73, 3902.74, 3902.75, 3902.76, and 539  
3902.77 of the Revised Code, as enacted in this act, apply to 540  
contracts between health plan issuers, as defined in section 541  
3922.01 of the Revised Code, and pharmacies entered into, 542  
modified, or renewed on or after the effective date of those 543  
sections. 544