As Introduced

136th General Assembly
Regular Session
2025-2026

S. B. No. 386

Senators Blessing, Liston

To amend sections 126.021, 126.024, 173.19, 1751.03, 3701.741, 3901.81, 3902.70, 3903.14, 3903.42, 3959.01, 3963.06, 4121.50, 4729.20, 4729.49, 4729.80, 4729.84, 4729.86, 5160.01, 5160.34, 5160.37, 5160.371, 5160.40, 5162.01, 5162.021, 5162.13, 5162.1310, 5162.73, 5164.01, 5164.38, 5164.46, 5164.74, 5164.751, 5166.01, 5166.40, 5166.405, 5166.406, 5168.75, 5168.76, 5739.01, and 5739.03; to amend, for the purpose of adopting a new section number as indicated in parentheses, section 5162.73 (5162.74); to enact new section 5162.73; and to repeal sections 1751.271, 3901.815, 3903.421, 5164.741, 5167.01, 5167.02, 5167.03, 5167.031, 5167.04, 5167.05, 5167.051, 5167.09, 5167.10, 5167.101, 5167.103, 5167.11, 5167.12, 5167.122, 5167.123, 5167.13, 5167.14, 5167.15, 5167.16, 5167.17, 5167.171, 5167.173, 5167.18, 5167.20, 5167.201, 5167.21, 5167.22, 5167.221, 5167.24, 5167.241, 5167.243, 5167.244, 5167.245, 5167.26, 5167.30, 5167.31, 5167.32, 5167.33, 5167.34, 5167.35, 5167.40, 5167.41, 5167.45, 5167.47, and 5739.051 of the Revised Code to eliminate the care management system from the Medicaid program and to name this act the Medicaid Savings Act.

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

Section 1. That sections 126.021, 126.024, 173.19, 1751.03, 3701.741, 3901.81, 3902.70, 3903.14, 3903.42, 3959.01, 3963.06, 4121.50, 4729.20, 4729.49, 4729.80, 4729.84, 4729.86, 5160.01, 5160.34, 5160.37, 5160.371, 5160.40, 5162.01, 5162.021, 5162.13, 5162.1310, 5162.73, 5164.01, 5164.38, 5164.46, 5164.74, 5164.751, 5166.01, 5166.40, 5166.405, 5166.406, 5168.75, 5168.76, 5739.01, and 5739.03 be amended; section 5162.73 (5162.74) be amended for the purpose of adopting a new section number as indicated in parentheses; and new section 5162.73 of the Revised Code be enacted to read as follows:

Sec. 126.021. The director of budget and management, as part of the submission to the governor under section 126.02 of the Revised Code, shall prepare and submit to the governor not later than the first day of January preceding the convening of the general assembly a medicaid caseload and expenditure forecast report, prepared in consultation with the department of medicaid. For each component identified in divisions (A) to (Q) of this section, the report shall include proposed, actual, or estimated medicaid program data for each fiscal year of the proposed budget biennium and for each fiscal year of the current budget biennium. If determined useful, the directors of budget and management and medicaid may choose to include additional years of data for components of the report.

The report shall include all of the following:

(A) A complete budget for the medicaid program delineated by the agency administering each component of the program, fund, appropriation item, and whether the spending is for services or

administration;

(B) A summary of medicaid service spending by eligibility group and subgroup and service delivery system;

(C) A detailed mapping of the summary spending provided in division (B) of this section into individual appropriation items and including state and federal shares of each appropriation item;

(D) A complete description of each policy proposal, including assumed start date and cost projection delineated by fiscal year, appropriation item, state and federal shares, eligibility group and subgroup, and service delivery system;

(E) The medicaid caseload delineated by eligibility group and subgroup and service delivery system;

(F) ~~The percentage of total medicaid enrollment that is comprised of medicaid recipients enrolled under the care management system established under section 5167.03 of the Revised Code and the percentage of total medicaid spending that the care management system comprises;~~

~~(G)~~ A detailed accounting of the care management system component of the medicaid budget by eligibility group and subgroup, including spending, member months, and per member per month capitation rates;

~~(H)~~ (G) A detailed accounting of the fee-for-service component of the medicaid budget by eligibility group and subgroup, including spending, member months, and per member per month costs;

~~(I)~~ (H) Historical spending data by service delivery system, medicaid provider and program, including at least the

following provider categories: hospital, pharmacy, waiver, nursing, home health care, professional medical and clinic, nursing facility, behavioral health care, and intermediate care facility for individuals with intellectual disabilities;

~~(J)~~ (I) A detailed accounting of the medicare buy-in and medicare Part D components of the medicaid budget by eligibility group and subgroup, including spending, average monthly premiums, and average rates;

~~(K)~~ (J) A summary of projected spending for each fiscal year delineated by forecast component and by baseline and policy proposals;

~~(L)~~ (K) A detailed calculation demonstrating the effect of a hypothetical one-dollar increase in medicaid home and community-based services wages for direct care providers for each fiscal year, delineated by provider, appropriation item, and state and federal shares;

~~(M)~~ (L) A detailed calculation demonstrating the effect of a hypothetical one percentage point increase in provider franchise fee revenue for each fiscal year, for each of the fees imposed under sections 5168.21, 5168.41, and 5168.76 of the Revised Code;

~~(N)~~ (M) A detailed calculation demonstrating the effect of a hypothetical one-dollar increase in nursing facility and intermediate care facility for individuals with intellectual disabilities per medicaid day payment rates;

~~(O)~~ (N) A detailed explanation of how the governor's medicaid budget recommendations satisfy the requirements of section 5162.70 of the Revised Code;

~~(P)~~ (O) The most recent report required under section

5162.70 of the Revised Code;

~~(Q)~~ (P) Any other information the director of budget and management or the medicaid director deems to be useful to facilitate a better understanding of the governor's medicaid budget recommendations.

Sec. 126.024. Beginning with the state budget that is introduced following ~~the effective date of this section~~September 30, 2025, and subsequent state budgets thereafter, the director of budget and management, in consultation with the medicaid director, shall request and propose multiple medicaid health care services general revenue fund appropriation items. At a minimum, the directors shall propose a separate general revenue fund appropriation item for the different health care services included in the medicaid program, including all of the following:

(A) ~~Services provided under the care management system;~~

~~(B)~~ Nursing facility services;

~~(C)~~ (B) Hospital services;

~~(D)~~ (C) Behavioral health services;

~~(E)~~ (D) Services provided under medicaid waiver components administered by the department of aging;

~~(F)~~ (E) Prescription drug services;

~~(G)~~ (F) Physician services;

~~(H)~~ (G) Services provided under the Ohio home care waiver program;

~~(I)~~ (H) Services provided under medicaid waiver components administered by the department of developmental disabilities;

~~(J)~~ (I) Services provided under the medicaid waiver component known as the Ohio resilience through integrated systems and excellence (OhioRISE) waiver;

~~(K)~~ (J) Any other medicaid health care services that the directors determine should have a separate general revenue fund appropriation item.

Sec. 173.19. (A) The office of the state long-term care ombudsman program, through the state long-term care ombudsman and the regional long-term care ombudsman programs, shall receive, investigate, and attempt to resolve complaints made by residents, recipients, sponsors, long-term care providers, or any person acting on behalf of a resident or recipient, relating to either of the following:

(1) The health, safety, welfare, or civil rights of a resident or recipient or any violation of a resident's rights described in sections 3721.10 to 3721.17 of the Revised Code;

(2) Any action or inaction or decision by any of the following that may adversely affect the health, safety, welfare, or rights of a resident or recipient: a long-term care provider or a representative of a long-term care provider~~; a medicaid managed care organization, as defined in section 5167.01 of the Revised Code; a government entity;~~ or a private social service agency.

(B) The department of aging shall adopt rules in accordance with Chapter 119. of the Revised Code regarding the handling of complaints received under this section, including procedures for conducting investigations of complaints. The rules shall include procedures to ensure that no representative of the office investigates any complaint involving a long-term

care provider with which the representative was once employed or associated.

The state ombudsman and regional programs shall establish procedures for handling complaints consistent with the department's rules. Complaints shall be dealt with in accordance with the procedures established under this division.

(C) The office of the state long-term care ombudsman program may decline to investigate any complaint if it determines any of the following:

(1) That the complaint is frivolous, vexatious, or not made in good faith;

(2) That the complaint was made so long after the occurrence of the incident on which it is based that it is no longer reasonable to conduct an investigation;

(3) That an adequate investigation cannot be conducted because of insufficient funds, insufficient staff, lack of staff expertise, or any other reasonable factor that would result in an inadequate investigation despite a good faith effort;

(4) That an investigation by the office would create a real or apparent conflict of interest.

(D) If a regional long-term care ombudsman program declines to investigate a complaint, it shall refer the complaint to the state long-term care ombudsman.

(E) Each complaint to be investigated by a regional program shall be assigned to a representative of the office of the state long-term care ombudsman program. If the representative determines that the complaint is valid, the representative shall assist the parties in attempting to resolve

it. If the representative is unable to resolve it, the representative shall refer the complaint to the state ombudsman.

In order to carry out the duties of sections 173.14 to 173.28 of the Revised Code, a representative has the right to private communication with residents and their sponsors and access to long-term care facilities, including the right to tour resident areas unescorted and the right to tour facilities unescorted as reasonably necessary to the investigation of a complaint. Access to facilities shall be during reasonable hours or, during investigation of a complaint, at other times appropriate to the complaint.

When community-based long-term care services are provided at a location other than the recipient's home, a representative has the right to private communication with the recipient and the recipient's sponsors and access to the community-based long-term care site, including the right to tour the site unescorted. Access to the site shall be during reasonable hours or, during the investigation of a complaint, at other times appropriate to the complaint.

(F) The state ombudsman shall determine whether complaints referred to the ombudsman under division (D) or (E) of this section warrant investigation. The ombudsman's determination in this matter is final.

(G) No long-term care provider or other entity, no person employed by a long-term care provider or other entity, and no other individual shall do either of the following:

(1) Knowingly deny a representative of the office of the state long-term care ombudsman program the right to private communication or access described in division (E) of this

section;

(2) Engage in willful interference.

As used in division (G)(2) of this section, "willful interference" means any action or inaction that is intended to prevent, interfere with, or impede a representative of the office of the state long-term care ombudsman program from exercising any of the rights or performing any of the duties of an ombudsman set forth in sections 173.14 to 173.28 of the Revised Code.

Sec. 1751.03. (A) Each application for a certificate of authority under this chapter shall be verified by an officer or authorized representative of the applicant, shall be in a format prescribed by the superintendent of insurance, and shall set forth or be accompanied by the following:

(1) A certified copy of the applicant's articles of incorporation and all amendments to the articles of incorporation;

(2) A copy of any regulations adopted for the government of the corporation, any bylaws, and any similar documents, and a copy of all amendments to these regulations, bylaws, and documents. The corporate secretary shall certify that these regulations, bylaws, documents, and amendments have been properly adopted or approved.

(3) A list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant, including all members of the board, the principal officers, and the person responsible for completing or filing financial statements with the department of insurance, accompanied by a completed original biographical affidavit and release of

information for each of these persons on forms acceptable to the department;

(4) A full and complete disclosure of the extent and nature of any contractual or other financial arrangement between the applicant and any provider or a person listed in division (A)(3) of this section, including, but not limited to, a full and complete disclosure of the financial interest held by any such provider or person in any health care facility, provider, or insurer that has entered into a financial relationship with the health insuring corporation;

(5) A description of the applicant, its facilities, and its personnel, including, but not limited to, the location, hours of operation, and telephone numbers of all contracted facilities;

(6) The applicant's projected annual enrollee population over a three-year period;

(7) A clear and specific description of the health care plan or plans to be used by the applicant, including a description of the proposed providers, procedures for accessing care, and the form of all proposed and existing contracts relating to the administration, delivery, or financing of health care services;

(8) A copy of each type of evidence of coverage and identification card or similar document to be issued to subscribers;

(9) A copy of each type of individual or group policy, contract, or agreement to be used;

(10) The schedule of the proposed contractual periodic prepayments or premium rates, or both, accompanied by

appropriate supporting data;

(11) A financial plan which provides a three-year projection of operating results, including the projected expenses, income, and sources of working capital;

(12) The enrollee complaint procedure to be utilized as required under section 1751.19 of the Revised Code;

(13) A description of the procedures and programs to be implemented on an ongoing basis to assure the quality of health care services delivered to enrollees, including, if applicable, a description of a quality assurance program complying with the requirements of sections 1751.73 to 1751.75 of the Revised Code;

(14) A statement describing the geographic area or areas to be served, by county;

(15) A copy of all solicitation documents;

(16) A balance sheet and other financial statements showing the applicant's assets, liabilities, income, and other sources of financial support;

(17) A description of the nature and extent of any reinsurance program to be implemented, and a demonstration that errors and omission insurance and, if appropriate, fidelity insurance, will be in place upon the applicant's receipt of a certificate of authority;

(18) Copies of all proposed or in force related-party or intercompany agreements with an explanation of the financial impact of these agreements on the applicant. If the applicant intends to enter into a contract for managerial or administrative services, with either an affiliated or an unaffiliated person, the applicant shall provide a copy of the

contract and a detailed description of the person to provide these services. The description shall include that person's experience in managing or administering health care plans, a copy of that person's most recent audited financial statement, and a completed biographical affidavit on a form acceptable to the superintendent for each of that person's principal officers and board members and for any additional employee to be directly involved in providing managerial or administrative services to the health insuring corporation. If the person to provide managerial or administrative services is affiliated with the health insuring corporation, the contract must provide for payment for services based on actual costs.

(19) A statement from the applicant's board that the admitted assets of the applicant have not been and will not be pledged or hypothecated;

(20) A statement from the applicant's board that the applicant will submit monthly financial statements during the first year of operations;

(21) The name and address of the applicant's Ohio statutory agent for service of process, notice, or demand;

(22) Copies of all documents the applicant filed with the secretary of state;

(23) The location of those books and records of the applicant that must be maintained, which books and records shall be maintained in Ohio if the applicant is a domestic corporation, and which may be maintained either in the applicant's state of domicile or in Ohio if the applicant is a foreign corporation;

(24) The applicant's federal identification number,

corporate address, and mailing address;

(25) An internal and external organizational chart;

(26) A list of the assets representing the initial net worth of the applicant;

(27) If the applicant has a parent company, the parent company's guaranty, on a form acceptable to the superintendent, that the applicant will maintain Ohio's minimum net worth. If no parent company exists, a statement regarding the availability of future funds if needed.

(28) The names and addresses of the applicant's actuary and external auditors;

(29) If the applicant is a foreign corporation, a copy of the most recent financial statements filed with the insurance regulatory agency in the applicant's state of domicile;

(30) If the applicant is a foreign corporation, a statement from the insurance regulatory agency of the applicant's state of domicile stating that the regulatory agency has no objection to the applicant applying for an Ohio license and that the applicant is in good standing in the applicant's state of domicile;

(31) Any other information that the superintendent may require~~;~~

~~(32) Documentation acceptable to the superintendent of the bond or securities required by section 1751.271 of the Revised Code~~.

(B)(1) A health insuring corporation, unless otherwise provided for in this chapter or in section 3901.321 of the Revised Code, shall file a timely notice with the superintendent

describing any change to the corporation's articles of incorporation or regulations, or any major modification to its operations as set out in the information required by division (A) of this section that affects any of the following:

(a) The solvency of the health insuring corporation;

(b) The health insuring corporation's continued provision of services that it has contracted to provide;

(c) The manner in which the health insuring corporation conducts its business.

(2) If the change or modification is to be the result of an action to be taken by the health insuring corporation, the notice shall be filed with the superintendent prior to the health insuring corporation taking the action. The action shall be deemed approved if the superintendent does not disapprove it within sixty days of filing.

(3) The filing of a notice pursuant to division (B)(1) or (2) of this section shall also serve as the submission of a notice when required for the superintendent's review for purposes of section 3901.341 of the Revised Code, if the notice contains all of the information that section 3901.341 of the Revised Code requires for such submissions and a copy of any written agreement. The filing of such a notice, for the purpose of satisfying this division and section 3901.341 of the Revised Code, shall be subject to the sixty-day review period of division (B)(2) of this section.

(C)(1) No health insuring corporation shall expand its approved service area until a copy of the request for expansion, accompanied by documentation of the network of providers, forms of all proposed or existing provider contracts relating to the

delivery of health care services, a schedule of proposed contractual periodic prepayments and premium rates for group contracts accompanied by appropriate supporting data, enrollment projections, plan of operation, and any other changes have been filed with the superintendent.

(2) Within seventy-five days after the superintendent's receipt of a complete filing under division (C)(1) of this section, the superintendent shall determine whether the plan for expansion is lawful, fair, and reasonable.

If the superintendent has not approved or disapproved all or a portion of a service area expansion within the seventy-five-day period, the filing shall be deemed approved.

(3) Disapproval of all or a portion of the filing shall be effected by written notice, which shall state the grounds for the order of disapproval and shall be given in accordance with Chapter 119. of the Revised Code.

(D) The agent named under division (A)(21) of this section shall be one of the following:

(1) A natural person who is a resident of this state;

(2) A domestic or foreign corporation, nonprofit corporation, limited liability company, partnership, limited partnership, limited liability partnership, limited partnership association, professional association, business trust, or unincorporated nonprofit association that has a business address in this state. If the agent is an entity other than a domestic corporation, the agent shall meet the requirements of Title XVII of the Revised Code for an entity of the agent's type to transact business or exercise privileges in this state.

Sec. 3701.741. (A) Each health care provider and medical

records company shall provide copies of medical records in accordance with this section.

(B) Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a patient's medical record shall charge not more than the amounts set forth in this section.

(1)(a) Except as provided in division (B)(1)(b) of this section, if the request is made by the patient, the patient's personal representative, or an individual authorized to access the patient's medical record through a valid power of attorney, total costs for copies and all services related to those copies shall be reasonable, cost-based amounts permitted to be charged to the patient under federal laws and regulations. Any per page charges shall not exceed the sum of the per page charges authorized in division (B)(2)(b) and (c) of this section.

(b) If the request is made by a person identified in division (B)(1)(a) of this section and the request is for access to digital records or electronically transmitted records, the total cost for that access or for the electronic transmission, and all related services, shall not exceed fifty dollars.

(2) If the request is made by anyone other than a person identified in division (B)(1)(a) of this section, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) An initial fee of sixteen dollars and eighty-four cents adjusted in accordance with section 3701.742 of the Revised Code, which shall compensate for the records search;

(b) Except as provided in division (B)(2)(c) of this

section, with respect to data recorded on paper or electronically, the following amounts adjusted in accordance with section 3701.742 of the Revised Code:

(i) One dollar and eleven cents per page for the first ten pages;

(ii) Fifty-seven cents per page for pages eleven through fifty;

(iii) Twenty-three cents per page for pages fifty-one and higher.

(c) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded on paper or film, one dollar and eighty-seven cents per page;

(d) The actual cost of any related postage incurred by the health care provider or medical records company.

(C)(1) On request, a health care provider or medical records company shall provide one copy of the patient's medical record and one copy of any records regarding treatment performed subsequent to the original request, not including copies of records already provided, without charge to the following:

(a) The bureau of workers' compensation, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

(b) The industrial commission, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

(c) The department of medicaid or a county department of job and family services, in accordance with Chapters 5160.,

5161., 5162., 5163., 5164., 5165., and 5166.~~, and 5167.~~ of the Revised Code and the rules adopted under those chapters;

(d) The attorney general, in accordance with sections 2743.51 to 2743.72 of the Revised Code and any rules that may be adopted under those sections;

(e) A patient, patient's personal representative, or authorized person if the medical record is necessary to support a claim under Title II or Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401 and 1381, as amended, and the request is accompanied by documentation that a claim has been filed.

(2) Nothing in division (C)(1) of this section requires a health care provider or medical records company to provide a copy without charge to any person or entity not listed in division (C)(1) of this section.

(D) Division (C) of this section shall not be construed to supersede any rule of the bureau of workers' compensation, the industrial commission, or the department of medicaid.

(E) A health care provider or medical records company may enter into a contract with either of the following for the copying of medical records at a fee other than as provided in division (B) of this section:

(1) A patient, a patient's personal representative, or an authorized person;

(2) An insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code.

(F) This section does not apply to medical records the copying of which is covered by section 173.20 of the Revised Code or by 42 C.F.R. 483.10.

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

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

(B) "Business day" means any day of the week excluding Saturday, Sunday, and a legal holiday, as defined in section 1.14 of the Revised Code.

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

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

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

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

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

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

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

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

(6) ~~A medicaid managed care organization that has entered into a contract with the department of medicaid pursuant to section 5167.10 of the Revised Code;~~

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

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

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

(H) "Pharmacy record" means any record stored electronically or as a hard copy by a pharmacy that relates to

the provision of dangerous drugs or pharmacy services or any other component of pharmacist care that is included in the practice of pharmacy.

Sec. 3902.70. As used in this section and section 3902.71 of the Revised Code:

(A) "340B covered entity" means an entity described in section 340B(a)(4) of the "Public Health Service Act," 42 U.S.C. 256b(a)(4) and includes any pharmacy under contract with the entity to dispense drugs on behalf of the entity.

(B) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.

(C) "Third-party administrator" has the same meaning as in section ~~5167.01~~ 4729.49 of the Revised Code.

Sec. 3903.14. (A) The superintendent of insurance as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the superintendent may employ such clerks and assistants as considered necessary. The compensation of the special deputies, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the superintendent, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the superintendent. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the superintendent may advance the costs so incurred out of any appropriation for the maintenance of the department of insurance. Any amounts so advanced for expenses of

administration shall be repaid to the superintendent for the use of the department out of the first available money of the insurer.

(B) The rehabilitator may take such action as the rehabilitator considers necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(C) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, director, trustee, broker, employee, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

(D) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens

upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(E) ~~In the case of a medicaid health insuring corporation that has posted a bond or deposited securities in accordance with section 1751.271 of the Revised Code, the plan proposed under division (D) of this section may include the use of the proceeds of the bond or securities to first pay the claims of contracted providers for covered health care services provided to medicaid recipients, then next to pay other claimants with any remaining funds, consistent with the priorities set forth in sections 3903.421 and 3903.42 of the Revised Code.~~

~~(F)~~ The rehabilitator shall have the power under sections 3903.26 and 3903.27 of the Revised Code to avoid fraudulent transfers.

~~(G) As used in this section:~~

~~(1) "Contracted provider" means a provider with a contract with a medicaid health insuring corporation to provide covered health care services to medicaid recipients.~~

~~(2) "Medicaid recipient" means a person enrolled in the medicaid program.~~

Sec. 3903.42. The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within

any class. The order of distribution of claims shall be:

(A) Class 1. The costs and expenses of administration, including but not limited to the following:

(1) The actual and necessary costs of preserving or recovering the assets of the insurer;

(2) Compensation for all services rendered in the liquidation;

(3) Any necessary filing fees;

(4) The fees and mileage payable to witnesses;

(5) Reasonable attorney's fees;

(6) The reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(B) Class 2. All claims under policies for losses incurred, including third party claims, ~~all claims of contracted providers against a medicaid health insuring corporation for covered health care services provided to medicaid recipients,~~ all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance, annuity policies, and funding agreements, whether for death proceeds, annuity proceeds, investment values, principal, or interest, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance,

or as gratuities. No payment by an employer to an employee shall be treated as a gratuity. Claims under nonassessable policies for unearned premium or other premium refunds.

(C) Class 3. Claims of the federal government.

(D) Class 4. Debts due to employees for services performed to the extent that they do not exceed one thousand dollars and represent payment for services performed within one year before the filing of the complaint for liquidation. Officers and directors shall not be entitled to the benefit of this priority. Such priority shall be in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

(E) Class 5. Claims of general creditors.

(F) Class 6. Claims of any state or local government. Claims, including those of any state or local governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under division (J) of this section.

(G) Class 7. Claims filed late or any other claims other than claims under divisions (H), (I), and (J) of this section.

(H) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(I) Class 9. Interest at the legal rate compounded annually on all claims in the classes prescribed in divisions

(A) to (H) of this section, except for claims of the federal government, from the date of the order for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the interest or dividend is declared, according to the terms of a plan proposed by the liquidator and approved by the court supervising the liquidation. The liquidator, with the approval of the court, may make reasonable approximate computations of interest to be paid under this division.

(J) Class 10. The claims of shareholders or other owners.

If any provision of this section or the application of any provision of this section to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this section, and to this end the provisions are severable.

(K) As used in sections 3903.42 and 3903.421 of the Revised Code, "contracted provider" and "medicaid recipient" have the same meanings as in section 3903.14 of the Revised Code.

Sec. 3959.01. As used in this chapter:

(A) "Administration fees" means any amount charged a covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs. "Administrator" includes a pharmacy benefit manager. "Administrator" does not include any

of the following:

(1) An insurance agent or solicitor licensed in this state whose activities are limited exclusively to the sale of insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company that is authorized to write life or sickness and accident insurance in this state.

(C) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

(D) "Contracted pharmacy" or "pharmacy" means a pharmacy located in this state participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a pharmacy services administration organization, group purchasing

organization, or another contracting agent.

(E) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan descriptions, and contracts of insurance.

(F) "Drug product reimbursement" means the amount paid by a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.

(G) "Fiduciary" has the meaning set forth in section 1002(21)(A) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C. 1001, as amended.

(H) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

(I) "Insurer" means an entity authorized to do the business of insurance in this state or, for the purposes of this section, a health insuring corporation authorized to issue health care plans in this state.

(J) "Managed care organization" means an entity that provides medical management and cost containment services ~~and includes a medicaid managed care organization, as defined in section 5167.01 of the Revised Code~~.

(K) "Maximum allowable cost" means a maximum drug product reimbursement for an individual drug or for a group of therapeutically and pharmaceutically equivalent multiple source drugs that are listed in the United States food and drug

administration's approved drug products with therapeutic equivalence evaluations, commonly referred to as the orange book.

(L) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost.

(M) "Multiple employer welfare arrangement" has the same meaning as in section 1739.01 of the Revised Code.

(N) "Pharmacy benefit manager" means an entity that contracts with pharmacies on behalf of an employer, a multiple employer welfare arrangement, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer to provide pharmacy health benefit services or administration. ~~"Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code.~~

(O) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description and includes a drug benefit plan administered by a pharmacy benefit manager.

(P) "Plan sponsor" means the person who establishes the plan.

(Q) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited to employer programs that pay claims up to a prearranged limit beyond which they purchase insurance coverage to protect against

unpredictable or catastrophic losses.

(R) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

(S) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details relative to the benefits provided to covered persons thereunder.

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

Sec. 3963.06. (A) If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form shall notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, not later than twenty-one days after the contracting entity receives the form.

(B) If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. The contracting entity shall send the request described in this division electronically, by facsimile, or by certified mail, return receipt requested.

(C)(1) ~~Except as otherwise provided in division (C)(2) of this section, the~~ The credentialing process under this section starts when a provider initially submits a credentialing form

upon the oral or written request of a contracting entity, and the provider shall submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, return receipt requested. Subject to division ~~(C)(3)~~ (C)(2) of this section, a contracting entity shall complete the credentialing process not later than ninety days after the contracting entity receives that credentialing form from the provider. The contracting entity shall allow the provider to submit a credentialing application prior to the provider's employment. A contracting entity that does not complete the credentialing process within the ninety-day period specified in this division is liable for either a civil penalty payable to the provider in the amount of five hundred dollars per day, including weekend days, starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied or retroactive reimbursement to the provider according to the terms of the contract for any basic health care services, specialty health care services, or supplemental health care services the provider provided to enrollees starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied. When the credentialing process of the contracting entity exceeds the ninety-day period, the contracting entity shall select the liability to which the contracting entity is subject and shall inform the provider of the contracting entity's selection.

(2) ~~The credentialing process for a medicaid managed care plan starts when the provider submits a credentialing form and the provider's national provider number issued by the centers for medicare and medicaid services.~~

~~(3)~~ The requirement that the credentialing process be

completed within the ninety-day period specified in division (C)(1) of this section does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity under that division is a hospital.

(D) Any communication between the provider and the contracting entity shall be electronically, by facsimile, or by certified mail, return receipt requested.

(E) If the state medical board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the educational commission for foreign medical graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the state medical board's web site or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the educational commission for foreign medical graduates, if applicable, as a condition for initially credentialing or recredentialing the physician.

Sec. 4121.50. Not later than July 1, 2012, the administrator of workers' compensation shall adopt rules in accordance with Chapter 119. of the Revised Code to implement a coordinated services program for claimants under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code who are found to have obtained prescription drugs that were reimbursed pursuant to an order of the administrator or of the industrial commission or by a self-insuring employer but were obtained at a frequency or in an amount that is not medically necessary. The program shall be implemented in a manner that is substantially

similar to the coordinated services programs established for the medicaid program under ~~sections~~ section 5164.758~~ and 5167.13~~ of the Revised Code.

Sec. 4729.20. As used in this section, "medication synchronization" means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

A pharmacist may dispense a drug in a manner that varies from the prescription for the drug by dispensing a quantity or amount of the drug that is less than a thirty-day supply, if the pharmacist's action is taken solely for the purpose of medication synchronization pursuant to section 1751.68, 3923.602, or 5164.7511~~, or 5167.12~~ of the Revised Code.

Sec. 4729.49. (A) As used in this section:

(1) "340B covered entity" has the same meaning as in section 3902.70 of the Revised Code.

(2) ~~"Medicaid managed care organization," and "third-party~~ "Third-party administrator" ~~have the same meanings as in section 5167.01 of the Revised Code~~means any person who adjusts or settles claims on behalf of an insuring entity in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs and includes a pharmacy benefit manager.

(B) A contract between a terminal distributor of dangerous drugs and a 340B covered entity shall require the terminal distributor to comply with division (C) of this section.

(C) When paying a 340B covered entity for a dangerous drug dispensed to a patient, a terminal distributor shall pay to the 340B covered entity the full reimbursement amount the terminal

distributor receives from the patient and the patient's health insurer, including a third-party administrator~~ or medicaid managed care organization~~, except that the terminal distributor may deduct from the full reimbursement amount a fee agreed on in writing by the terminal distributor and the 340B covered entity.

Sec. 4729.80. (A) If the state board of pharmacy establishes and maintains a drug database pursuant to section 4729.75 of the Revised Code, the board is authorized or required to provide information from the database only as follows:

(1) On receipt of a request from a designated representative of a government entity responsible for the licensure, regulation, or discipline of health care professionals with authority to prescribe, administer, or dispense drugs, the board may provide to the representative information from the database relating to the professional who is the subject of an active investigation being conducted by the government entity or relating to a professional who is acting as an expert witness for the government entity in such an investigation.

(2) On receipt of a request from a federal officer, or a state or local officer of this or any other state, whose duties include enforcing laws relating to drugs, the board shall provide to the officer information from the database relating to the person who is the subject of an active investigation of a drug abuse offense, as defined in section 2925.01 of the Revised Code, being conducted by the officer's employing government entity.

(3) Pursuant to a subpoena issued by a grand jury, the board shall provide to the grand jury information from the database relating to the person who is the subject of an

investigation being conducted by the grand jury.

(4) Pursuant to a subpoena, search warrant, or court order in connection with the investigation or prosecution of a possible or alleged criminal offense, the board shall provide information from the database as necessary to comply with the subpoena, search warrant, or court order.

(5) On receipt of a request from a prescriber or the prescriber's delegate approved by the board, the board shall provide to the prescriber a report of information from the database relating to a patient who is either a current patient of the prescriber or a potential patient of the prescriber based on a referral of the patient to the prescriber, if all of the following conditions are met:

(a) The prescriber certifies in a form specified by the board that it is for the purpose of providing medical treatment to the patient who is the subject of the request;

(b) The prescriber has not been denied access to the database by the board.

(6) On receipt of a request from a pharmacist or the pharmacist's delegate approved by the board, the board shall provide to the pharmacist information from the database relating to a current patient of the pharmacist, if the pharmacist certifies in a form specified by the board that it is for the purpose of the pharmacist's practice of pharmacy involving the patient who is the subject of the request and the pharmacist has not been denied access to the database by the board.

(7) On receipt of a request from an individual seeking the individual's own database information in accordance with the procedure established in rules adopted under section 4729.84 of

the Revised Code, the board may provide to the individual the individual's own prescription history.

(8) ~~On receipt of a request from a medical director or a pharmacy director of a managed care organization that has entered into a contract with the department of medicaid under section 5167.10 of the Revised Code and a data security agreement with the board required by section 5167.14 of the Revised Code, the board shall provide to the medical director or the pharmacy director information from the database relating to a medicaid recipient enrolled in the managed care organization, including information in the database related to prescriptions for the recipient that were not covered or reimbursed under a program administered by the department.~~

~~(9)~~ On receipt of a request from the medicaid director, the board shall provide to the director information from the database relating to a recipient of a program administered by the department of medicaid, including information in the database related to prescriptions for the recipient that were not covered or paid by a program administered by the department.

~~(10)~~ (9) On receipt of a request from a medical director of a managed care organization that has entered into a contract with the administrator of workers' compensation under division (B)(4) of section 4121.44 of the Revised Code and a data security agreement with the board required by section 4121.447 of the Revised Code, the board shall provide to the medical director information from the database relating to a claimant under Chapter 4121., 4123., 4127., or 4131. of the Revised Code assigned to the managed care organization, including information in the database related to prescriptions for the claimant that were not covered or reimbursed under Chapter 4121., 4123.,

4127., or 4131. of the Revised Code, if the administrator of workers' compensation confirms, upon request from the board, that the claimant is assigned to the managed care organization.

~~(11)~~ (10) On receipt of a request from the administrator of workers' compensation, the board shall provide to the administrator information from the database relating to a claimant under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, including information in the database related to prescriptions for the claimant that were not covered or reimbursed under Chapter 4121., 4123., 4127., or 4131. of the Revised Code.

~~(12)~~ (11) On receipt of a request from a prescriber or the prescriber's delegate approved by the board, the board shall provide to the prescriber information from the database relating to a patient's mother, if the prescriber certifies in a form specified by the board that it is for the purpose of providing medical treatment to a newborn or infant patient diagnosed as opioid dependent and the prescriber has not been denied access to the database by the board.

~~(13)~~ (12) On receipt of a request from the director of health, the board shall provide to the director information from the database relating to the duties of the director or the department of health in implementing the Ohio violent death reporting system established under section 3701.93 of the Revised Code.

~~(14)~~ (13) On receipt of a request from a requestor described in division (A)(1), (2), (5), or (6) of this section who is from or participating with another state's prescription monitoring program, the board may provide to the requestor information from the database, but only if there is a written

agreement under which the information is to be used and disseminated according to the laws of this state.

~~(15)~~ (14) On receipt of a request from a delegate of a retail dispensary licensed under Chapter 3796. of the Revised Code who is approved by the board to serve as the dispensary's delegate, the board shall provide to the delegate a report of information from the database pertaining only to a patient's use of medical marijuana, if both of the following conditions are met:

(a) The delegate certifies in a form specified by the board that it is for the purpose of dispensing medical marijuana for use in accordance with Chapter 3796. of the Revised Code.

(b) The retail dispensary or delegate has not been denied access to the database by the board.

~~(16)~~ (15) On receipt of a request from a judge of a program certified by the Ohio supreme court as a specialized docket program for drugs, the board shall provide to the judge, or an employee of the program who is designated by the judge to receive the information, information from the database that relates specifically to a current or prospective program participant.

~~(17)~~ (16) On receipt of a request from a coroner, deputy coroner, or coroner's delegate approved by the board, the board shall provide to the requestor information from the database relating to a deceased person about whom the coroner is conducting or has conducted an autopsy or investigation.

~~(18)~~ (17) On receipt of a request from a prescriber, the board may provide to the prescriber a summary of the prescriber's prescribing record if such a record is created by

the board. Information in the summary is subject to the confidentiality requirements of this chapter.

~~(19)~~ (18) On receipt of a request from a pharmacy's responsible person designated under section 4729.54 of the Revised Code, the board may provide to the responsible person a summary of the pharmacy's dispensing record if such a record is created by the board. Information in the summary is subject to the confidentiality requirements of this chapter.

~~(20)~~ (19) The board may provide information from the database without request to a prescriber or pharmacist who is authorized to use the database pursuant to this chapter.

~~(21)(a)~~ (20)(a) On receipt of a request from a prescriber or pharmacist, or the prescriber's or pharmacist's delegate, who is a designated representative of a peer review committee, the board shall provide to the committee information from the database relating to a prescriber who is subject to the committee's evaluation, supervision, or discipline if the information is to be used for one of those purposes. The board shall provide only information that it determines, in accordance with rules adopted under section 4729.84 of the Revised Code, is appropriate to be provided to the committee.

(b) As used in division ~~(A)(21)(a)~~ (A)(20)(a) of this section, "peer review committee" has the same meaning as in section 2305.25 of the Revised Code, except that it includes only a peer review committee of a hospital or a peer review committee of a nonprofit health care corporation that is a member of the hospital or of which the hospital is a member.

~~(22)~~ (21) On receipt of a request from a requestor described in division (A)(5) or (6) of this section who is from

or participating with a prescription monitoring program that is operated by a federal agency and approved by the board, the board may provide to the requestor information from the database, but only if there is a written agreement under which the information is to be used and disseminated according to the laws of this state.

~~(23)~~ (22) Any personal health information submitted to the board pursuant to section 4729.772 of the Revised Code may be provided by the board only as authorized by the submitter of the information and in accordance with rules adopted under section 4729.84 of the Revised Code.

~~(24)~~ (23) On receipt of a request from a person described in division (A)(5), (6), or ~~(17)~~ (16) of this section who is participating in a drug overdose fatality review committee described in section 307.631 of the Revised Code, the board may provide to the requestor information from the database, but only if there is a written agreement under which the information is to be used and disseminated according to the laws of this state.

~~(25)~~ (24) On receipt of a request from a person described in division (A)(5), (6), or ~~(17)~~ (16) of this section who is participating in a suicide fatality review committee described in section 307.641 of the Revised Code, the board may provide to the requestor information from the database, but only if there is a written agreement under which the information is to be used and disseminated according to the laws of this state.

~~(26)~~ (25) On receipt of a request from a designated representative of the division of cannabis control in the department of commerce, the board shall provide to the representative information from the database relating to an individual who, or entity that, is the subject of an active

investigation being conducted by the division.

(B) The state board of pharmacy shall maintain a record of each individual or entity that requests information from the database pursuant to this section. In accordance with rules adopted under section 4729.84 of the Revised Code, the board may use the records to document and report statistics and law enforcement outcomes.

The board may provide records of an individual's requests for database information only to the following:

(1) A designated representative of a government entity that is responsible for the licensure, regulation, or discipline of health care professionals with authority to prescribe, administer, or dispense drugs who is involved in an active criminal or disciplinary investigation being conducted by the government entity of the individual who submitted the requests for database information;

(2) A federal officer, or a state or local officer of this or any other state, whose duties include enforcing laws relating to drugs and who is involved in an active investigation being conducted by the officer's employing government entity of the individual who submitted the requests for database information;

(3) A designated representative of the department of medicaid regarding a prescriber who is treating or has treated a recipient of a program administered by the department and who submitted the requests for database information.

(C) Information contained in the database and any information obtained from it is confidential and is not a public record. Information contained in the records of requests for information from the database is confidential and is not a

public record. Information contained in the database that does not identify a person, including any licensee or registrant of the board or other entity, may be released in summary, statistical, or aggregate form.

(D) A pharmacist or prescriber shall not be held liable in damages to any person in any civil action for injury, death, or loss to person or property on the basis that the pharmacist or prescriber did or did not seek or obtain information from the database.

Sec. 4729.84. For purposes of establishing and maintaining a drug database pursuant to section 4729.75 of the Revised Code, the state board of pharmacy shall adopt rules in accordance with Chapter 119. of the Revised Code to carry out and enforce sections 4729.75 to 4729.83 of the Revised Code. The rules shall specify all of the following:

(A) A means of identifying each patient, each terminal distributor of dangerous drugs, each purchase at wholesale of dangerous drugs, and each retail dispensary licensed under Chapter 3796. of the Revised Code about which information is entered into the drug database;

(B) Requirements for the transmission of information from terminal distributors of dangerous drugs, manufacturers of dangerous drugs, outsourcing facilities, repackagers of dangerous drugs, wholesale distributors of dangerous drugs, prescribers, and retail dispensaries;

(C) An electronic format for the submission of information from persons identified in division (B) of this section;

(D) A procedure whereby a person unable to submit information electronically may obtain a waiver to submit

information in another format;

(E) A procedure whereby the board may grant a request from a law enforcement agency or a government entity responsible for the licensure, regulation, or discipline of licensed health professionals authorized to prescribe drugs that information that has been stored for three years be retained when the information pertains to an open investigation being conducted by the agency or entity;

(F) A procedure whereby a person identified in division (B) of this section may apply for an extension to the time by which information must be transmitted to the board;

(G) A procedure whereby a person or government entity to which the board is authorized to provide information may submit a request to the board for the information and the board may verify the identity of the requestor;

(H) Standards for determining what information is appropriate to be provided under division ~~(A)(21)~~ (A)(20) of section 4729.80 of the Revised Code;

(I) A procedure whereby the board can use the database request records required by division (B) of section 4729.80 of the Revised Code to document and report statistics and law enforcement outcomes;

(J) A procedure whereby an individual may request the individual's own database information and the board may verify the identity of the requestor;

(K) A reasonable fee that the board may charge under section 4729.83 of the Revised Code for providing an individual with the individual's own database information pursuant to section 4729.80 of the Revised Code;

(L) The other specific dangerous drugs that, in addition to controlled substances, must be included in the database;

(M) The types of pharmacies licensed as terminal distributors of dangerous drugs that are required to submit prescription information to the board pursuant to section 4729.77 of the Revised Code;

(N) Additional data fields, recognized by the American society for automation in pharmacy, that licensed terminal distributors of dangerous drugs must submit to the board pursuant to section 4729.77 of the Revised Code;

(O) The information regarding medical marijuana dispensed to a patient that a retail dispensary is required to submit to the board pursuant to section 4729.771 of the Revised Code;

(P) Requirements for the transmission of information pursuant to section 4729.772 of the Revised Code and requirements for the release of such information by the board.

Sec. 4729.86. If the state board of pharmacy establishes and maintains a drug database pursuant to section 4729.75 of the Revised Code, all of the following apply:

(A)(1) No person identified in divisions (A)(1) to ~~(13)~~ (12), ~~(15)~~(14) to ~~(26)~~(25), or (B) of section 4729.80 of the Revised Code shall disseminate any written or electronic information the person receives from the drug database or otherwise provide another person access to the information that the person receives from the database, except as follows:

(a) When necessary in the investigation or prosecution of a possible or alleged criminal offense;

(b) When a person provides the information to the

prescriber, pharmacist, or retail dispensary licensed under Chapter 3796. of the Revised Code for whom the person is approved by the board to serve as a delegate of the prescriber, pharmacist, or retail dispensary for purposes of requesting and receiving information from the drug database under division (A)(5), (6), or ~~(15)~~ (14) of section 4729.80 of the Revised Code;

(c) When a prescriber, pharmacist, or retail dispensary licensed under Chapter 3796. of the Revised Code provides the information to a person who is approved by the board to serve as such a delegate of the prescriber, pharmacist, or retail dispensary;

(d) When a prescriber or pharmacist includes the information in a medical record, as defined in section 3701.74 of the Revised Code.

(2) No person shall provide false information to the state board of pharmacy with the intent to obtain or alter information contained in the drug database.

(3) No person shall obtain drug database information by any means except as provided under section 4729.80 or 4729.81 of the Revised Code.

(B) A person shall not use information obtained pursuant to division (A) of section 4729.80 of the Revised Code as evidence in any civil or administrative proceeding.

(C)(1) Except as provided in division (C)(2) of this section, after providing notice and affording an opportunity for a hearing in accordance with Chapter 119. of the Revised Code, the board may restrict a person from obtaining further information from the drug database if any of the following is the case:

(a) The person violates division (A)(1), (2), or (3) of this section;

(b) The person is a requestor identified in division (A) ~~(14)~~(13) or ~~(22)~~(21) of section 4729.80 of the Revised Code and the board determines that the person's actions in another state would have constituted a violation of division (A)(1), (2), or (3) of this section;

(c) The person fails to comply with division (B) of this section, regardless of the jurisdiction in which the failure to comply occurred;

(d) The person creates, by clear and convincing evidence, a threat to the security of information contained in the database.

(2) If the board determines that allegations regarding a person's actions warrant restricting the person from obtaining further information from the drug database without a prior hearing, the board may summarily impose the restriction. A telephone conference call may be used for reviewing the allegations and taking a vote on the summary restriction. The summary restriction shall remain in effect, unless removed by the board, until the board's final adjudication order becomes effective.

(3) The board shall determine the extent to which the person is restricted from obtaining further information from the database.

Sec. 5160.01. As used in this chapter:

(A) "Dual eligible individual" has the same meaning as in the "Social Security Act," section 1915(h)(2)(B), 42 U.S.C. 1396n(h)(2)(B). A dual eligible individual is a medicare-

medicaid enrollee (MME).

(B) "Exchange" has the same meaning as in 45 C.F.R. 155.20.

(C) "Federal financial participation" means the federal government's share of expenditures made by an entity in implementing a medical assistance program.

(D) "Medical assistance program" means all of the following:

(1) The medicaid program;

(2) The children's health insurance program;

(3) The refugee medical assistance program;

(4) Any other program that provides medical assistance and state statutes authorize the department of medicaid to administer.

(E) "Medical assistance recipient" means a recipient of a medical assistance program. To the extent appropriate in the context, "medical assistance recipient" includes an individual applying for a medical assistance program, a former medical assistance recipient, or both.

(F) ~~"Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.~~

~~(G)~~ "Refugee medical assistance program" means the program that the department of medicaid administers pursuant to section 5160.50 of the Revised Code.

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 health care 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 authorization request that is not for an urgent care service, of the time the request is received by the department or its designee. Division (B)(4) of this section does not apply to emergency services.

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

(c) 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.

(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)(c) 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 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 twelve-month 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, in accordance with section 4729.38 of the Revised Code, of any drug that has received a twelve-month approval under division (B)(6)(a) of this section when there is a release of either of the following:

(a) 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;

(b) An interchangeable biological product, as defined in section 3715.01 of the Revised Code.

(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 provider 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 provider 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.

Sec. 5160.37. (A) A medical assistance recipient's enrollment in a medical assistance program gives an automatic right of recovery to the department of medicaid and a county department of job and family services against the liability of a third party for the cost of medical assistance paid on behalf of the recipient. When an action or claim is brought against a third party by a medical assistance recipient, any payment, settlement or compromise of the action or claim, or any court award or judgment, is subject to the recovery right of the department of medicaid or county department. ~~Except in the case of a medical assistance recipient who receives medical assistance through a medicaid managed care organization, the~~ The department's or county department's claim shall not exceed the amount of medical assistance paid by the department or county

department on behalf of the recipient. A payment, settlement, compromise, judgment, or award that excludes the cost of medical assistance paid for by the department or county department shall not preclude a department from enforcing its rights under this section.

~~(B)(1) In the case of a medical assistance recipient who receives medical assistance through a medicaid managed care organization that has a capitation agreement with a provider, the amount of the department's or county department's claim shall be the amount the medicaid managed care organization would have paid in the absence of a capitation agreement.~~

~~(2) In the case of a medical assistance recipient who receives medical assistance through a medicaid managed care organization that does not have a capitation agreement with a provider, the amount of the department's or county department's claim shall be the amount the medicaid managed care organization pays for medical assistance rendered to the recipient, even if that amount is more than the amount the department or county department pays to the medicaid managed care organization for the recipient's medical assistance.~~

~~(C)~~ (B) A medical assistance recipient, and the recipient's attorney, if any, shall cooperate with the departments. In furtherance of this requirement, the medical assistance recipient, or the recipient's attorney, if any, shall, not later than thirty days after initiating informal recovery activity or filing a legal recovery action against a third party, provide written notice of the activity or action to the department of medicaid or county department if it has paid for medical assistance under a medical assistance program.

~~(D)~~ (C) The written notice that must be given under

division ~~(C)~~ (B) of this section shall disclose the identity and address of any third party against whom the medical assistance recipient has or may have a right of recovery.

~~(E)~~ (D) No settlement, compromise, judgment, or award or any recovery in any action or claim by a medical assistance recipient where the department or county department has a right of recovery shall be made final without first giving the department or county department written notice as described in division ~~(C)~~ (B) of this section and a reasonable opportunity to perfect its rights of recovery. If the department or county department is not given the appropriate written notice, the medical assistance recipient and, if there is one, the recipient's attorney, are liable to reimburse the department or county department for the recovery received to the extent of medical assistance payments made by the department or county department.

~~(F)~~ (E) The department or county department shall be permitted to enforce its recovery rights against the third party even though it accepted prior payments in discharge of its rights under this section if, at the time the department or county department received such payments, it was not aware that additional medical expenses had been incurred but had not yet been paid by the department or county department. The third party becomes liable to the department or county department as soon as the third party is notified in writing of the valid claims for recovery under this section.

~~(G)(1)~~ (F)(1) Subject to division ~~(G)(2)~~ (F)(2) of this section, the right of recovery of the department or county department does not apply to that portion of any judgment, award, settlement, or compromise of a claim, to the extent of

attorneys' fees, costs, or other expenses incurred by a medical assistance recipient in securing the judgment, award, settlement, or compromise, or to the extent of medical, surgical, and hospital expenses paid by such recipient from the recipient's own resources.

(2) Reasonable attorneys' fees, not to exceed one-third of the total judgment, award, settlement, or compromise, plus costs and other expenses incurred by the medical assistance recipient in securing the judgment, award, settlement, or compromise, shall first be deducted from the total judgment, award, settlement, or compromise. After fees, costs, and other expenses are deducted from the total judgment, award, settlement, or compromise, there shall be a rebuttable presumption that the department of medicaid or county department shall receive no less than one-half of the remaining amount, or the actual amount of medical assistance paid, whichever is less. A party may rebut the presumption in accordance with division ~~(L)(1)~~ (K)(1), (2), or (3) of this section, as applicable.

~~(H)~~ (G) A right of recovery created by this section may be enforced separately or jointly by the department of medicaid or county department. To enforce its recovery rights, the department or county department may do any of the following:

(1) Intervene or join in any action or proceeding brought by the medical assistance recipient or on the recipient's behalf against any third party who may be liable for the cost of medical assistance paid;

(2) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical assistance paid;

(3) Initiate legal proceedings in conjunction with any injured, diseased, or disabled medical assistance recipient or the recipient's attorney or representative.

~~(I)~~ (H) A medical assistance recipient shall not assess attorney fees, costs, or other expenses against the department of medicaid or a county department when the department or county department enforces its right of recovery created by this section.

~~(J)~~ (I) The right of recovery given to the department under this section includes payments made by a third party under contract with a person having a duty to support.

~~(K)~~ (J) The department of medicaid may assign to a medical assistance provider the right of recovery given to the department under this section with respect to any claim for which the department has notified the provider that the department intends to recoup the department's prior payment for the claim.

~~(L)(1)~~ (K)(1) Prior to any payment to the department or a county department pursuant to the department's or county department's right of recovery under this section, a party that desires to rebut the presumption in division ~~(G)~~ (F) of this section shall submit to the department or county department a request for a hearing in accordance with the procedure the department establishes in rules required by division ~~(O)~~ (N) of this section. The amount sought by the department or county department shall be held in escrow or in an interest on lawyers' trust account until the hearing examiner renders a decision or the case is otherwise concluded. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

(2) A medical assistance recipient who has repaid money, on or after September 29, 2007, to the department or a county department pursuant to the department's or county department's right of recovery under this section, section 5160.38 of the Revised Code, or former section 5101.58 or 5101.59 of the Revised Code may request a hearing to rebut the presumption in division ~~(G)~~ (F) of this section. The request shall be made in accordance with the procedure the department establishes for this purpose in rules required by division ~~(O)~~ (N) of this section. It must be made not later than one hundred eighty days after September 29, 2015, or ninety days after the payment is made, whichever is later. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

(3) A medical assistance recipient who has repaid money, between April 6, 2007 and September 28, 2007, to the department or a county department pursuant to the department's or county department's right of recovery under this section, section 5160.38 of the Revised Code, or former section 5101.58 or 5101.59 of the Revised Code may request a hearing to rebut the presumption in division ~~(G)~~ (F) of this section. The request shall be made not later than one hundred eighty days after ~~the effective date of this amendment~~ September 30, 2025, in accordance with the procedure the department establishes for this purpose in rules required by division ~~(O)~~ (N) of this section. The presumption is successfully rebutted if the requestor demonstrates by clear and convincing evidence that a different allocation is warranted.

(4) With respect to a hearing requested under division ~~(I)(1)~~ (K)(1), (2), or (3) of this section, all of the following are the case:

(a) The hearing examiner may consider, but is not bound by the allocation of, medical expenses specified in a settlement agreement between the medical assistance recipient and the relevant third party;

(b) The department or county department may raise affirmative defenses during the hearing, including the existence of a prior settlement with the medical assistance recipient, the doctrine of accord and satisfaction, or the common law principle of res judicata;

(c) If the parties agree, live testimony shall not be presented at the hearing;

(d) The hearing may be governed by rules adopted under section 5160.02 of the Revised Code. If such rules are adopted, Chapter 119. of the Revised Code applies to the hearing only to the extent specified in those rules;

(e) The hearing examiner's decision is binding on the department or county department and the medical assistance recipient unless the decision is reversed or modified on appeal to the medicaid director as described in division ~~(M)~~ (L) of this section;

(f) A request for a hearing may be submitted by any of the following:

(i) The medical assistance recipient;

(ii) The medical assistance recipient's authorized representative;

(iii) The executor or administrator of a medical assistance recipient's estate authorized to make or pursue a request;

(iv) A court-appointed guardian;

(v) An attorney who has been directly retained by the medical assistance recipient, or the recipient's parent, legal guardian, or court-appointed guardian.

~~(M)(1)~~ (L)(1) A medical assistance recipient who disagrees with a hearing examiner's decision under division ~~(L)~~ (K) of this section may file an administrative appeal with the medicaid director in accordance with the procedure the department establishes for this purpose in rules required by division ~~(O)~~ (N) of this section. A hearing is not required during the administrative appeal, but the director or the director's designee shall review the hearing examiner's decision and any prior relevant administrative action. After the review, the director or the director's designee shall affirm, modify, remand, or reverse the hearing decision. A decision made under this division is final and binding on the department or county department and the medical assistance recipient unless it is reversed or modified on appeal to a court of common pleas as described in division ~~(N)~~ (M) of this section.

(2) An administrative appeal may be governed by rules adopted under section 5160.02 of the Revised Code. If such rules are adopted, Chapter 119. of the Revised Code applies to an administrative appeal only to the extent specified in those rules.

~~(N)~~ (M) A party to an administrative appeal described in division ~~(M)~~ (L) of this section may file an appeal with a court of common pleas in accordance with section 119.12 of the Revised Code.

~~(O)~~ (N) The medicaid director shall adopt rules under

section 5160.02 of the Revised Code as necessary to implement this section, including rules establishing procedures a party may use to request a hearing under division ~~(L)(1)~~(K)(1), (2), or (3) of this section or an administrative appeal under division ~~(M)(1)~~(L)(1) of this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

~~(P)~~(O) Divisions ~~(L)~~(K) to ~~(N)~~(M) of this section are remedial in nature and shall be liberally construed by the courts of this state in accordance with section 1.11 of the Revised Code. Those divisions specify the sole remedy available to a party who claims the department or a county department has received or is to receive more money than entitled to receive under this section, section 5160.38 of the Revised Code, or former section 5101.58 or 5101.59 of the Revised Code.

Sec. 5160.371. In addition to the requirement of division ~~(C)~~(B) of section 5160.37 of the Revised Code to cooperate with the department of medicaid and county department of job and family services, a medical assistance recipient and the recipient's attorney, if any, shall cooperate with each medical provider of the recipient. Cooperation with a medical provider shall consist of disclosing to the provider all information the recipient and attorney, if any, possess that would assist the provider in determining each third party that is responsible for the payment or processing of a claim for medical assistance provided to the recipient. If disclosure is not made in accordance with this section, the recipient and the recipient's attorney, if any, are liable to reimburse the department or county department for the amount that would have been paid by a third party had the third party been disclosed to the provider by the recipient or the recipient's attorney.

Sec. 5160.40. (A) As used in this section, "business day" means any day of the week excluding Saturday, Sunday, and a legal holiday, as defined in section 1.14 of the Revised Code.

(B) Subject to ~~divisions~~ division (C) ~~and (D)~~ of this section, a third party shall do all of the following:

(1) Accept the department of medicaid's right of recovery under section 5160.37 of the Revised Code and the assignment of rights to the department that are described in section 5160.38 of the Revised Code;

(2) Respond to an inquiry by the department regarding a claim for payment of a medical item or service that was submitted to the third party not later than six years after the date of the provision of such medical item or service;

(3) Respond to the department's request for payment of a claim described in division (B)(2) of this section not later than sixty business days after receipt of written proof of the claim, either by paying the claim or issuing a written denial to the department;

(4) Not charge a fee to do either of the following for a claim described in division (B)(2) of this section:

(a) Determine whether the claim should be paid;

(b) Process the claim.

(5) Pay a claim described in division (B)(2) of this section;

(6) Not deny a claim submitted by the department solely on the basis of the date of submission of the claim, type or format of the claim form, or a failure by the medical assistance recipient who is the subject of the claim to present proper

documentation of coverage at the time of service, if both of the following have occurred:

(a) The claim was submitted by the department not later than six years after the date of the provision of the medical item or service.

(b) An action by the department to enforce its right of recovery under section 5160.37 of the Revised Code on the claim was commenced not later than six years after the department's submission of the claim.

(7) Consider the department's payment of a claim for a medical item or service to be the equivalent of the medical assistance recipient having obtained prior authorization for the item or service from the third party;

(8) Not deny a claim described in division (B)(7) of this section that is submitted by the department solely on the basis of the medical assistance recipient's failure to obtain prior authorization for the medical item or service.

(C) ~~For purposes of the requirements in division (B) of this section, a third party shall treat a medicaid managed care organization as the department for a claim if the individual who is the subject of the claim received a medical item or service through a medicaid managed care organization and the department has assigned its right of recovery for the claim to the medicaid managed care organization. Even if the department assigned its right of recovery to a medicaid managed care organization, the department may, beginning one year from the date the organization paid the claim, recoup from a third party an amount that was assigned to the organization but not collected.~~

~~(D)~~ If the department of medicaid, as permitted by

division ~~(K)~~ (J) of section 5160.37 of the Revised Code, assigns to a medical assistance provider the department's right of recovery for a claim for which it has notified the provider that it intends to recoup its prior payment for a claim, a third party shall treat the provider as the department and shall pay the provider the greater of the following:

(1) The amount the department intends to recoup from the provider for the claim.

(2) If the third party and the provider have an agreement that requires the third party to pay the provider at the time the provider presents the claim to the third party, the amount that is to be paid under that agreement.

~~(E)~~ (D) The time limitations associated with the requirements in divisions (B)(2) and (6) of this section apply only to submissions of claims to, and payments of claims by, a health insurer to which the "Social Security Act," section 1902(a)(25)(I), 42 U.S.C. 1396a(a)(25)(I), applies.

Sec. 5162.01. (A) As used in the Revised Code:

(1) "Medicaid" and "medicaid program" mean the program of medical assistance established by Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq., including any medical assistance provided under the medicaid state plan or a federal medicaid waiver granted by the United States secretary of health and human services.

(2) "Medicare" and "medicare program" mean the federal health insurance program established by Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.

(B) As used in this chapter:

(1) "Exchange" has the same meaning as in 45 C.F.R. 155.20.

(2) "Expansion eligibility group" has the same meaning as in section 5163.01 of the Revised Code.

(3) "Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

(4) "Federal poverty line" means the official poverty line defined by the United States office of management and budget based on the most recent data available from the United States bureau of the census and revised by the United States secretary of health and human services pursuant to the "Omnibus Budget Reconciliation Act of 1981," section 673(2), 42 U.S.C. 9902(2).

(5) "Healthcheck" has the same meaning as in section 5164.01 of the Revised Code.

(6) "Healthy start component" means the component of the medicaid program that covers pregnant women and children and is identified in rules adopted under section 5162.02 of the Revised Code as the healthy start component.

(7) "Home and community-based services" means services provided under a home and community-based services medicaid waiver component.

(8) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

(9) "ICF/IID" has the same meaning as in section 5124.01 of the Revised Code.

(10) "Individualized education program" has the same meaning as in section 3323.011 of the Revised Code.

(11) "Medicaid managed care organization" ~~has the same meaning as in section 5167.01 of the Revised Code~~means a managed care organization that, on the effective date of this amendment, is under contract with the department of medicaid to administer medicaid benefits to medicaid recipients.

(12) ~~"Medicaid MCO plan" has the same meaning as in section 5167.01 of the Revised Code.~~

~~(13)~~ "Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

~~(14)~~(13) "Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

~~(15)~~(14) "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code;

~~(16)~~(15) "Nursing facility" and "nursing facility services" have the same meanings as in section 5165.01 of the Revised Code.

~~(17)~~(16) "Ordering or referring only provider" means a medicaid provider who orders, prescribes, refers, or certifies a service or item reported on a claim for medicaid payment but does not bill for medicaid services.

~~(18)~~(17) "Political subdivision" means a municipal corporation, township, county, school district, or other body corporate and politic responsible for governmental activities only in a geographical area smaller than that of the state.

~~(19)~~(18) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(20)~~(19) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

~~(21)~~ (20) "Qualified medicaid school provider" means the board of education of a city, local, or exempted village school district, the governing board of an educational service center, the governing authority of a community school established under Chapter 3314. of the Revised Code, and Ohio deaf and blind education services to which both of the following apply:

(a) It holds a valid provider agreement.

(b) It meets all other conditions for participation in the medicaid school component of the medicaid program established in rules authorized by section 5162.364 of the Revised Code.

~~(22)~~ (21) "State agency" means every organized body, office, or agency, other than the department of medicaid, established by the laws of the state for the exercise of any function of state government.

~~(23)~~ (22) "Vendor offset" means a reduction of a medicaid payment to a medicaid provider to correct a previous, incorrect medicaid payment to that provider.

Sec. 5162.021. The medicaid director shall adopt rules under sections 5160.02, 5162.02, 5163.02, 5164.02, 5165.02, and 5166.02~~, and 5167.02~~ of the Revised Code as necessary to authorize the directors of other state agencies to adopt rules regarding medicaid components, or aspects of medicaid components, the other state agencies administer pursuant to contracts entered into under section 5162.35 of the Revised Code.

Sec. 5162.13. (A) On or before the first day of January of each year, the department of medicaid shall complete a report on the effectiveness of the medicaid program in meeting the health care needs of low-income pregnant women, infants, and children.

The report shall include all of the following, delineated by race and ethnic group:

(1) The estimated number of pregnant women, infants, and children eligible for the program;

(2) The actual number of eligible persons enrolled in the program;

(3) The actual number of enrolled pregnant women categorized by estimated gestational age at time of enrollment;

(4) The average number of days between ~~the following events:~~

~~(a) A~~ a pregnant woman's application for medicaid and enrollment in the ~~fee-for-service component of~~ medicaid~~;~~

~~(b) A pregnant woman's application for enrollment in a medicaid managed care organization and enrollment in the managed care organization~~ program.

The information described in ~~divisions (A)(4)(a) and (b)~~division (A)(4) of this section shall also be delineated by county and the urban and rural communities specified in rules adopted under section 3701.142 of the Revised Code.

(5) The number of prenatal, postpartum, and child health visits;

(6) The estimated number of enrolled women of child-bearing age who use a tobacco product;

(7) The estimated number of enrolled women of child-bearing age who participate in a tobacco cessation program or who use a tobacco cessation product;

(8) The rates at which enrolled pregnant women receive

addiction or mental health services, progesterone therapy, and any other service specified by the department;

(9) A report on birth outcomes, including a comparison of low-birthweight births and infant mortality rates of medicaid recipients with the general female child-bearing and infant population in this state;

(10) A comparison of the prenatal, delivery, and child health costs of the program with such costs of similar programs in other states, where available;

(11) A report on performance data generated by the component of the state innovation model (SIM) grant pertaining to episode-based payments for perinatal care that was awarded to this state by the center for medicare and medicaid innovation in the United States centers for medicare and medicaid services;

(12) A report on funds allocated for infant mortality reduction initiatives in the urban and rural communities specified in rules adopted under section 3701.142 of the Revised Code;

(13) A report on the results of client responses to questions related to pregnancy services and healthcheck that are asked by the personnel of county departments of job and family services;

(14) ~~A comparison of the performance of the fee-for-service component of medicaid with the performance of each medicaid managed care organization on perinatal health metrics;~~

~~(15)~~ A report demonstrating cost savings resulting from program investments;

~~(16)~~ (15) Beginning two years after April 30, 2024, a

report on the medicaid coverage of doula services required by section 5164.071 of the Revised Code, including:

(a) Outcomes related to maternal health and maternal morbidity;

(b) Infant health outcomes;

(c) The average costs of providing doula services to mothers and infants;

(d) Estimated cost increases or savings as a result of providing doula coverage.

(B) The department shall submit the report to the general assembly in accordance with section 101.68 of the Revised Code. The department also shall make the report available to the public.

(C) The department shall provide to the legislative service commission a copy of the data used to calculate the information required in the report under division ~~(A)(16)~~ (A)(15) of this section.

Sec. 5162.1310. (A) The department of medicaid shall periodically evaluate the success that members of the expansion eligibility group have with the following:

(1) Obtaining employer-sponsored health insurance coverage;

(2) Improving health conditions that would otherwise prevent or inhibit stable employment;

(3) Improving the conditions of their employment, including duration and hours of employment.

(B) ~~For the purpose of aiding the department's evaluations~~

~~under this section, medicaid managed care organizations shall collect and submit to the department relevant data about members of the expansion eligibility group who are enrolled in the organizations' medicaid MCO plans. The department may request that a medicaid managed care organization collect and submit to the department additional data the department needs for the evaluation.~~

~~(C)~~ The department shall complete a report for each evaluation conducted under this section. The director shall provide a copy of the report to the general assembly in accordance with section 101.68 of the Revised Code.

Sec. 5162.73. (A) As used in this section:

(1) "Administrative services organization" or "ASO" means an entity contracted by the department of medicaid to perform administrative functions related to the medicaid program, including claims processing, prior authorization review, provider credentialing and recruitment, customer service and grievance resolution, and data analytics and utilization monitoring. An "administrative services organization" or "ASO" is not a managed care organization and is a nonfinancial risk-bearing entity.

(2) "Care coordination" means a set of services provided by physicians, nurses, community health workers, behavioral health providers, and other licensed health care providers to ensure that patients receive appropriate, timely, and culturally responsive care across the continuum of health services.

(3) "Financial risk-bearing medicaid managed care organization" means a medicaid managed care organization that contracts with the department of medicaid to provide

administrative services on a financial risk-bearing basis which entails payment on a capitated basis and incentivizes the organization to maximize internal profit by restricting care at the expense of medicaid recipients.

(4) "Managed fee-for-service" means a medicaid delivery model that combines direct payment to medicaid providers for each encounter or service provided to a medicaid recipient with periodic capitated payments for a range of additional indirect services, including care coordination and quality improvement.

(B)(1) Not later than thirty days after the effective date of this section, the medicaid director shall convene a workgroup to establish a transition plan concerning the termination of the care management system established under the former version of section 5167.03 of the Revised Code that existed immediately prior to the effective date of this section.

(2) The workgroup shall consist of medicaid recipients; medicaid providers, including dentists, hospital representatives, and nursing home representatives; representatives of the Ohio association of community health centers; representatives of the Ohio association of area agencies on aging; and other stakeholders as determined by the director. Workgroup members shall be evenly distributed from the following regions of this state as follows:

(a) Region 1: Ashtabula, Cuyahoga, Geauga, Lake, Lorain;

(b) Region 2: Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood;

(c) Region 3: Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence,

Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Vinton, Washington;

(d) Region 4: Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, Warren;

(e) Region 5: Crawford, Delaware, Fairfield, Fayette, Franklin, Hardin, Knox, Licking, Logan, Madison, Marion, Morrow, Pickaway, Union, Wyandot;

(f) Region 6: Ashland, Carroll, Columbiana, Holmes, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Wayne;

(g) Region 7: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, Shelby.

(3) The workgroup shall meet to establish recommendations for terminating the care management system and transitioning medicaid recipients to an ASO-based model. In establishing recommendations for the transition, the workgroup shall consider all of the following:

(a) The number of administrative services organizations the department of medicaid should contract with to perform administrative functions related to the medicaid program following termination of the care management system;

(b) The medicaid program responsibilities that will be overseen by administrative services organizations;

(c) The medicaid payment rate for services provided by medicaid providers under the managed fee-for-service component of the medicaid program, including whether providers should receive medicaid payment in an amount that equals one hundred per cent of the medicare payment rate for similar services;

(d) How cost savings realized from the termination of the care management system will be redistributed within the medicaid program;

(e) How to structure the care coordination component of the medicaid program, including how to transition care coordination from medicaid managed care organizations to medicaid providers and how to provide providers with requisite training. In considering the structure of the care coordination component of the medicaid program, the workgroup shall delineate the scope of care coordination activities that primary care providers will be responsible for overseeing and determine a capitated payment rate for care coordination services provided by medicaid providers.

(f) How to structure and monitor office-based quality improvement activities. In considering quality improvement activities, the workgroup shall consider including a mechanism for determining high-impact clinical goals for improvement, creation of metrics to measure quality improvements, and establishing incentives for provider participation in quality improvement activities that include capitated payments, compensation for achieving intended outcomes, and continuing medical education credits.

(4) Not later than twelve months after the workgroup is convened, the workgroup shall submit a report to the medicaid director detailing the workgroup's recommendations for terminating the care management system.

(C) Upon receipt of the report submitted by the workgroup, the director shall do all of the following:

(1) Adopt rules in accordance with Chapter 119. of the

Revised Code to implement this section;

(2) Through a procurement process, select one or more administrative services organizations as a replacement for the care management system. As part of the procurement process, the director shall do all of the following:

(a) Accept applications from entities seeking to become an administrative services organization;

(b) Establish eligibility criteria an entity must meet in order to become an administrative services organization;

(c) Not later than one hundred eighty days after receipt of the workgroup's report, select and contract with one or more administrative services organizations.

(3) Not later than one hundred eighty days after receipt of the workgroup's report, seek all necessary federal approval from the United States centers for medicare and medicaid services to implement this section.

(D) Beginning on the first day of the fiscal biennium that begins after the medicaid director enters into contracts with selected administrative services organizations under division (C)(2) of this section, the director shall not renew any existing contracts or agreements between the department of medicaid and a financial risk-bearing medicaid managed care organization or enter into a new contract or agreement with a financial risk-bearing medicaid managed care organization.

(E)(1) As soon as practicable after the first day of that fiscal biennium, the department shall transition all medicaid recipients enrolled in financial risk-bearing medicaid managed care organization plans to the fee-for-service component of the medicaid program or to the managed fee-for-service component in

accordance with the rules adopted under division (C)(1) of this section.

(2) The department shall prepare and distribute guidance materials to assist individuals transitioning from a medicaid managed care organization as described in division (E)(1) of this section.

(F) Upon completing the transition described in division (E) of this section, the medicaid director shall terminate all contracts or agreements entered into between the department and financial risk-bearing medicaid managed care organizations. The director shall provide financial risk-bearing medicaid managed care organizations with at least thirty days' notice prior to terminating a contract or agreement under this section. Each financial risk-bearing medicaid managed care organization shall ensure that medicaid providers receive payment for incurred but not reported expenses prior to the financial risk-bearing medicaid managed care organization's termination from participation in the care management system.

(G) The medicaid director shall prepare and submit an annual report to the general assembly and the governor detailing the actions the department of medicaid takes in accordance with this section. The report shall include all of the following:

(1) Medicaid program financial performance metrics related to the transition from the care management system, including the amount of total savings experienced by the medicaid program as a result of the transition;

(2) Clinical outcomes for and resource utilization by medicaid recipients who transition from the care management system to the ASO system;

(3) Any other information that the director considers relevant regarding the transition.

(H) The medicaid director shall ensure that one hundred per cent of all cost savings realized as a result of terminating the care management system are reinvested into the medicaid program.

(I) In enacting this section, it is the intent of the general assembly to terminate the care management system established under the former version of section 5167.03 of the Revised Code that existed immediately prior to the effective date of this section.

Sec. ~~5162.73~~ 5162.74. (A) The ~~Department~~ department of ~~Medicaid~~ medicaid may establish and administer a program to provide dental services to pregnant ~~Medicaid~~ medicaid recipients. If the program is established, all of the following shall apply:

(1) Medicaid recipients who are members of the group described in section 5163.06 of the Revised Code shall be eligible to receive two dental cleanings per year.

(2) The ~~Department~~ department shall give priority to those ~~Medicaid~~ medicaid recipients residing in areas of the state with high preterm birth rates.

(3) The ~~Department~~ department shall inform ~~Medicaid~~ medicaid recipients about the program and market the program to ~~Medicaid~~ medicaid recipients.

(B) The ~~Department~~ department of ~~Medicaid~~ medicaid shall establish reimbursement rates for entities that educate ~~Medicaid~~ medicaid recipients about the importance of prenatal and postnatal dental care as part of the program described in

section 3701.615 of the Revised Code, including reimbursement rates for all or part of the costs associated with developing and distributing educational materials related to the importance of prenatal and postnatal dental care.

Sec. 5164.01. As used in this chapter:

(A) "Adjudication" has the same meaning as in section 119.01 of the Revised Code.

(B) "Behavioral health redesign" means revisions to the medicaid program's coverage of community behavioral health services beginning July 1, 2017, including revisions that update medicaid billing codes and payment rates for community behavioral health services.

(C) "Clean claim" has the same meaning as in 42 C.F.R. 447.45(b).

(D) "Community behavioral health services" means both of the following:

(1) Alcohol and drug addiction services provided by a community addiction services provider, as defined in section 5119.01 of the Revised Code;

(2) Mental health services provided by a community mental health services provider, as defined in section 5119.01 of the Revised Code.

(E) "Early and periodic screening, diagnostic, and treatment services" has the same meaning as in the "Social Security Act," section 1905(r), 42 U.S.C. 1396d(r).

(F) "Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

(G) "Federal poverty line" has the same meaning as in section 5162.01 of the Revised Code.

(H) "Healthcheck" means the component of the medicaid program that provides early and periodic screening, diagnostic, and treatment services.

(I) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

(J) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(K) "ICDS participant" means a dual eligible individual who participates in the integrated care delivery system.

(L) "ICF/IID" has the same meaning as in section 5124.01 of the Revised Code.

(M) "Integrated care delivery system" and "ICDS" mean the demonstration project authorized by section 5164.91 of the Revised Code.

(N) "Mandatory services" means the health care services and items that must be covered by the medicaid state plan as a condition of the state receiving federal financial participation for the medicaid program.

(O) ~~"Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.~~

~~(P)~~ "Medicaid provider" means a person or government entity with a valid provider agreement to provide medicaid services to medicaid recipients. To the extent appropriate in the context, "medicaid provider" includes a person or government entity applying for a provider agreement, a former medicaid

provider, or both.

~~(Q)~~ (P) "Medicaid services" means either or both of the following:

(1) Mandatory services;

(2) Optional services that the medicaid program covers.

~~(R)~~ (Q) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(S)~~ (R) "Optional services" means the health care services and items that may be covered by the medicaid state plan or a federal medicaid waiver and for which the medicaid program receives federal financial participation.

~~(T)~~ (S) "Prescribed drug" has the same meaning as in 42 C.F.R. 440.120.

~~(U)~~ (T) "Provider agreement" means an agreement to which all of the following apply:

(1) It is between a medicaid provider and the department of medicaid;

(2) It provides for the medicaid provider to provide medicaid services to medicaid recipients;

(3) It complies with 42 C.F.R. 431.107(b).

~~(V)~~ (U) "State plan home and community-based services" means home and community-based services that, as authorized by section 1915(i) of the "Social Security Act," 42 U.S.C. 1396n(i), may be covered by the medicaid program pursuant to an amendment to the medicaid state plan.

~~(W)~~ (V) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.

Sec. 5164.38. (A) As used in this section:

(1) "Party" has the same meaning as in division (G) of section 119.01 of the Revised Code.

(2) "Revalidate" means to approve a medicaid provider's continued enrollment as a medicaid provider in accordance with the revalidation process established in rules authorized by section 5164.32 of the Revised Code.

(B) This section does not apply to ~~either of the following:~~

~~(1) Any action taken or decision made by the department of medicaid with respect to entering into or refusing to enter into a contract with a managed care organization pursuant to section 5167.10 of the Revised Code;~~

~~(2) Any~~ any action taken by the department under division (D)(2) of section 5124.60, division (D)(1) or (2) of section 5124.61, or sections 5165.60 to 5165.89 of the Revised Code.

(C) Except as provided in division (E) of this section and section 5164.58 of the Revised Code, the department shall do any of the following by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code:

(1) Refuse to enter into a provider agreement with a medicaid provider;

(2) Refuse to revalidate a medicaid provider's provider agreement;

(3) Suspend or terminate a medicaid provider's provider agreement;

(4) Take any action based upon a final fiscal audit of a

medicaid provider.

(D) Any party who is adversely affected by the issuance of an adjudication order under division (C) of this section may appeal to the court of common pleas in accordance with section 119.12 of the Revised Code.

(E) The department is not required to comply with division (C)(1), (2), or (3) of this section whenever any of the following occur:

(1) The terms of a provider agreement require the medicaid provider to hold a license, permit, or certificate or maintain a certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the department of medicaid, and the license, permit, certificate, or certification has been denied, revoked, not renewed, suspended, or otherwise limited.

(2) The terms of a provider agreement require the medicaid provider to hold a license, permit, or certificate or maintain certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the department of medicaid, and the provider has not obtained the license, permit, certificate, or certification.

(3) The medicaid provider's application for a provider agreement is denied, or the provider's provider agreement is terminated or not revalidated, because of or pursuant to any of the following:

(a) The termination, refusal to renew, or denial of a license, permit, certificate, or certification by an official, board, commission, department, division, bureau, or other agency

of this state other than the department of medicaid, notwithstanding the fact that the provider may hold a license, permit, certificate, or certification from an official, board, commission, department, division, bureau, or other agency of another state;

(b) Division (D) or (E) of section 5164.35 of the Revised Code;

(c) The provider's termination, suspension, or exclusion from the medicare program or from another state's medicaid program and, in either case, the termination, suspension, or exclusion is binding on the provider's participation in the medicaid program in this state;

(d) The provider's pleading guilty to or being convicted of a criminal activity materially related to either the medicare or medicaid program;

(e) The provider or its owner, officer, authorized agent, associate, manager, or employee having been convicted of one of the offenses that caused the provider's provider agreement to be suspended pursuant to section 5164.36 of the Revised Code;

(f) The provider's failure to provide the department the national provider identifier assigned the provider by the national provider system pursuant to 45 C.F.R. 162.408.

(4) The medicaid provider's application for a provider agreement is denied, or the provider's provider agreement is terminated or suspended, as a result of action by the United States department of health and human services and that action is binding on the provider's medicaid participation.

(5) The medicaid provider's provider agreement and medicaid payments to the provider are suspended under section

5164.36 or 5164.37 of the Revised Code.

(6) The medicaid provider's application for a provider agreement is denied because the provider's application was not complete;

(7) The medicaid provider's provider agreement is converted under section 5164.32 of the Revised Code from a provider agreement that is not time-limited to a provider agreement that is time-limited.

(8) Unless the medicaid provider is a nursing facility or ICF/IID, the provider's provider agreement is not revalidated pursuant to division (B)(1) of section 5164.32 of the Revised Code.

(9) The medicaid provider's provider agreement is suspended, terminated, or not revalidated because of either of the following:

(a) Any reason authorized or required by one or more of the following: 42 C.F.R. 455.106, 455.23, 455.416, 455.434, or 455.450;

(b) The provider has not billed or otherwise submitted a medicaid claim for two years or longer.

(F) In the case of a medicaid provider described in division (E)(3)(f), (6), (7), or (9)(b) of this section, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to the medicaid provider's address on record with the department. The notice may be sent by regular mail.

(G) The department may withhold payments for medicaid services rendered by a medicaid provider during the pendency of

proceedings initiated under division (C)(1), (2), or (3) of this section. If the proceedings are initiated under division (C)(4) of this section, the department may withhold payments only to the extent that they equal amounts determined in a final fiscal audit as being due the state. This division does not apply if the department fails to comply with section 119.07 of the Revised Code, requests a continuance of the hearing, or does not issue a decision within thirty days after the hearing is completed. This division does not apply to nursing facilities and ICFs/IID.

Sec. 5164.46. (A) As used in this section, "electronic claims submission process" means any of the following:

(1) Electronic interchange of data;

(2) Direct entry of data through an internet-based mechanism implemented by the department of medicaid;

(3) Any other process for the electronic submission of claims that is specified in rules adopted under section 5162.02 of the Revised Code.

(B) Not later than January 1, 2013, and except as provided in division (C) of this section, each medicaid provider shall do both of the following:

(1) Use only an electronic claims submission process to submit to the department of medicaid claims for medicaid payment for medicaid services provided to medicaid recipients;

(2) Arrange to receive medicaid payment from the department by means of electronic funds transfer.

(C) Division (B) of this section does not apply to any of the following:

(1) A nursing facility;

(2) An ICF/IID;

(3) ~~A medicaid managed care organization;~~

~~(4)~~ Any other medicaid provider or type of medicaid provider designated in rules adopted under section 5162.02 of the Revised Code.

(D) The department shall not process a medicaid claim submitted on or after January 1, 2013, unless the claim is submitted through an electronic claims submission process in accordance with this section.

Sec. 5164.74. The medicaid director shall adopt rules under section 5164.02 of the Revised Code governing the calculation and payment of, and the allocation of payments for, graduate medical education costs associated with medicaid services rendered to medicaid recipients~~. Subject to section 5164.741 of the Revised Code, the rules shall provide for payment of graduate medical education costs associated with medicaid services rendered to medicaid recipients, including recipients enrolled in a medicaid managed care organization,~~ that the department of medicaid determines are allowable and reasonable.

Sec. 5164.751. (A) As used in this section, "state maximum allowable cost" means the per unit amount the medicaid program pays a terminal distributor of dangerous drugs for a prescribed drug included in the state maximum allowable cost program established under division (B) of this section. "State maximum allowable cost" excludes dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.

(B) ~~Subject to section 5167.123 of the Revised Code, the~~

The medicaid director shall establish a state maximum allowable cost program for purposes of managing medicaid payments to terminal distributors of dangerous drugs for prescribed drugs identified by the director pursuant to this division. The director shall do all of the following with respect to the program:

(1) Identify and create a list of prescribed drugs to be included in the program.

(2) Update the list of prescribed drugs described in division (B)(1) of this section on a weekly basis.

(3) Review the state maximum allowable cost for each prescribed drug included on the list described in division (B)(1) of this section on a weekly basis.

Sec. 5166.01. As used in this chapter:

"209(b) option" means the option described in section 1902(f) of the "Social Security Act," 42 U.S.C. 1396a(f), under which the medicaid program's eligibility requirements for aged, blind, and disabled individuals are more restrictive than the eligibility requirements for the supplemental security income program.

"Administrative agency" means, with respect to a home and community-based services medicaid waiver component, the department of medicaid or, if a state agency or political subdivision contracts with the department under section 5162.35 of the Revised Code to administer the component, that state agency or political subdivision.

~~"Care management system" has the same meaning as in section 5167.01 of the Revised Code.~~

"Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

~~"Enrollee" has the same meaning as in section 5167.01 of the Revised Code.~~

"Expansion eligibility group" has the same meaning as in section 5163.01 of the Revised Code.

"Federal poverty line" has the same meaning as in section 5162.01 of the Revised Code.

"Home and community-based services medicaid waiver component" means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital services, nursing facility services, or ICF/IID services.

"Hospital" has the same meaning as in section 3727.01 of the Revised Code.

"Hospital long-term care unit" has the same meaning as in section 5168.40 of the Revised Code.

"ICDS participant" has the same meaning as in section 5164.01 of the Revised Code.

"ICF/IID" and "ICF/IID services" have the same meanings as in section 5124.01 of the Revised Code.

"Integrated care delivery system" and "ICDS" have the same meanings as in section 5164.01 of the Revised Code.

"Level of care determination" means a determination of whether an individual needs the level of care provided by a hospital, nursing facility, or ICF/IID and whether the individual, if determined to need that level of care, would

receive hospital services, nursing facility services, or ICF/IID services if not for a home and community-based services medicaid waiver component.

"Medicaid buy-in for workers with disabilities program" has the same meaning as in section 5163.01 of the Revised Code.

~~"Medicaid MCO plan" has the same meaning as in section 5167.01 of the Revised Code.~~

"Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

"Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

"Medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under section 1115 or 1915 of the "Social Security Act," 42 U.S.C. 1315 or 1396n. "Medicaid waiver component" does not include the care management system or services delivered under a prepaid inpatient health plan, as defined in 42 C.F.R. 438.2.

"Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of the "Social Security Act," 42 U.S.C. 1382c(a)(2) or (3).

"Nursing facility" and "nursing facility services" have the same meanings as in section 5165.01 of the Revised Code.

"Ohio home care waiver program" means the home and community-based services medicaid waiver component that is known as Ohio home care and was created pursuant to section 5166.11 of the Revised Code.

"Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

"Residential treatment facility" means a residential facility licensed by the department of ~~mental~~ behavioral health ~~and addiction services~~ under section 5119.34 of the Revised Code, or an institution certified by the department of children and youth under section 5103.03 of the Revised Code, that serves children and either has more than sixteen beds or is part of a campus of multiple facilities or institutions that, combined, have a total of more than sixteen beds.

"Skilled nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

Sec. 5166.40. (A) As used in sections 5166.40 to 5166.409 of the Revised Code:

(1) "Adult" means an individual who is at least eighteen years of age.

(2) "Buckeye account" means a modified health savings account established under section 5166.402 of the Revised Code.

(3) "Contribution" means the amounts that an individual contributes to the individual's buckeye account and are contributed to the account on the individual's behalf under divisions (C) and (D) of section 5166.402 of the Revised Code. "Contribution" does not mean the portion of an individual's buckeye account that consists of medicaid funds deposited under division (B) of section 5166.402 of the Revised Code or section 5166.404 of the Revised Code.

(4) "Core portion" means the portion of a healthy Ohio program participant's buckeye account that consists of the following:

(a) The amount of contributions to the account;

(b) The amounts awarded to the account under divisions (C) and (D) of section 5166.404 of the Revised Code.

(5) "Eligible employer-sponsored health plan" has the same meaning as in section 5000A(f)(2) of the "Internal Revenue Code of 1986," 26 U.S.C. 5000A(f)(2).

(6) "Healthy Ohio program" means the medicaid waiver component established under sections 5166.40 to 5166.409 of the Revised Code under which medicaid recipients specified in division (B) of this section enroll in comprehensive health plans and contribute to buckeye accounts.

(7) "Healthy Ohio program debit swipe card" means a debit swipe card issued by a managed care organization to a healthy Ohio program participant under section 5166.403 of the Revised Code.

(8) "Not-for-profit organization" means an organization that is exempt from federal income taxation under section 501(a) and (c)(3) of the "Internal Revenue Code of 1986," 26 U.S.C. 501(a) and (c)(3).

(9) "Ward of the state" means an individual who is a ward, as defined in section 2111.01 of the Revised Code.

(10) "Workforce development activity" and "local board" have the same meanings as in section 6301.01 of the Revised Code.

(B) The medicaid director shall establish a medicaid waiver component to be known as the healthy Ohio program. Each adult medicaid recipient, other than a ward of the state, determined to be eligible for medicaid on the basis of either of

the following shall participate in the healthy Ohio program:

(1) On the basis of being included in the category identified by the department of medicaid as covered families and children;

(2) On the basis of being included in the expansion eligibility group.

(C) Except as provided in section 5166.406 of the Revised Code, a healthy Ohio program participant shall not receive medicaid services under the fee-for-service component of medicaid ~~or participate in the care management system~~.

Sec. 5166.405. (A) A healthy Ohio program participant's participation in the program shall cease if any of the following applies:

(1) Unless the participant is pregnant, a monthly installment payment to the participant's buckeye account is sixty days late.

(2) The participant fails to submit documentation needed for a redetermination of the participant's eligibility for medicaid before the sixty-first day after the documentation is requested.

(3) The participant becomes eligible for medicaid on a basis other than being included in the category identified by the department of medicaid as covered families and children or being included in the expansion eligibility group.

(4) The participant becomes a ward of the state.

(5) The participant ceases to be eligible for medicaid.

(6) The participant exhausts the annual or lifetime payout

limit specified in division (D) of section 5166.401 of the Revised Code.

(7) The participant requests that the participant's participation be terminated.

(B) A healthy Ohio program participant who ceases to participate in the program under division (A)(1) or (2) of this section may not resume participation until the former participant pays the full amount of the monthly installment payment or submits the documentation needed for the former participant's medicaid eligibility redetermination. The former participant shall not be transferred to the fee-for-service component of medicaid ~~or the care management system~~ as a result of ceasing to participate in the healthy Ohio program under division (A)(1) or (2) of this section.

(C) Except as provided in section 5166.407 of the Revised Code, a healthy Ohio program participant who ceases to participate in the program shall be provided the contributions that are in the participant's buckeye account at the time the participant ceases participation.

Sec. 5166.406. If a healthy Ohio program participant exhausts the annual or lifetime payout limits specified in division (D) of section 5166.401 of the Revised Code, the participant shall be transferred to the fee-for-service component of medicaid ~~or the care management system~~. A participant who exhausts the annual payout limit for a year shall resume participation in the healthy Ohio program at the beginning of the immediately following year if division (B) of section 5166.40 of the Revised Code continues to apply to the participant.

Sec. 5168.75. As used in sections 5168.75 to 5168.86 of the Revised Code:

(A) "Basic health care services" means all of the services listed in division (A)(1) of section 1751.01 of the Revised Code.

(B) ~~"Care management system" has the same meaning as in section 5167.01 of the Revised Code.~~

~~(C)~~ "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

~~(D)~~ (C) "Franchise fee" means the fee imposed on health insuring corporation plans under section 5168.76 of the Revised Code.

~~(E)~~ (D) "Health insuring corporation" has the same meaning as in section 1751.01 of the Revised Code, except it does not mean a corporation that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, only supplemental health care services or only specialty health care services.

~~(F)~~ (E) "Health insuring corporation plan" means a policy, contract, certificate, or agreement of a health insuring corporation under which the corporation pays for, reimburses, provides, delivers, arranges for, or otherwise makes available basic health care services. "Health insuring corporation plan" does not mean any of the following:

(1) A policy, contract, certificate, or agreement under which a health insuring corporation pays for, reimburses, provides, delivers, arranges for, or otherwise makes available only supplemental health care services or only specialty health

care services;

(2) An approved health benefits plan described in 5 U.S.C. 8903 or 8903a, if imposing the franchise fee on the plan would violate 5 U.S.C. 8909(f);

(3) A medicare advantage plan authorized by Part C of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-21 et seq.

~~(G)~~ (F) "Indirect guarantee percentage" means the percentage specified in section 1903(w)(4)(C)(ii) of the "Social Security Act," 42 U.S.C. 1396b(w)(4)(C)(ii), that is to be used in determining whether a health care class is indirectly held harmless for any portion of the costs of a broad-based health-care-related tax. If the indirect guarantee percentage changes during a fiscal year, the indirect guarantee percentage is the following:

(1) For the part of the fiscal year before the change takes effect, the percentage in effect before the change;

(2) For the part of the fiscal year beginning with the date the indirect guarantee percentage changes, the new percentage.

~~(H) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.~~

~~(I)~~ (G) "Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

~~(J)~~ (H) "Ohio medicaid member month" means a month in which a medicaid recipient residing in this state is enrolled in a health insuring corporation plan.

~~(K)~~ (I) "Other Ohio member month" means a month in which a

resident of this state who is not a medicaid recipient is enrolled in a health insuring corporation plan.

~~(I)~~ (J) "Rate year" means the fiscal year for which a franchise fee is imposed.

Sec. 5168.76. (A) For the purposes specified in section 5168.85 of the Revised Code and subject to sections 5168.82, 5168.83, and 5168.84 of the Revised Code, a franchise fee is hereby imposed each month beginning with July 2017 on each health insuring corporation plan. The franchise fee shall have a component based on Ohio medicaid member months and another component based on other Ohio member months.

(B) The department of medicaid shall determine the amount of the monthly franchise fee to be imposed on a health insuring corporation plan under the component based on Ohio medicaid member months. The determination shall be made as part of the process of determining the annual capitated payment rates to be paid to medicaid managed care organizations under the care management system, for so long as the department continues that system. The following rates shall be used as part of the determination:

	1	2
A	CUMULATIVE TOTAL NUMBER OF OHIO MEDICAID MEMBER MONTHS	APPLICABLE RATE
B	For the first 250,000	$56
C	For 250,001 to 500,000	$45
D	For 500,001 and above	$26

(C) The amount of the monthly franchise fee to be imposed on a health insuring corporation plan under the component based on other Ohio member months shall be determined by multiplying the number of other Ohio member months that the health insuring corporation plan had for the month by the applicable rate or rates. The applicable rate or rates to be used in the calculation for a health insuring corporation plan for a month shall depend on the cumulative total number of other Ohio member months the health insuring corporation plan had for all of a rate year's months that ended before the beginning of the month in which the franchise fee is due.

The following table shows the applicable rate or rates:

	1	2
A	CUMULATIVE TOTAL NUMBER OF OTHER OHIO MEMBER MONTHS	APPLICABLE RATE
B	For the first 150,000	$2
C	For 150,001 and above	$1

Sec. 5739.01. As used in this chapter:

(A) "Person" includes individuals, receivers, assignees, trustees in bankruptcy, estates, firms, partnerships, associations, joint-stock companies, joint ventures, clubs, societies, corporations, the state and its political subdivisions, and combinations of individuals of any form.

(B) "Sale" and "selling" include all of the following transactions for a consideration in any manner, whether

absolutely or conditionally, whether for a price or rental, in money or by exchange, and by any means whatsoever:

(1) All transactions by which title or possession, or both, of tangible personal property, is or is to be transferred, or a license to use or consume tangible personal property is or is to be granted;

(2) All transactions by which lodging by a hotel is or is to be furnished to transient guests;

(3) All transactions by which:

(a) An item of tangible personal property is or is to be repaired, except property, the purchase of which would not be subject to the tax imposed by section 5739.02 of the Revised Code;

(b) An item of tangible personal property is or is to be installed, except property, the purchase of which would not be subject to the tax imposed by section 5739.02 of the Revised Code or property that is or is to be incorporated into and will become a part of a production, transmission, transportation, or distribution system for the delivery of a public utility service;

(c) The service of washing, cleaning, waxing, polishing, or painting a motor vehicle is or is to be furnished;

(d) Laundry and dry cleaning services are or are to be provided;

(e) Automatic data processing, computer services, or electronic information services are or are to be provided for use in business when the true object of the transaction is the receipt by the consumer of automatic data processing, computer

services, or electronic information services rather than the receipt of personal or professional services to which automatic data processing, computer services, or electronic information services are incidental or supplemental. Notwithstanding any other provision of this chapter, such transactions that occur between members of an affiliated group are not sales. An "affiliated group" means two or more persons related in such a way that one person owns or controls the business operation of another member of the group. In the case of corporations with stock, one corporation owns or controls another if it owns more than fifty per cent of the other corporation's common stock with voting rights.

(f) Telecommunications service, including prepaid calling service, prepaid wireless calling service, or ancillary service, is or is to be provided, but not including coin-operated telephone service;

(g) Landscaping and lawn care service is or is to be provided;

(h) Private investigation and security service is or is to be provided;

(i) Information services or tangible personal property is provided or ordered by means of a nine hundred telephone call;

(j) Building maintenance and janitorial service is or is to be provided;

(k) Exterminating service is or is to be provided;

(l) Physical fitness facility service is or is to be provided;

(m) Recreation and sports club service is or is to be

provided;

(n) Satellite broadcasting service is or is to be provided;

(o) Personal care service is or is to be provided to an individual. As used in this division, "personal care service" includes skin care, the application of cosmetics, manicuring, pedicuring, hair removal, tattooing, body piercing, tanning, massage, and other similar services. "Personal care service" does not include a service provided by or on the order of a licensed physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or chiropractor, or the cutting, coloring, or styling of an individual's hair.

(p) The transportation of persons by motor vehicle or aircraft is or is to be provided, when the transportation is entirely within this state, except for transportation provided by an ambulance service, by a transit bus, as defined in section 5735.01 of the Revised Code, and transportation provided by a citizen of the United States holding a certificate of public convenience and necessity issued under 49 U.S.C. 41102;

(q) Motor vehicle towing service is or is to be provided. As used in this division, "motor vehicle towing service" means the towing or conveyance of a wrecked, disabled, or illegally parked motor vehicle.

(r) Snow removal service is or is to be provided. As used in this division, "snow removal service" means the removal of snow by any mechanized means, but does not include the providing of such service by a person that has less than five thousand dollars in sales of such service during the calendar year.

(s) Electronic publishing service is or is to be provided

to a consumer for use in business, except that such transactions occurring between members of an affiliated group, as defined in division (B)(3)(e) of this section, are not sales.

(4) All transactions by which printed, imprinted, overprinted, lithographic, multilithic, blueprinted, photostatic, or other productions or reproductions of written or graphic matter are or are to be furnished or transferred;

(5) The production or fabrication of tangible personal property for a consideration for consumers who furnish either directly or indirectly the materials used in the production of fabrication work; and include the furnishing, preparing, or serving for a consideration of any tangible personal property consumed on the premises of the person furnishing, preparing, or serving such tangible personal property. Except as provided in section 5739.03 of the Revised Code, a construction contract pursuant to which tangible personal property is or is to be incorporated into a structure or improvement on and becoming a part of real property is not a sale of such tangible personal property. The construction contractor is the consumer of such tangible personal property, provided that the sale and installation of carpeting, the sale and installation of agricultural land tile, the sale and erection or installation of portable grain bins, or the provision of landscaping and lawn care service and the transfer of property as part of such service is never a construction contract.

As used in division (B)(5) of this section:

(a) "Agricultural land tile" means fired clay or concrete tile, or flexible or rigid perforated plastic pipe or tubing, incorporated or to be incorporated into a subsurface drainage system appurtenant to land used or to be used primarily in

production by farming, agriculture, horticulture, or floriculture. The term does not include such materials when they are or are to be incorporated into a drainage system appurtenant to a building or structure even if the building or structure is used or to be used in such production.

(b) "Portable grain bin" means a structure that is used or to be used by a person engaged in farming or agriculture to shelter the person's grain and that is designed to be disassembled without significant damage to its component parts.

(6) All transactions in which all of the shares of stock of a closely held corporation are transferred, or an ownership interest in a pass-through entity, as defined in section 5733.04 of the Revised Code, is transferred, if the corporation or pass-through entity is not engaging in business and its entire assets consist of boats, planes, motor vehicles, or other tangible personal property operated primarily for the use and enjoyment of the shareholders or owners;

(7) All transactions in which a warranty, maintenance or service contract, or similar agreement by which the vendor of the warranty, contract, or agreement agrees to repair or maintain the tangible personal property of the consumer is or is to be provided;

(8) The transfer of copyrighted motion picture films used solely for advertising purposes, except that the transfer of such films for exhibition purposes is not a sale;

(9) All transactions by which tangible personal property is or is to be stored, except such property that the consumer of the storage holds for sale in the regular course of business;

(10) All transactions in which "guaranteed auto

protection" is provided whereby a person promises to pay to the consumer the difference between the amount the consumer receives from motor vehicle insurance and the amount the consumer owes to a person holding title to or a lien on the consumer's motor vehicle in the event the consumer's motor vehicle suffers a total loss under the terms of the motor vehicle insurance policy or is stolen and not recovered, if the protection and its price are included in the purchase or lease agreement;

(11)(a) Except as provided in division (B)(11)(b) of this section, all transactions by which health care services are paid for, reimbursed, provided, delivered, arranged for, or otherwise made available by a medicaid health insuring corporation pursuant to the corporation's contract with the state.

(b) If the centers for medicare and medicaid services of the United States department of health and human services determines that the taxation of transactions described in division (B)(11)(a) of this section constitutes an impermissible health care-related tax under the "Social Security Act," section 1903(w), 42 U.S.C. 1396b(w), and regulations adopted thereunder, the medicaid director shall notify the tax commissioner of that determination. Beginning with the first day of the month following that notification, the transactions described in division (B)(11)(a) of this section are not sales for the purposes of this chapter or Chapter 5741. of the Revised Code. The tax commissioner shall order that the collection of taxes under sections 5739.02, 5739.021, 5739.023, 5739.026, 5741.02, 5741.021, 5741.022, and 5741.023 of the Revised Code shall cease for transactions occurring on or after that date.

(12) All transactions by which a specified digital product is provided for permanent use or less than permanent use,

regardless of whether continued payment is required.

(13) All transactions by a delivery network company for the company's delivery network services, provided the company has a waiver issued under section 5741.072 of the Revised Code.

Except as provided in this section, "sale" and "selling" do not include transfers of interest in leased property where the original lessee and the terms of the original lease agreement remain unchanged, or professional, insurance, or personal service transactions that involve the transfer of tangible personal property as an inconsequential element, for which no separate charges are made.

(C) "Vendor" means the person providing the service or by whom the transfer effected or license given by a sale is or is to be made or given and, for sales described in division (B)(3)(i) of this section, the telecommunications service vendor that provides the nine hundred telephone service; if two or more persons are engaged in business at the same place of business under a single trade name in which all collections on account of sales by each are made, such persons shall constitute a single vendor.

Physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, dentists, hospitals, and veterinarians who are engaged in selling tangible personal property as received from others, such as eyeglasses, mouthwashes, dentifrices, or similar articles, are vendors. Veterinarians who are engaged in transferring to others for a consideration drugs, the dispensing of which does not require an order of a licensed veterinarian, physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner under federal law, are vendors.

The operator of any peer-to-peer car sharing program shall be considered to be the vendor.

(D)(1) "Consumer" means the person for whom the service is provided, to whom the transfer effected or license given by a sale is or is to be made or given, to whom the service described in division (B)(3)(f) or (i) of this section is charged, or to whom the admission is granted.

(2) Physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, dentists, hospitals, and blood banks operated by nonprofit institutions and persons licensed to practice veterinary medicine, surgery, and dentistry are consumers of all tangible personal property and services purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service, or the practice of veterinary medicine, surgery, and dentistry. In addition to being consumers of drugs administered by them or by their assistants according to their direction, veterinarians also are consumers of drugs that under federal law may be dispensed only by or upon the order of a licensed veterinarian, physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, when transferred by them to others for a consideration to provide treatment to animals as directed by the veterinarian.

(3) A person who performs a facility management, or similar service contract for a contractee is a consumer of all tangible personal property and services purchased for use in connection with the performance of such contract, regardless of whether title to any such property vests in the contractee. The purchase of such property and services is not subject to the exception for resale under division (E) of this section.

(4)(a) In the case of a person who purchases printed matter for the purpose of distributing it or having it distributed to the public or to a designated segment of the public, free of charge, that person is the consumer of that printed matter, and the purchase of that printed matter for that purpose is a sale.

(b) In the case of a person who produces, rather than purchases, printed matter for the purpose of distributing it or having it distributed to the public or to a designated segment of the public, free of charge, that person is the consumer of all tangible personal property and services purchased for use or consumption in the production of that printed matter. That person is not entitled to claim exemption under division (B)(42)(f) of section 5739.02 of the Revised Code for any material incorporated into the printed matter or any equipment, supplies, or services primarily used to produce the printed matter.

(c) The distribution of printed matter to the public or to a designated segment of the public, free of charge, is not a sale to the members of the public to whom the printed matter is distributed or to any persons who purchase space in the printed matter for advertising or other purposes.

(5) A person who makes sales of any of the services listed in division (B)(3) of this section is the consumer of any tangible personal property used in performing the service. The purchase of that property is not subject to the resale exception under division (E) of this section.

(6) A person who engages in highway transportation for hire is the consumer of all packaging materials purchased by that person and used in performing the service, except for packaging materials sold by such person in a transaction

separate from the service.

(7) In the case of a transaction for health care services under division (B)(11) of this section, a medicaid health insuring corporation is the consumer of such services. The purchase of such services by a medicaid health insuring corporation is not subject to the exception for resale under division (E) of this section or to the exemptions provided under divisions (B)(12), (18), (19), and (22) of section 5739.02 of the Revised Code.

(E) "Retail sale" and "sales at retail" include all sales, except those in which the purpose of the consumer is to resell the thing transferred or benefit of the service provided, by a person engaging in business, in the form in which the same is, or is to be, received by the person.

(F) "Business" includes any activity engaged in by any person with the object of gain, benefit, or advantage, either direct or indirect. "Business" does not include the activity of a person in managing and investing the person's own funds.

(G) "Engaging in business" means commencing, conducting, or continuing in business, and liquidating a business when the liquidator thereof holds itself out to the public as conducting such business. Making a casual sale is not engaging in business.

(H)(1)(a) "Price," except as provided in divisions (H)(2), (3), and (4) of this section, means the total amount of consideration, including cash, credit, property, and services, for which tangible personal property or services are sold, leased, or rented, valued in money, whether received in money or otherwise, without any deduction for any of the following:

(i) The vendor's cost of the property sold;

(ii) The cost of materials used, labor or service costs, interest, losses, all costs of transportation to the vendor, all taxes imposed on the vendor, including the tax imposed under Chapter 5751. of the Revised Code, and any other expense of the vendor;

(iii) Charges by the vendor for any services necessary to complete the sale;

(iv) Delivery charges. As used in this division, "delivery charges" means charges by the vendor for preparation and delivery to a location designated by the consumer of tangible personal property or a service, including transportation, shipping, postage, handling, crating, and packing.

(v) Installation charges;

(vi) Credit for any trade-in.

(b) "Price" includes consideration received by the vendor from a third party, if the vendor actually receives the consideration from a party other than the consumer, and the consideration is directly related to a price reduction or discount on the sale; the vendor has an obligation to pass the price reduction or discount through to the consumer; the amount of the consideration attributable to the sale is fixed and determinable by the vendor at the time of the sale of the item to the consumer; and one of the following criteria is met:

(i) The consumer presents a coupon, certificate, or other document to the vendor to claim a price reduction or discount where the coupon, certificate, or document is authorized, distributed, or granted by a third party with the understanding that the third party will reimburse any vendor to whom the coupon, certificate, or document is presented;

(ii) The consumer identifies the consumer's self to the seller as a member of a group or organization entitled to a price reduction or discount. A preferred customer card that is available to any patron does not constitute membership in such a group or organization.

(iii) The price reduction or discount is identified as a third party price reduction or discount on the invoice received by the consumer, or on a coupon, certificate, or other document presented by the consumer.

(c) "Price" does not include any of the following:

(i) Discounts, including cash, term, or coupons that are not reimbursed by a third party that are allowed by a vendor and taken by a consumer on a sale;

(ii) Interest, financing, and carrying charges from credit extended on the sale of tangible personal property or services, if the amount is separately stated on the invoice, bill of sale, or similar document given to the purchaser;

(iii) Any taxes legally imposed directly on the consumer that are separately stated on the invoice, bill of sale, or similar document given to the consumer. For the purpose of this division, the tax imposed under Chapter 5751. of the Revised Code is not a tax directly on the consumer, even if the tax or a portion thereof is separately stated.

(iv) Notwithstanding divisions (H)(1)(b)(i) to (iii) of this section, any discount allowed by an automobile manufacturer to its employee, or to the employee of a supplier, on the purchase of a new motor vehicle from a new motor vehicle dealer in this state.

(v) The dollar value of a gift card that is not sold by a

vendor or purchased by a consumer and that is redeemed by the consumer in purchasing tangible personal property or services if the vendor is not reimbursed and does not receive compensation from a third party to cover all or part of the gift card value. For the purposes of this division, a gift card is not sold by a vendor or purchased by a consumer if it is distributed pursuant to an awards, loyalty, or promotional program. Past and present purchases of tangible personal property or services by the consumer shall not be treated as consideration exchanged for a gift card.

(2) In the case of a sale of any new motor vehicle by a new motor vehicle dealer, as defined in section 4517.01 of the Revised Code, in which another motor vehicle is accepted by the dealer as part of the consideration received, "price" has the same meaning as in division (H)(1) of this section, reduced by the credit afforded the consumer by the dealer for the motor vehicle received in trade.

(3) In the case of a sale of any watercraft or outboard motor by a watercraft dealer licensed in accordance with section 1547.543 of the Revised Code, in which another watercraft, watercraft and trailer, or outboard motor is accepted by the dealer as part of the consideration received, "price" has the same meaning as in division (H)(1) of this section, reduced by the credit afforded the consumer by the dealer for the watercraft, watercraft and trailer, or outboard motor received in trade. As used in this division, "watercraft" includes an outdrive unit attached to the watercraft.

(4) In the case of transactions for health care services under division (B)(11) of this section, "price" means the amount of managed care premiums received each month by a medicaid

health insuring corporation.

(I) "Receipts" means the total amount of the prices of the sales of vendors, provided that the dollar value of gift cards distributed pursuant to an awards, loyalty, or promotional program, and cash discounts allowed and taken on sales at the time they are consummated are not included, minus any amount deducted as a bad debt pursuant to section 5739.121 of the Revised Code. "Receipts" does not include the sale price of property returned or services rejected by consumers when the full sale price and tax are refunded either in cash or by credit.

(J) "Place of business" means any location at which a person engages in business.

(K) "Premises" includes any real property or portion thereof upon which any person engages in selling tangible personal property at retail or making retail sales and also includes any real property or portion thereof designated for, or devoted to, use in conjunction with the business engaged in by such person.

(L) "Casual sale" means a sale of an item of tangible personal property, in person or online, that was obtained by the person making the sale, through purchase or otherwise, for the person's own use and was previously subject to any state's taxing jurisdiction on its sale or use, and includes such items acquired for the seller's use that are sold by an auctioneer employed directly by the person for such purpose, provided the location of such sales is not the auctioneer's physical permanent place of business. As used in this division, "permanent place of business" includes any physical location where such auctioneer has conducted more than two auctions

during the year.

(M) "Hotel" means every establishment kept, used, maintained, advertised, or held out to the public to be a place where sleeping accommodations are offered to guests, in which five or more rooms are used for the accommodation of such guests, whether the rooms are in one or several structures, except as otherwise provided in section 5739.091 of the Revised Code.

(N) "Transient guests" means persons occupying a room or rooms for sleeping accommodations for less than thirty consecutive days.

(O) "Making retail sales" means the effecting of transactions wherein one party is obligated to pay the price and the other party is obligated to provide a service or to transfer title to or possession of the item sold. "Making retail sales" does not include the preliminary acts of promoting or soliciting the retail sales, other than the distribution of printed matter which displays or describes and prices the item offered for sale, nor does it include delivery of a predetermined quantity of tangible personal property or transportation of property or personnel to or from a place where a service is performed.

(P) "Used directly in the rendition of a public utility service" means that property that is to be incorporated into and will become a part of the consumer's production, transmission, transportation, or distribution system and that retains its classification as tangible personal property after such incorporation; fuel or power used in the production, transmission, transportation, or distribution system; and tangible personal property used in the repair and maintenance of the production, transmission, transportation, or distribution

system, including only such motor vehicles as are specially designed and equipped for such use. Tangible personal property and services used primarily in providing highway transportation for hire are not used directly in the rendition of a public utility service. In this definition, "public utility" includes a citizen of the United States holding, and required to hold, a certificate of public convenience and necessity issued under 49 U.S.C. 41102.

(Q) "Refining" means removing or separating a desirable product from raw or contaminated materials by distillation or physical, mechanical, or chemical processes.

(R) "Assembly" and "assembling" mean attaching or fitting together parts to form a product, but do not include packaging a product.

(S) "Manufacturing operation" means a process in which materials are changed, converted, or transformed into a different state or form from which they previously existed and includes refining materials, assembling parts, and preparing raw materials and parts by mixing, measuring, blending, or otherwise committing such materials or parts to the manufacturing process. "Manufacturing operation" does not include packaging.

(T) "Fiscal officer" means, with respect to a regional transit authority, the secretary-treasurer thereof, and with respect to a county that is a transit authority, the fiscal officer of the county transit board if one is appointed pursuant to section 306.03 of the Revised Code or the county auditor if the board of county commissioners operates the county transit system.

(U) "Transit authority" means a regional transit authority

created pursuant to section 306.31 of the Revised Code or a county in which a county transit system is created pursuant to section 306.01 of the Revised Code. For the purposes of this chapter, a transit authority must extend to at least the entire area of a single county. A transit authority that includes territory in more than one county must include all the area of the most populous county that is a part of such transit authority. County population shall be measured by the most recent census taken by the United States census bureau.

(V) "Legislative authority" means, with respect to a regional transit authority, the board of trustees thereof, and with respect to a county that is a transit authority, the board of county commissioners.

(W) "Territory of the transit authority" means all of the area included within the territorial boundaries of a transit authority as they from time to time exist. Such territorial boundaries must at all times include all the area of a single county or all the area of the most populous county that is a part of such transit authority. County population shall be measured by the most recent census taken by the United States census bureau.

(X) "Providing a service" means providing or furnishing anything described in division (B)(3) of this section for consideration.

(Y)(1)(a) "Automatic data processing" means processing of others' data, including keypunching or similar data entry services together with verification thereof, or providing access to computer equipment for the purpose of processing data.

(b) "Computer services" means providing services

consisting of specifying computer hardware configurations and evaluating technical processing characteristics, computer programming, and training of computer programmers and operators, provided in conjunction with and to support the sale, lease, or operation of taxable computer equipment or systems.

(c) "Electronic information services" means providing access to computer equipment by means of telecommunications equipment for the purpose of either of the following:

(i) Examining or acquiring data stored in or accessible to the computer equipment;

(ii) Placing data into the computer equipment to be retrieved by designated recipients with access to the computer equipment.

"Electronic information services" does not include electronic publishing.

(d) "Automatic data processing, computer services, or electronic information services" shall not include personal or professional services.

(2) As used in divisions (B)(3)(e) and (Y)(1) of this section, "personal and professional services" means all services other than automatic data processing, computer services, or electronic information services, including but not limited to:

(a) Accounting and legal services such as advice on tax matters, asset management, budgetary matters, quality control, information security, and auditing and any other situation where the service provider receives data or information and studies, alters, analyzes, interprets, or adjusts such material;

(b) Analyzing business policies and procedures;

(c) Identifying management information needs;

(d) Feasibility studies, including economic and technical analysis of existing or potential computer hardware or software needs and alternatives;

(e) Designing policies, procedures, and custom software for collecting business information, and determining how data should be summarized, sequenced, formatted, processed, controlled, and reported so that it will be meaningful to management;

(f) Developing policies and procedures that document how business events and transactions are to be authorized, executed, and controlled;

(g) Testing of business procedures;

(h) Training personnel in business procedure applications;

(i) Providing credit information to users of such information by a consumer reporting agency, as defined in the "Fair Credit Reporting Act," 84 Stat. 1114, 1129 (1970), 15 U.S.C. 1681a(f), or as hereafter amended, including but not limited to gathering, organizing, analyzing, recording, and furnishing such information by any oral, written, graphic, or electronic medium;

(j) Providing debt collection services by any oral, written, graphic, or electronic means;

(k) Providing digital advertising services;

(l) Providing services to electronically file any federal, state, or local individual income tax return, report, or other related document or schedule with a federal, state, or local government entity or to electronically remit a payment of any

such individual income tax to such an entity. For the purpose of this division, "individual income tax" does not include federal, state, or local taxes withheld by an employer from an employee's compensation.

The services listed in divisions (Y)(2)(a) to (l) of this section are not automatic data processing or computer services.

(Z) "Highway transportation for hire" means the transportation of personal property belonging to others for consideration by any of the following:

(1) The holder of a permit or certificate issued by this state or the United States authorizing the holder to engage in transportation of personal property belonging to others for consideration over or on highways, roadways, streets, or any similar public thoroughfare;

(2) A person who engages in the transportation of personal property belonging to others for consideration over or on highways, roadways, streets, or any similar public thoroughfare but who could not have engaged in such transportation on December 11, 1985, unless the person was the holder of a permit or certificate of the types described in division (Z)(1) of this section;

(3) A person who leases a motor vehicle to and operates it for a person described by division (Z)(1) or (2) of this section.

"Highway transportation for hire" does not include delivery network services.

(AA)(1) "Telecommunications service" means the electronic transmission, conveyance, or routing of voice, data, audio, video, or any other information or signals to a point, or

between or among points. "Telecommunications service" includes such transmission, conveyance, or routing in which computer processing applications are used to act on the form, code, or protocol of the content for purposes of transmission, conveyance, or routing without regard to whether the service is referred to as voice-over internet protocol service or is classified by the federal communications commission as enhanced or value-added. "Telecommunications service" does not include any of the following:

(a) Data processing and information services that allow data to be generated, acquired, stored, processed, or retrieved and delivered by an electronic transmission to a consumer where the consumer's primary purpose for the underlying transaction is the processed data or information;

(b) Installation or maintenance of wiring or equipment on a customer's premises;

(c) Tangible personal property;

(d) Advertising, including directory advertising;

(e) Billing and collection services provided to third parties;

(f) Internet access service;

(g) Radio and television audio and video programming services, regardless of the medium, including the furnishing of transmission, conveyance, and routing of such services by the programming service provider. Radio and television audio and video programming services include, but are not limited to, cable service, as defined in 47 U.S.C. 522(6), and audio and video programming services delivered by commercial mobile radio service providers, as defined in 47 C.F.R. 20.3;

(h) Ancillary service;

(i) Digital products delivered electronically, including software, music, video, reading materials, or ring tones.

(2) "Ancillary service" means a service that is associated with or incidental to the provision of telecommunications service, including conference bridging service, detailed telecommunications billing service, directory assistance, vertical service, and voice mail service. As used in this division:

(a) "Conference bridging service" means an ancillary service that links two or more participants of an audio or video conference call, including providing a telephone number. "Conference bridging service" does not include telecommunications services used to reach the conference bridge.

(b) "Detailed telecommunications billing service" means an ancillary service of separately stating information pertaining to individual calls on a customer's billing statement.

(c) "Directory assistance" means an ancillary service of providing telephone number or address information.

(d) "Vertical service" means an ancillary service that is offered in connection with one or more telecommunications services, which offers advanced calling features that allow customers to identify callers and manage multiple calls and call connections, including conference bridging service.

(e) "Voice mail service" means an ancillary service that enables the customer to store, send, or receive recorded messages. "Voice mail service" does not include any vertical services that the customer may be required to have in order to utilize the voice mail service.

(3) "900 service" means an inbound toll telecommunications service purchased by a subscriber that allows the subscriber's customers to call in to the subscriber's prerecorded announcement or live service, and which is typically marketed under the name "900 service" and any subsequent numbers designated by the federal communications commission. "900 service" does not include the charge for collection services provided by the seller of the telecommunications service to the subscriber, or services or products sold by the subscriber to the subscriber's customer.

(4) "Prepaid calling service" means the right to access exclusively telecommunications services, which must be paid for in advance and which enables the origination of calls using an access number or authorization code, whether manually or electronically dialed, and that is sold in predetermined units or dollars of which the number declines with use in a known amount.

(5) "Prepaid wireless calling service" means a telecommunications service that provides the right to utilize mobile telecommunications service as well as other non-telecommunications services, including the download of digital products delivered electronically, and content and ancillary services, that must be paid for in advance and that is sold in predetermined units or dollars of which the number declines with use in a known amount.

(6) "Value-added non-voice data service" means a telecommunications service in which computer processing applications are used to act on the form, content, code, or protocol of the information or data primarily for a purpose other than transmission, conveyance, or routing.

(7) "Coin-operated telephone service" means a telecommunications service paid for by inserting money into a telephone accepting direct deposits of money to operate.

(8) "Customer" has the same meaning as in section 5739.034 of the Revised Code.

(BB) "Laundry and dry cleaning services" means removing soil or dirt from towels, linens, articles of clothing, or other fabric items that belong to others and supplying towels, linens, articles of clothing, or other fabric items. "Laundry and dry cleaning services" does not include the provision of self-service facilities for use by consumers to remove soil or dirt from towels, linens, articles of clothing, or other fabric items.

(CC) "Magazines distributed as controlled circulation publications" means magazines containing at least twenty-four pages, at least twenty-five per cent editorial content, issued at regular intervals four or more times a year, and circulated without charge to the recipient, provided that such magazines are not owned or controlled by individuals or business concerns which conduct such publications as an auxiliary to, and essentially for the advancement of the main business or calling of, those who own or control them.

(DD) "Landscaping and lawn care service" means the services of planting, seeding, sodding, removing, cutting, trimming, pruning, mulching, aerating, applying chemicals, watering, fertilizing, and providing similar services to establish, promote, or control the growth of trees, shrubs, flowers, grass, ground cover, and other flora, or otherwise maintaining a lawn or landscape grown or maintained by the owner for ornamentation or other nonagricultural purpose. However,

"landscaping and lawn care service" does not include the providing of such services by a person who has less than five thousand dollars in sales of such services during the calendar year.

(EE) "Private investigation and security service" means the performance of any activity for which the provider of such service is required to be licensed pursuant to Chapter 4749. of the Revised Code, or would be required to be so licensed in performing such services in this state, and also includes the services of conducting polygraph examinations and of monitoring or overseeing the activities on or in, or the condition of, the consumer's home, business, or other facility by means of electronic or similar monitoring devices. "Private investigation and security service" does not include special duty services provided by off-duty police officers, deputy sheriffs, and other peace officers regularly employed by the state or a political subdivision.

(FF) "Information services" means providing conversation, giving consultation or advice, playing or making a voice or other recording, making or keeping a record of the number of callers, and any other service provided to a consumer by means of a nine hundred telephone call, except when the nine hundred telephone call is the means by which the consumer makes a contribution to a recognized charity.

(GG) "Research and development" means designing, creating, or formulating new or enhanced products, equipment, or manufacturing processes, and also means conducting scientific or technological inquiry and experimentation in the physical sciences with the goal of increasing scientific knowledge which may reveal the bases for new or enhanced products, equipment, or

manufacturing processes.

(HH) "Qualified research and development equipment" means either of the following:

(1) Capitalized tangible personal property, and leased personal property that would be capitalized if purchased, used by a person primarily to perform research and development;

(2) Any tangible personal property used by a megaproject operator primarily to perform research and development at the site of a megaproject that satisfies the criteria described in division (A)(11)(a)(ii) of section 122.17 of the Revised Code during the period that the megaproject operator has an agreement for such megaproject with the tax credit authority under division (D) of that section that remains in effect and has not expired or been terminated.

"Qualified research and development equipment" does not include tangible personal property primarily used in testing, as defined in division (A)(4) of section 5739.011 of the Revised Code, or used for recording or storing test results, unless such property is primarily used by the consumer in testing the product, equipment, or manufacturing process being created, designed, or formulated by the consumer in the research and development activity or in recording or storing such test results.

(II) "Building maintenance and janitorial service" means cleaning the interior or exterior of a building and any tangible personal property located therein or thereon, including any services incidental to such cleaning for which no separate charge is made. However, "building maintenance and janitorial service" does not include the providing of such service by a

person who has less than five thousand dollars in sales of such service during the calendar year. As used in this division, "cleaning" does not include sanitation services necessary for an establishment described in 21 U.S.C. 608 to comply with rules and regulations adopted pursuant to that section.

(JJ) "Exterminating service" means eradicating or attempting to eradicate vermin infestations from a building or structure, or the area surrounding a building or structure, and includes activities to inspect, detect, or prevent vermin infestation of a building or structure.

(KK) "Physical fitness facility service" means all transactions by which a membership is granted, maintained, or renewed, including initiation fees, membership dues, renewal fees, monthly minimum fees, and other similar fees and dues, by a physical fitness facility such as an athletic club, health spa, or gymnasium, which entitles the member to use the facility for physical exercise.

(LL) "Recreation and sports club service" means all transactions by which a membership is granted, maintained, or renewed, including initiation fees, membership dues, renewal fees, monthly minimum fees, and other similar fees and dues, by a recreation and sports club, which entitles the member to use the facilities of the organization. "Recreation and sports club" means an organization that has ownership of, or controls or leases on a continuing, long-term basis, the facilities used by its members and includes an aviation club, gun or shooting club, yacht club, card club, swimming club, tennis club, golf club, country club, riding club, amateur sports club, or similar organization.

(MM) "Livestock" means farm animals commonly raised for

food, food production, or other agricultural purposes, including, but not limited to, cattle, sheep, goats, swine, poultry, and captive deer. "Livestock" does not include invertebrates, amphibians, reptiles, domestic pets, animals for use in laboratories or for exhibition, or other animals not commonly raised for food or food production.

(NN) "Livestock structure" means a building or structure used exclusively for the housing, raising, feeding, or sheltering of livestock, and includes feed storage or handling structures and structures for livestock waste handling.

(OO) "Horticulture" means the growing, cultivation, and production of flowers, fruits, herbs, vegetables, sod, mushrooms, and nursery stock. As used in this division, "nursery stock" has the same meaning as in section 927.51 of the Revised Code.

(PP) "Horticulture structure" means a building or structure used exclusively for the commercial growing, raising, or overwintering of horticultural products, and includes the area used for stocking, storing, and packing horticultural products when done in conjunction with the production of those products.

(QQ) "Newspaper" means an unbound publication bearing a title or name that is regularly published, at least as frequently as biweekly, and distributed from a fixed place of business to the public in a specific geographic area, and that contains a substantial amount of news matter of international, national, or local events of interest to the general public.

(RR)(1) "Feminine hygiene products" means tampons, panty liners, menstrual cups, sanitary napkins, and other similar

tangible personal property designed for feminine hygiene in connection with the human menstrual cycle, but does not include grooming and hygiene products.

(2) "Grooming and hygiene products" means soaps and cleaning solutions, shampoo, toothpaste, mouthwash, antiperspirants, and sun tan lotions and screens, regardless of whether any of these products are over-the-counter drugs.

(3) "Over-the-counter drugs" means a drug that contains a label that identifies the product as a drug as required by 21 C.F.R. 201.66, which label includes a drug facts panel or a statement of the active ingredients with a list of those ingredients contained in the compound, substance, or preparation.

(SS)(1) "Lease" or "rental" means any transfer of the possession or control of tangible personal property for a fixed or indefinite term, for consideration. "Lease" or "rental" includes future options to purchase or extend, and agreements described in 26 U.S.C. 7701(h)(1) covering motor vehicles and trailers where the amount of consideration may be increased or decreased by reference to the amount realized upon the sale or disposition of the property. "Lease" or "rental" does not include:

(a) A transfer of possession or control of tangible personal property under a security agreement or a deferred payment plan that requires the transfer of title upon completion of the required payments;

(b) A transfer of possession or control of tangible personal property under an agreement that requires the transfer of title upon completion of required payments and payment of an

option price that does not exceed the greater of one hundred dollars or one per cent of the total required payments;

(c) Providing tangible personal property along with an operator for a fixed or indefinite period of time, if the operator is necessary for the property to perform as designed. For purposes of this division, the operator must do more than maintain, inspect, or set up the tangible personal property.

(2) "Lease" and "rental," as defined in division (SS) of this section, shall not apply to leases or rentals that exist before June 26, 2003.

(3) "Lease" and "rental" have the same meaning as in division (SS)(1) of this section regardless of whether a transaction is characterized as a lease or rental under generally accepted accounting principles, the Internal Revenue Code, Title XIII of the Revised Code, or other federal, state, or local laws.

(TT) "Mobile telecommunications service" has the same meaning as in the "Mobile Telecommunications Sourcing Act," Pub. L. No. 106-252, 114 Stat. 631 (2000), 4 U.S.C.A. 124(7), as amended, and, on and after August 1, 2003, includes related fees and ancillary services, including universal service fees, detailed billing service, directory assistance, service initiation, voice mail service, and vertical services, such as caller ID and three-way calling.

(UU) "Certified service provider" has the same meaning as in section 5740.01 of the Revised Code.

(VV) "Satellite broadcasting service" means the distribution or broadcasting of programming or services by satellite directly to the subscriber's receiving equipment

without the use of ground receiving or distribution equipment, except the subscriber's receiving equipment or equipment used in the uplink process to the satellite, and includes all service and rental charges, premium channels or other special services, installation and repair service charges, and any other charges having any connection with the provision of the satellite broadcasting service.

(WW) "Tangible personal property" means personal property that can be seen, weighed, measured, felt, or touched, or that is in any other manner perceptible to the senses. For purposes of this chapter and Chapter 5741. of the Revised Code, "tangible personal property" includes motor vehicles, electricity, water, gas, steam, and prewritten computer software.

(XX) "Municipal gas utility" means a municipal corporation that owns or operates a system for the distribution of natural gas.

(YY) "Computer" means an electronic device that accepts information in digital or similar form and manipulates it for a result based on a sequence of instructions.

(ZZ) "Computer software" means a set of coded instructions designed to cause a computer or automatic data processing equipment to perform a task.

(AAA) "Delivered electronically" means delivery of computer software from the seller to the purchaser by means other than tangible storage media.

(BBB) "Prewritten computer software" means computer software, including prewritten upgrades, that is not designed and developed by the author or other creator to the specifications of a specific purchaser. The combining of two or

more prewritten computer software programs or prewritten portions thereof does not cause the combination to be other than prewritten computer software. "Prewritten computer software" includes software designed and developed by the author or other creator to the specifications of a specific purchaser when it is sold to a person other than the purchaser. If a person modifies or enhances computer software of which the person is not the author or creator, the person shall be deemed to be the author or creator only of such person's modifications or enhancements. Prewritten computer software or a prewritten portion thereof that is modified or enhanced to any degree, where such modification or enhancement is designed and developed to the specifications of a specific purchaser, remains prewritten computer software; provided, however, that where there is a reasonable, separately stated charge or an invoice or other statement of the price given to the purchaser for the modification or enhancement, the modification or enhancement shall not constitute prewritten computer software.

(CCC)(1) "Food" means substances, whether in liquid, concentrated, solid, frozen, dried, or dehydrated form, that are sold for ingestion or chewing by humans and are consumed for their taste or nutritional value. "Food" does not include alcoholic beverages, dietary supplements, soft drinks, or tobacco.

(2) As used in division (CCC)(1) of this section:

(a) "Dietary supplements" means any product, other than tobacco, that is intended to supplement the diet and that is intended for ingestion in tablet, capsule, powder, softgel, gelcap, or liquid form, or, if not intended for ingestion in such a form, is not represented as conventional food for use as

a sole item of a meal or of the diet; that is required to be labeled as a dietary supplement, identifiable by the "supplement facts" box found on the label, as required by 21 C.F.R. 101.36; and that contains one or more of the following dietary ingredients:

(i) A vitamin;

(ii) A mineral;

(iii) An herb or other botanical;

(iv) An amino acid;

(v) A dietary substance for use by humans to supplement the diet by increasing the total dietary intake;

(vi) A concentrate, metabolite, constituent, extract, or combination of any ingredient described in divisions (CCC)(2)(a)(i) to (v) of this section.

(b) "Soft drinks" means nonalcoholic beverages that contain natural or artificial sweeteners. "Soft drinks" does not include beverages that contain milk or milk products, soy, rice, or similar milk substitutes, or that contains greater than fifty per cent vegetable or fruit juice by volume.

(DDD) "Drug" means a compound, substance, or preparation, and any component of a compound, substance, or preparation, other than food, dietary supplements, or alcoholic beverages that is recognized in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States, or official national formulary, and supplements to them; is intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease; or is intended to affect the structure or any function of the body.

(EEE) "Prescription" means an order, formula, or recipe issued in any form of oral, written, electronic, or other means of transmission by a duly licensed practitioner authorized by the laws of this state to issue a prescription.

(FFF) "Durable medical equipment" means equipment, including repair and replacement parts for such equipment, that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is not worn in or on the body. "Durable medical equipment" does not include mobility enhancing equipment.

(GGG) "Mobility enhancing equipment" means equipment, including repair and replacement parts for such equipment, that is primarily and customarily used to provide or increase the ability to move from one place to another and is appropriate for use either in a home or a motor vehicle, that is not generally used by persons with normal mobility, and that does not include any motor vehicle or equipment on a motor vehicle normally provided by a motor vehicle manufacturer. "Mobility enhancing equipment" does not include durable medical equipment.

(HHH) "Prosthetic device" means a replacement, corrective, or supportive device, including repair and replacement parts for the device, worn on or in the human body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body. As used in this division, before July 1, 2019, "prosthetic device" does not include corrective eyeglasses, contact lenses, or dental prosthesis. On or after July 1, 2019, "prosthetic device" does not include dental prosthesis but does include corrective eyeglasses or contact lenses.

(III)(1) "Fractional aircraft ownership program" means a program in which persons within an affiliated group sell and manage fractional ownership program aircraft, provided that at least one hundred airworthy aircraft are operated in the program and the program meets all of the following criteria:

(a) Management services are provided by at least one program manager within an affiliated group on behalf of the fractional owners.

(b) Each program aircraft is owned or possessed by at least one fractional owner.

(c) Each fractional owner owns or possesses at least a one-sixteenth interest in at least one fixed-wing program aircraft.

(d) A dry-lease aircraft interchange arrangement is in effect among all of the fractional owners.

(e) Multi-year program agreements are in effect regarding the fractional ownership, management services, and dry-lease aircraft interchange arrangement aspects of the program.

(2) As used in division (III)(1) of this section:

(a) "Affiliated group" has the same meaning as in division (B)(3)(e) of this section.

(b) "Fractional owner" means a person that owns or possesses at least a one-sixteenth interest in a program aircraft and has entered into the agreements described in division (III)(1)(e) of this section.

(c) "Fractional ownership program aircraft" or "program aircraft" means a turbojet aircraft that is owned or possessed by a fractional owner and that has been included in a dry-lease

aircraft interchange arrangement and agreement under divisions (III)(1)(d) and (e) of this section, or an aircraft a program manager owns or possesses primarily for use in a fractional aircraft ownership program.

(d) "Management services" means administrative and aviation support services furnished under a fractional aircraft ownership program in accordance with a management services agreement under division (III)(1)(e) of this section, and offered by the program manager to the fractional owners, including, at a minimum, the establishment and implementation of safety guidelines; the coordination of the scheduling of the program aircraft and crews; program aircraft maintenance; program aircraft insurance; crew training for crews employed, furnished, or contracted by the program manager or the fractional owner; the satisfaction of record-keeping requirements; and the development and use of an operations manual and a maintenance manual for the fractional aircraft ownership program.

(e) "Program manager" means the person that offers management services to fractional owners pursuant to a management services agreement under division (III)(1)(e) of this section.

(JJJ) "Electronic publishing" means providing access to one or more of the following primarily for business customers, including the federal government or a state government or a political subdivision thereof, to conduct research: news; business, financial, legal, consumer, or credit materials; editorials, columns, reader commentary, or features; photos or images; archival or research material; legal notices, identity verification, or public records; scientific, educational,

instructional, technical, professional, trade, or other literary materials; or other similar information which has been gathered and made available by the provider to the consumer in an electronic format. Providing electronic publishing includes the functions necessary for the acquisition, formatting, editing, storage, and dissemination of data or information that is the subject of a sale.

(KKK) ~~"Medicaid health insuring corporation" means a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code and is under contract with the department of medicaid pursuant to section 5167.10 of the Revised Code.~~

~~(LLL)~~ "Managed care premium" means any premium, capitation, or other payment a medicaid health insuring corporation receives for providing or arranging for the provision of health care services to its members or enrollees residing in this state.

~~(MMM)~~ (LLL) "Captive deer" means deer and other cervidae that have been legally acquired, or their offspring, that are privately owned for agricultural or farming purposes.

~~(NNN)~~ (MMM) "Gift card" means a document, card, certificate, or other record, whether tangible or intangible, that may be redeemed by a consumer for a dollar value when making a purchase of tangible personal property or services.

~~(OOO)~~ (NNN) "Specified digital product" means an electronically transferred digital audiovisual work, digital audio work, or digital book.

As used in division ~~(OOO)~~ (NNN) of this section:

(1) "Digital audiovisual work" means a series of related

images that, when shown in succession, impart an impression of motion, together with accompanying sounds, if any.

(2) "Digital audio work" means a work that results from the fixation of a series of musical, spoken, or other sounds, including digitized sound files that are downloaded onto a device and that may be used to alert the customer with respect to a communication.

(3) "Digital book" means a work that is generally recognized in the ordinary and usual sense as a book.

(4) "Electronically transferred" means obtained by the purchaser by means other than tangible storage media.

~~(PPP)~~ (OOO) "Digital advertising services" means providing access, by means of telecommunications equipment, to computer equipment that is used to enter, upload, download, review, manipulate, store, add, or delete data for the purpose of electronically displaying, delivering, placing, or transferring promotional advertisements to potential customers about products or services or about industry or business brands.

~~(QQQ)~~ (PPP) "Peer-to-peer car sharing program" has the same meaning as in section 4516.01 of the Revised Code.

~~(RRR)~~ (QQQ) "Megaproject" and "megaproject operator" have the same meanings as in section 122.17 of the Revised Code.

~~(SSS) (1)~~ (RRR) (1) "Diaper" means an absorbent garment worn by humans who are incapable of, or have difficulty, controlling their bladder or bowel movements.

(2) "Children's diaper" means a diaper marketed to be worn by children.

(3) "Adult diaper" means a diaper other than a children's

diaper.

~~(TTT)~~(SSS) "Sales tax holiday" means three or more dates on which sales of all eligible tangible personal property are exempt from the taxes levied under sections 5739.02, 5739.021, 5739.023, 5739.026, 5741.02, 5741.021, 5741.022, and 5741.023 of the Revised Code.

~~(UUU)~~(TTT) "Eligible tangible personal property" means any item of tangible personal property that meets both of the following requirements:

(1) The price of the item does not exceed five hundred dollars;

(2) The item is not a watercraft or outboard motor required to be titled pursuant to Chapter 1548. of the Revised Code, a motor vehicle, an alcoholic beverage, tobacco, a vapor product as defined in section 5743.01 of the Revised Code, or an item that contains marijuana as defined in section 3796.01 of the Revised Code.

~~(VVV)~~(UUU) "Alcoholic beverages" means beverages that are suitable for human consumption and contain one-half of one per cent or more of alcohol by volume.

~~(WWW)~~(VVV) "Tobacco" means cigarettes, cigars, chewing or pipe tobacco, or any other item that contains tobacco.

~~(XXX)(1)~~(WWW)(1) "Delivery network company" means a person that operates a business platform, including a web site or mobile application, to facilitate delivery network services.

(2) "Delivery network courier" means an individual connected to a consumer through a delivery network company and who provides delivery network services to that consumer.

(3) "Delivery network services" means both of the following when performed as part of a single transaction:

(a) Pickup of a local product by a delivery network courier from a local merchant that is not under common ownership or control of the delivery network company through which the transaction was initiated, and which may include selection, collection, and purchase of the local product;

(b) Delivery by the delivery network courier of that local product to a location designated by the consumer that is not more than seventy-five miles from the local merchant's place of business where the pickup described in division (XXX)(3)(a) of this section occurs.

(4) "Local merchant" means a person engaged in selling local products from a temporary or fixed place of business in this state, including a kitchen, restaurant, grocery store, retail store, or convenience store.

(5) "Local product" means any tangible personal property, including food, but excluding freight, mail, or a package to which postage is affixed.

Sec. 5739.03. (A) Except as provided in section 5739.05 ~~or section 5739.051~~ of the Revised Code, the tax imposed by or pursuant to section 5739.02, 5739.021, 5739.023, or 5739.026 of the Revised Code shall be paid by the consumer to the vendor, and each vendor shall collect from the consumer, as a trustee for the state of Ohio, the full and exact amount of the tax payable on each taxable sale, in the manner and at the times provided as follows:

(1) If the price is, at or prior to the provision of the service or the delivery of possession of the thing sold to the

consumer, paid in currency passed from hand to hand by the consumer or the consumer's agent to the vendor or the vendor's agent, the vendor or the vendor's agent shall collect the tax with and at the same time as the price;

(2) If the price is otherwise paid or to be paid, the vendor or the vendor's agent shall, at or prior to the provision of the service or the delivery of possession of the thing sold to the consumer, charge the tax imposed by or pursuant to section 5739.02, 5739.021, 5739.023, or 5739.026 of the Revised Code to the account of the consumer, which amount shall be collected by the vendor from the consumer in addition to the price. Such sale shall be reported on and the amount of the tax applicable thereto shall be remitted with the return for the period in which the sale is made, and the amount of the tax shall become a legal charge in favor of the vendor and against the consumer.

(B)(1)(a) If any sale is claimed to be exempt under division (E) of section 5739.01 of the Revised Code or under section 5739.02 of the Revised Code, with the exception of divisions (B)(1) to (11), (28), (48), (55), (59), or (62) of section 5739.02 of the Revised Code, the consumer must provide to the vendor, and the vendor must obtain from the consumer, a certificate specifying the reason that the sale is not legally subject to the tax. The certificate shall be in such form, and shall be provided either in a hard copy form or electronic form, as the tax commissioner prescribes.

(b) A vendor that obtains a fully completed exemption certificate from a consumer is relieved of liability for collecting and remitting tax on any sale covered by that certificate. If it is determined the exemption was improperly

claimed, the consumer shall be liable for any tax due on that sale under section 5739.02, 5739.021, 5739.023, or 5739.026 or Chapter 5741. of the Revised Code. Relief under this division from liability does not apply to any of the following:

(i) A vendor that fraudulently fails to collect tax;

(ii) A vendor that solicits consumers to participate in the unlawful claim of an exemption;

(iii) A vendor that accepts an exemption certificate from a consumer that claims an exemption based on who purchases or who sells property or a service, when the subject of the transaction sought to be covered by the exemption certificate is actually received by the consumer at a location operated by the vendor in this state, and this state has posted to its web site an exemption certificate form that clearly and affirmatively indicates that the claimed exemption is not available in this state;

(iv) A vendor that accepts an exemption certificate from a consumer who claims a multiple points of use exemption under division (D) of section 5739.033 of the Revised Code, if the item purchased is tangible personal property, other than prewritten computer software.

(2) The vendor shall maintain records, including exemption certificates, of all sales on which a consumer has claimed an exemption, and provide them to the tax commissioner on request.

(3) The tax commissioner may establish an identification system whereby the commissioner issues an identification number to a consumer that is exempt from payment of the tax. The consumer must present the number to the vendor, if any sale is claimed to be exempt as provided in this section.

(4) If no certificate is provided or obtained within ninety days after the date on which such sale is consummated, it shall be presumed that the tax applies. Failure to have so provided or obtained a certificate shall not preclude a vendor, within one hundred twenty days after the tax commissioner gives written notice of intent to levy an assessment, from either establishing that the sale is not subject to the tax, or obtaining, in good faith, a fully completed exemption certificate.

(5) Certificates need not be obtained nor provided where the identity of the consumer is such that the transaction is never subject to the tax imposed or where the item of tangible personal property sold or the service provided is never subject to the tax imposed, regardless of use, or when the sale is in interstate commerce.

(6) If a transaction is claimed to be exempt under division (B)(13) of section 5739.02 of the Revised Code, the contractor shall obtain certification of the claimed exemption from the contractee. This certification shall be in addition to an exemption certificate provided by the contractor to the vendor. A contractee that provides a certification under this division shall be deemed to be the consumer of all items purchased by the contractor under the claim of exemption, if it is subsequently determined that the exemption is not properly claimed. The certification shall be in such form as the tax commissioner prescribes.

(7) If a transaction is claimed to be exempt under division (B)(13) of section 5739.02 of the Revised Code, the person that leases a sports facility, as defined in section 307.696 of the Revised Code, wholly owned by a county may

provide and sign, on behalf of the county, an exemption certificate required under this section for that exemption.

(C) As used in this division, "contractee" means a person who seeks to enter or enters into a contract or agreement with a contractor or vendor for the construction of real property or for the sale and installation onto real property of tangible personal property.

Any contractor or vendor may request from any contractee a certification of what portion of the property to be transferred under such contract or agreement is to be incorporated into the realty and what portion will retain its status as tangible personal property after installation is completed. The contractor or vendor shall request the certification by certified mail delivered to the contractee, return receipt requested. Upon receipt of such request and prior to entering into the contract or agreement, the contractee shall provide to the contractor or vendor a certification sufficiently detailed to enable the contractor or vendor to ascertain the resulting classification of all materials purchased or fabricated by the contractor or vendor and transferred to the contractee. This requirement applies to a contractee regardless of whether the contractee holds a direct payment permit under section 5739.031 of the Revised Code or provides to the contractor or vendor an exemption certificate as provided under this section.

For the purposes of the taxes levied by this chapter and Chapter 5741. of the Revised Code, the contractor or vendor may in good faith rely on the contractee's certification. Notwithstanding division (B) of section 5739.01 of the Revised Code, if the tax commissioner determines that certain property certified by the contractee as tangible personal property

pursuant to this division is, in fact, real property, the contractee shall be considered to be the consumer of all materials so incorporated into that real property and shall be liable for the applicable tax, and the contractor or vendor shall be excused from any liability on those materials.

If a contractee fails to provide such certification upon the request of the contractor or vendor, the contractor or vendor shall comply with the provisions of this chapter and Chapter 5741. of the Revised Code without the certification. If the tax commissioner determines that such compliance has been performed in good faith and that certain property treated as tangible personal property by the contractor or vendor is, in fact, real property, the contractee shall be considered to be the consumer of all materials so incorporated into that real property and shall be liable for the applicable tax, and the construction contractor or vendor shall be excused from any liability on those materials.

This division does not apply to any contract or agreement where the tax commissioner determines as a fact that a certification under this division was made solely on the decision or advice of the contractor or vendor.

(D) Notwithstanding division (B) of section 5739.01 of the Revised Code, whenever the total rate of tax imposed under this chapter is increased after the date after a construction contract is entered into, the contractee shall reimburse the construction contractor for any additional tax paid on tangible property consumed or services received pursuant to the contract.

(E) A vendor who files a petition for reassessment contesting the assessment of tax on sales for which the vendor obtained no valid exemption certificates and for which the

vendor failed to establish that the sales were properly not subject to the tax during the one-hundred-twenty-day period allowed under division (B) of this section, may present to the tax commissioner additional evidence to prove that the sales were properly subject to a claim of exception or exemption. The vendor shall file such evidence within ninety days of the receipt by the vendor of the notice of assessment, except that, upon application and for reasonable cause, the period for submitting such evidence shall be extended thirty days.

The commissioner shall consider such additional evidence in reaching the final determination on the assessment and petition for reassessment.

(F) Whenever a vendor refunds the price, minus any separately stated delivery charge, of an item of tangible personal property on which the tax imposed under this chapter has been paid, the vendor shall also refund the amount of tax paid, minus the amount of tax attributable to the delivery charge.

Section 2. That existing sections 126.021, 126.024, 173.19, 1751.03, 3701.741, 3901.81, 3902.70, 3903.14, 3903.42, 3959.01, 3963.06, 4121.50, 4729.20, 4729.49, 4729.80, 4729.84, 4729.86, 5160.01, 5160.34, 5160.37, 5160.371, 5160.40, 5162.01, 5162.021, 5162.13, 5162.1310, 5162.73, 5164.01, 5164.38, 5164.46, 5164.74, 5164.751, 5166.01, 5166.40, 5166.405, 5166.406, 5168.75, 5168.76, 5739.01, and 5739.03 of the Revised Code are hereby repealed.

Section 3. That sections 1751.271, 3901.815, 3903.421, 5164.741, 5167.01, 5167.02, 5167.03, 5167.031, 5167.04, 5167.05, 5167.051, 5167.09, 5167.10, 5167.101, 5167.103, 5167.11, 5167.12, 5167.122, 5167.123, 5167.13, 5167.14, 5167.15, 5167.16,

5167.17, 5167.171, 5167.173, 5167.18, 5167.20, 5167.201, 5167.21, 5167.22, 5167.221, 5167.24, 5167.241, 5167.243, 5167.244, 5167.245, 5167.26, 5167.30, 5167.31, 5167.32, 5167.33, 5167.34, 5167.35, 5167.40, 5167.41, 5167.45, 5167.47, and 5739.051 of the Revised Code are hereby repealed.

Section 4. This act shall be known as the Medicaid Savings Act.