

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, 1
1751.03, 3701.741, 3901.81, 3902.70, 3903.14, 2
3903.42, 3959.01, 3963.06, 4121.50, 4729.20, 3
4729.49, 4729.80, 4729.84, 4729.86, 5160.01, 4
5160.34, 5160.37, 5160.371, 5160.40, 5162.01, 5
5162.021, 5162.13, 5162.1310, 5162.73, 5164.01, 6
5164.38, 5164.46, 5164.74, 5164.751, 5166.01, 7
5166.40, 5166.405, 5166.406, 5168.75, 5168.76, 8
5739.01, and 5739.03; to amend, for the purpose 9
of adopting a new section number as indicated in 10
parentheses, section 5162.73 (5162.74); to enact 11
new section 5162.73; and to repeal sections 12
1751.271, 3901.815, 3903.421, 5164.741, 5167.01, 13
5167.02, 5167.03, 5167.031, 5167.04, 5167.05, 14
5167.051, 5167.09, 5167.10, 5167.101, 5167.103, 15
5167.11, 5167.12, 5167.122, 5167.123, 5167.13, 16
5167.14, 5167.15, 5167.16, 5167.17, 5167.171, 17
5167.173, 5167.18, 5167.20, 5167.201, 5167.21, 18
5167.22, 5167.221, 5167.24, 5167.241, 5167.243, 19
5167.244, 5167.245, 5167.26, 5167.30, 5167.31, 20
5167.32, 5167.33, 5167.34, 5167.35, 5167.40, 21
5167.41, 5167.45, 5167.47, and 5739.051 of the 22
Revised Code to eliminate the care management 23
system from the Medicaid program and to name 24
this act the Medicaid Savings Act. 25

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

Section 1. That sections 126.021, 126.024, 173.19, 26
1751.03, 3701.741, 3901.81, 3902.70, 3903.14, 3903.42, 3959.01, 27
3963.06, 4121.50, 4729.20, 4729.49, 4729.80, 4729.84, 4729.86, 28
5160.01, 5160.34, 5160.37, 5160.371, 5160.40, 5162.01, 5162.021, 29
5162.13, 5162.1310, 5162.73, 5164.01, 5164.38, 5164.46, 5164.74, 30
5164.751, 5166.01, 5166.40, 5166.405, 5166.406, 5168.75, 31
5168.76, 5739.01, and 5739.03 be amended; section 5162.73 32
(5162.74) be amended for the purpose of adopting a new section 33
number as indicated in parentheses; and new section 5162.73 of 34
the Revised Code be enacted to read as follows: 35

Sec. 126.021. The director of budget and management, as 36
part of the submission to the governor under section 126.02 of 37
the Revised Code, shall prepare and submit to the governor not 38
later than the first day of January preceding the convening of 39
the general assembly a medicaid caseload and expenditure 40
forecast report, prepared in consultation with the department of 41
medicaid. For each component identified in divisions (A) to (Q) 42
of this section, the report shall include proposed, actual, or 43
estimated medicaid program data for each fiscal year of the 44
proposed budget biennium and for each fiscal year of the current 45
budget biennium. If determined useful, the directors of budget 46
and management and medicaid may choose to include additional 47
years of data for components of the report. 48

The report shall include all of the following: 49

(A) A complete budget for the medicaid program delineated 50
by the agency administering each component of the program, fund, 51
appropriation item, and whether the spending is for services or 52

administration;	53
(B) A summary of medicaid service spending by eligibility	54
group and subgroup and service delivery system;	55
(C) A detailed mapping of the summary spending provided in	56
division (B) of this section into individual appropriation items	57
and including state and federal shares of each appropriation	58
item;	59
(D) A complete description of each policy proposal,	60
including assumed start date and cost projection delineated by	61
fiscal year, appropriation item, state and federal shares,	62
eligibility group and subgroup, and service delivery system;	63
(E) The medicaid caseload delineated by eligibility group	64
and subgroup and service delivery system;	65
(F) The percentage of total medicaid enrollment that is	66
comprised of medicaid recipients enrolled under the care	67
management system established under section 5167.03 of the	68
Revised Code and the percentage of total medicaid spending that	69
the care management system comprises;	70
(G) A detailed accounting of the care management system	71
component of the medicaid budget by eligibility group and	72
subgroup, including spending, member months, and per member per	73
month capitation rates;	74
(H) <u>(G)</u> A detailed accounting of the fee-for-service	75
component of the medicaid budget by eligibility group and	76
subgroup, including spending, member months, and per member per	77
month costs;	78
(I) <u>(H)</u> Historical spending data by service delivery	79
system, medicaid provider and program, including at least the	80

following provider categories: hospital, pharmacy, waiver, 81
nursing, home health care, professional medical and clinic, 82
nursing facility, behavioral health care, and intermediate care 83
facility for individuals with intellectual disabilities; 84

~~(J)~~ (I) A detailed accounting of the medicare buy-in and 85
medicare Part D components of the medicaid budget by eligibility 86
group and subgroup, including spending, average monthly 87
premiums, and average rates; 88

~~(K)~~ (J) A summary of projected spending for each fiscal 89
year delineated by forecast component and by baseline and policy 90
proposals; 91

~~(L)~~ (K) A detailed calculation demonstrating the effect of 92
a hypothetical one-dollar increase in medicaid home and 93
community-based services wages for direct care providers for 94
each fiscal year, delineated by provider, appropriation item, 95
and state and federal shares; 96

~~(M)~~ (L) A detailed calculation demonstrating the effect of 97
a hypothetical one percentage point increase in provider 98
franchise fee revenue for each fiscal year, for each of the fees 99
imposed under sections 5168.21, 5168.41, and 5168.76 of the 100
Revised Code; 101

~~(N)~~ (M) A detailed calculation demonstrating the effect of 102
a hypothetical one-dollar increase in nursing facility and 103
intermediate care facility for individuals with intellectual 104
disabilities per medicaid day payment rates; 105

~~(O)~~ (N) A detailed explanation of how the governor's 106
medicaid budget recommendations satisfy the requirements of 107
section 5162.70 of the Revised Code; 108

~~(P)~~ (O) The most recent report required under section 109

5162.70 of the Revised Code; 110

~~(Q)~~ (P) Any other information the director of budget and 111
management or the medicaid director deems to be useful to 112
facilitate a better understanding of the governor's medicaid 113
budget recommendations. 114

Sec. 126.024. Beginning with the state budget that is 115
introduced following ~~the effective date of this section~~ September 116
30, 2025, and subsequent state budgets thereafter, the director 117
of budget and management, in consultation with the medicaid 118
director, shall request and propose multiple medicaid health 119
care services general revenue fund appropriation items. At a 120
minimum, the directors shall propose a separate general revenue 121
fund appropriation item for the different health care services 122
included in the medicaid program, including all of the 123
following: 124

~~(A)~~ ~~Services provided under the care management system;~~ 125

~~(B)~~ Nursing facility services; 126

~~(C)~~ (B) Hospital services; 127

~~(D)~~ (C) Behavioral health services; 128

~~(E)~~ (D) Services provided under medicaid waiver components 129
administered by the department of aging; 130

~~(F)~~ (E) Prescription drug services; 131

~~(G)~~ (F) Physician services; 132

~~(H)~~ (G) Services provided under the Ohio home care waiver 133
program; 134

~~(I)~~ (H) Services provided under medicaid waiver components 135
administered by the department of developmental disabilities; 136

~~(J)~~(I) Services provided under the medicaid waiver 137
component known as the Ohio resilience through integrated 138
systems and excellence (OhioRISE) waiver; 139

~~(K)~~(J) Any other medicaid health care services that the 140
directors determine should have a separate general revenue fund 141
appropriation item. 142

Sec. 173.19. (A) The office of the state long-term care 143
ombudsman program, through the state long-term care ombudsman 144
and the regional long-term care ombudsman programs, shall 145
receive, investigate, and attempt to resolve complaints made by 146
residents, recipients, sponsors, long-term care providers, or 147
any person acting on behalf of a resident or recipient, relating 148
to either of the following: 149

(1) The health, safety, welfare, or civil rights of a 150
resident or recipient or any violation of a resident's rights 151
described in sections 3721.10 to 3721.17 of the Revised Code; 152

(2) Any action or inaction or decision by any of the 153
following that may adversely affect the health, safety, welfare, 154
or rights of a resident or recipient: a long-term care provider 155
or a representative of a long-term care provider; ~~a medicaid-~~ 156
~~managed care organization, as defined in section 5167.01 of the~~ 157
~~Revised Code; a government entity;~~ or a private social service 158
agency. 159

(B) The department of aging shall adopt rules in 160
accordance with Chapter 119. of the Revised Code regarding the 161
handling of complaints received under this section, including 162
procedures for conducting investigations of complaints. The 163
rules shall include procedures to ensure that no representative 164
of the office investigates any complaint involving a long-term 165

care provider with which the representative was once employed or 166
associated. 167

The state ombudsman and regional programs shall establish 168
procedures for handling complaints consistent with the 169
department's rules. Complaints shall be dealt with in accordance 170
with the procedures established under this division. 171

(C) The office of the state long-term care ombudsman 172
program may decline to investigate any complaint if it 173
determines any of the following: 174

(1) That the complaint is frivolous, vexatious, or not 175
made in good faith; 176

(2) That the complaint was made so long after the 177
occurrence of the incident on which it is based that it is no 178
longer reasonable to conduct an investigation; 179

(3) That an adequate investigation cannot be conducted 180
because of insufficient funds, insufficient staff, lack of staff 181
expertise, or any other reasonable factor that would result in 182
an inadequate investigation despite a good faith effort; 183

(4) That an investigation by the office would create a 184
real or apparent conflict of interest. 185

(D) If a regional long-term care ombudsman program 186
declines to investigate a complaint, it shall refer the 187
complaint to the state long-term care ombudsman. 188

(E) Each complaint to be investigated by a regional 189
program shall be assigned to a representative of the office of 190
the state long-term care ombudsman program. If the 191
representative determines that the complaint is valid, the 192
representative shall assist the parties in attempting to resolve 193

it. If the representative is unable to resolve it, the 194
representative shall refer the complaint to the state ombudsman. 195

In order to carry out the duties of sections 173.14 to 196
173.28 of the Revised Code, a representative has the right to 197
private communication with residents and their sponsors and 198
access to long-term care facilities, including the right to tour 199
resident areas unescorted and the right to tour facilities 200
unescorted as reasonably necessary to the investigation of a 201
complaint. Access to facilities shall be during reasonable hours 202
or, during investigation of a complaint, at other times 203
appropriate to the complaint. 204

When community-based long-term care services are provided 205
at a location other than the recipient's home, a representative 206
has the right to private communication with the recipient and 207
the recipient's sponsors and access to the community-based long- 208
term care site, including the right to tour the site unescorted. 209
Access to the site shall be during reasonable hours or, during 210
the investigation of a complaint, at other times appropriate to 211
the complaint. 212

(F) The state ombudsman shall determine whether complaints 213
referred to the ombudsman under division (D) or (E) of this 214
section warrant investigation. The ombudsman's determination in 215
this matter is final. 216

(G) No long-term care provider or other entity, no person 217
employed by a long-term care provider or other entity, and no 218
other individual shall do either of the following: 219

(1) Knowingly deny a representative of the office of the 220
state long-term care ombudsman program the right to private 221
communication or access described in division (E) of this 222

section; 223

(2) Engage in willful interference. 224

As used in division (G) (2) of this section, "willful 225
interference" means any action or inaction that is intended to 226
prevent, interfere with, or impede a representative of the 227
office of the state long-term care ombudsman program from 228
exercising any of the rights or performing any of the duties of 229
an ombudsman set forth in sections 173.14 to 173.28 of the 230
Revised Code. 231

Sec. 1751.03. (A) Each application for a certificate of 232
authority under this chapter shall be verified by an officer or 233
authorized representative of the applicant, shall be in a format 234
prescribed by the superintendent of insurance, and shall set 235
forth or be accompanied by the following: 236

(1) A certified copy of the applicant's articles of 237
incorporation and all amendments to the articles of 238
incorporation; 239

(2) A copy of any regulations adopted for the government 240
of the corporation, any bylaws, and any similar documents, and a 241
copy of all amendments to these regulations, bylaws, and 242
documents. The corporate secretary shall certify that these 243
regulations, bylaws, documents, and amendments have been 244
properly adopted or approved. 245

(3) A list of the names, addresses, and official positions 246
of the persons responsible for the conduct of the applicant, 247
including all members of the board, the principal officers, and 248
the person responsible for completing or filing financial 249
statements with the department of insurance, accompanied by a 250
completed original biographical affidavit and release of 251

information for each of these persons on forms acceptable to the 252
department; 253

(4) A full and complete disclosure of the extent and 254
nature of any contractual or other financial arrangement between 255
the applicant and any provider or a person listed in division 256
(A) (3) of this section, including, but not limited to, a full 257
and complete disclosure of the financial interest held by any 258
such provider or person in any health care facility, provider, 259
or insurer that has entered into a financial relationship with 260
the health insuring corporation; 261

(5) A description of the applicant, its facilities, and 262
its personnel, including, but not limited to, the location, 263
hours of operation, and telephone numbers of all contracted 264
facilities; 265

(6) The applicant's projected annual enrollee population 266
over a three-year period; 267

(7) A clear and specific description of the health care 268
plan or plans to be used by the applicant, including a 269
description of the proposed providers, procedures for accessing 270
care, and the form of all proposed and existing contracts 271
relating to the administration, delivery, or financing of health 272
care services; 273

(8) A copy of each type of evidence of coverage and 274
identification card or similar document to be issued to 275
subscribers; 276

(9) A copy of each type of individual or group policy, 277
contract, or agreement to be used; 278

(10) The schedule of the proposed contractual periodic 279
prepayments or premium rates, or both, accompanied by 280

appropriate supporting data; 281

(11) A financial plan which provides a three-year 282
projection of operating results, including the projected 283
expenses, income, and sources of working capital; 284

(12) The enrollee complaint procedure to be utilized as 285
required under section 1751.19 of the Revised Code; 286

(13) A description of the procedures and programs to be 287
implemented on an ongoing basis to assure the quality of health 288
care services delivered to enrollees, including, if applicable, 289
a description of a quality assurance program complying with the 290
requirements of sections 1751.73 to 1751.75 of the Revised Code; 291

(14) A statement describing the geographic area or areas 292
to be served, by county; 293

(15) A copy of all solicitation documents; 294

(16) A balance sheet and other financial statements 295
showing the applicant's assets, liabilities, income, and other 296
sources of financial support; 297

(17) A description of the nature and extent of any 298
reinsurance program to be implemented, and a demonstration that 299
errors and omission insurance and, if appropriate, fidelity 300
insurance, will be in place upon the applicant's receipt of a 301
certificate of authority; 302

(18) Copies of all proposed or in force related-party or 303
intercompany agreements with an explanation of the financial 304
impact of these agreements on the applicant. If the applicant 305
intends to enter into a contract for managerial or 306
administrative services, with either an affiliated or an 307
unaffiliated person, the applicant shall provide a copy of the 308

contract and a detailed description of the person to provide 309
these services. The description shall include that person's 310
experience in managing or administering health care plans, a 311
copy of that person's most recent audited financial statement, 312
and a completed biographical affidavit on a form acceptable to 313
the superintendent for each of that person's principal officers 314
and board members and for any additional employee to be directly 315
involved in providing managerial or administrative services to 316
the health insuring corporation. If the person to provide 317
managerial or administrative services is affiliated with the 318
health insuring corporation, the contract must provide for 319
payment for services based on actual costs. 320

(19) A statement from the applicant's board that the 321
admitted assets of the applicant have not been and will not be 322
pledged or hypothecated; 323

(20) A statement from the applicant's board that the 324
applicant will submit monthly financial statements during the 325
first year of operations; 326

(21) The name and address of the applicant's Ohio 327
statutory agent for service of process, notice, or demand; 328

(22) Copies of all documents the applicant filed with the 329
secretary of state; 330

(23) The location of those books and records of the 331
applicant that must be maintained, which books and records shall 332
be maintained in Ohio if the applicant is a domestic 333
corporation, and which may be maintained either in the 334
applicant's state of domicile or in Ohio if the applicant is a 335
foreign corporation; 336

(24) The applicant's federal identification number, 337

corporate address, and mailing address;	338
(25) An internal and external organizational chart;	339
(26) A list of the assets representing the initial net worth of the applicant;	340 341
(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.	342 343 344 345 346
(28) The names and addresses of the applicant's actuary and external auditors;	347 348
(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;	349 350 351
(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;	352 353 354 355 356 357
(31) Any other information that the superintendent may require;	358 359
 (32) Documentation acceptable to the superintendent of the bond or securities required by section 1751.271 of the Revised Code.	360 361 362
(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	363 364 365

describing any change to the corporation's articles of 366
incorporation or regulations, or any major modification to its 367
operations as set out in the information required by division 368
(A) of this section that affects any of the following: 369

(a) The solvency of the health insuring corporation; 370

(b) The health insuring corporation's continued provision 371
of services that it has contracted to provide; 372

(c) The manner in which the health insuring corporation 373
conducts its business. 374

(2) If the change or modification is to be the result of 375
an action to be taken by the health insuring corporation, the 376
notice shall be filed with the superintendent prior to the 377
health insuring corporation taking the action. The action shall 378
be deemed approved if the superintendent does not disapprove it 379
within sixty days of filing. 380

(3) The filing of a notice pursuant to division (B) (1) or 381
(2) of this section shall also serve as the submission of a 382
notice when required for the superintendent's review for 383
purposes of section 3901.341 of the Revised Code, if the notice 384
contains all of the information that section 3901.341 of the 385
Revised Code requires for such submissions and a copy of any 386
written agreement. The filing of such a notice, for the purpose 387
of satisfying this division and section 3901.341 of the Revised 388
Code, shall be subject to the sixty-day review period of 389
division (B) (2) of this section. 390

(C) (1) No health insuring corporation shall expand its 391
approved service area until a copy of the request for expansion, 392
accompanied by documentation of the network of providers, forms 393
of all proposed or existing provider contracts relating to the 394

delivery of health care services, a schedule of proposed 395
contractual periodic prepayments and premium rates for group 396
contracts accompanied by appropriate supporting data, enrollment 397
projections, plan of operation, and any other changes have been 398
filed with the superintendent. 399

(2) Within seventy-five days after the superintendent's 400
receipt of a complete filing under division (C) (1) of this 401
section, the superintendent shall determine whether the plan for 402
expansion is lawful, fair, and reasonable. 403

If the superintendent has not approved or disapproved all 404
or a portion of a service area expansion within the seventy- 405
five-day period, the filing shall be deemed approved. 406

(3) Disapproval of all or a portion of the filing shall be 407
effected by written notice, which shall state the grounds for 408
the order of disapproval and shall be given in accordance with 409
Chapter 119. of the Revised Code. 410

(D) The agent named under division (A) (21) of this section 411
shall be one of the following: 412

(1) A natural person who is a resident of this state; 413

(2) A domestic or foreign corporation, nonprofit 414
corporation, limited liability company, partnership, limited 415
partnership, limited liability partnership, limited partnership 416
association, professional association, business trust, or 417
unincorporated nonprofit association that has a business address 418
in this state. If the agent is an entity other than a domestic 419
corporation, the agent shall meet the requirements of Title XVII 420
of the Revised Code for an entity of the agent's type to 421
transact business or exercise privileges in this state. 422

Sec. 3701.741. (A) Each health care provider and medical 423

records company shall provide copies of medical records in 424
accordance with this section. 425

(B) Except as provided in divisions (C) and (E) of this 426
section, a health care provider or medical records company that 427
receives a request for a copy of a patient's medical record 428
shall charge not more than the amounts set forth in this 429
section. 430

(1) (a) Except as provided in division (B) (1) (b) of this 431
section, if the request is made by the patient, the patient's 432
personal representative, or an individual authorized to access 433
the patient's medical record through a valid power of attorney, 434
total costs for copies and all services related to those copies 435
shall be reasonable, cost-based amounts permitted to be charged 436
to the patient under federal laws and regulations. Any per page 437
charges shall not exceed the sum of the per page charges 438
authorized in division (B) (2) (b) and (c) of this section. 439

(b) If the request is made by a person identified in 440
division (B) (1) (a) of this section and the request is for access 441
to digital records or electronically transmitted records, the 442
total cost for that access or for the electronic transmission, 443
and all related services, shall not exceed fifty dollars. 444

(2) If the request is made by anyone other than a person 445
identified in division (B) (1) (a) of this section, total costs 446
for copies and all services related to those copies shall not 447
exceed the sum of the following: 448

(a) An initial fee of sixteen dollars and eighty-four 449
cents adjusted in accordance with section 3701.742 of the 450
Revised Code, which shall compensate for the records search; 451

(b) Except as provided in division (B) (2) (c) of this 452

section, with respect to data recorded on paper or 453
electronically, the following amounts adjusted in accordance 454
with section 3701.742 of the Revised Code: 455

(i) One dollar and eleven cents per page for the first ten 456
pages; 457

(ii) Fifty-seven cents per page for pages eleven through 458
fifty; 459

(iii) Twenty-three cents per page for pages fifty-one and 460
higher. 461

(c) With respect to data resulting from an x-ray, magnetic 462
resonance imaging (MRI), or computed axial tomography (CAT) scan 463
and recorded on paper or film, one dollar and eighty-seven cents 464
per page; 465

(d) The actual cost of any related postage incurred by the 466
health care provider or medical records company. 467

(C) (1) On request, a health care provider or medical 468
records company shall provide one copy of the patient's medical 469
record and one copy of any records regarding treatment performed 470
subsequent to the original request, not including copies of 471
records already provided, without charge to the following: 472

(a) The bureau of workers' compensation, in accordance 473
with Chapters 4121. and 4123. of the Revised Code and the rules 474
adopted under those chapters; 475

(b) The industrial commission, in accordance with Chapters 476
4121. and 4123. of the Revised Code and the rules adopted under 477
those chapters; 478

(c) The department of medicaid or a county department of 479
job and family services, in accordance with Chapters 5160., 480

5161., 5162., 5163., 5164., 5165., and 5166., ~~and 5167.~~ of the 481
Revised Code and the rules adopted under those chapters; 482

(d) The attorney general, in accordance with sections 483
2743.51 to 2743.72 of the Revised Code and any rules that may be 484
adopted under those sections; 485

(e) A patient, patient's personal representative, or 486
authorized person if the medical record is necessary to support 487
a claim under Title II or Title XVI of the "Social Security 488
Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401 and 1381, as amended, 489
and the request is accompanied by documentation that a claim has 490
been filed. 491

(2) Nothing in division (C) (1) of this section requires a 492
health care provider or medical records company to provide a 493
copy without charge to any person or entity not listed in 494
division (C) (1) of this section. 495

(D) Division (C) of this section shall not be construed to 496
supersede any rule of the bureau of workers' compensation, the 497
industrial commission, or the department of medicaid. 498

(E) A health care provider or medical records company may 499
enter into a contract with either of the following for the 500
copying of medical records at a fee other than as provided in 501
division (B) of this section: 502

(1) A patient, a patient's personal representative, or an 503
authorized person; 504

(2) An insurer authorized under Title XXXIX of the Revised 505
Code to do the business of sickness and accident insurance in 506
this state or health insuring corporations holding a certificate 507
of authority under Chapter 1751. of the Revised Code. 508

(F) This section does not apply to medical records the 509
copying of which is covered by section 173.20 of the Revised 510
Code or by 42 C.F.R. 483.10. 511

Sec. 3901.81. As used in this section and sections 512
3901.811 to 3901.815 of the Revised Code: 513

(A) "Auditing entity" means any person or government 514
entity that performs a pharmacy audit, including a payer, a 515
pharmacy benefit manager, or a third-party administrator 516
licensed under Chapter 3959. of the Revised Code. 517

(B) "Business day" means any day of the week excluding 518
Saturday, Sunday, and a legal holiday, as defined in section 519
1.14 of the Revised Code. 520

(C) "Concurrent review" means a claims review within five 521
business days of submission of claims for payment for the 522
provision of dangerous drugs for which the payer or the auditing 523
entity does not impose a penalty or demand to recoup money from 524
the pharmacy in any amount. 525

(D) "Dangerous drug," "pharmacy," "practice of pharmacy," 526
and "prescription" have the same meanings as in section 4729.01 527
of the Revised Code. 528

(E) "Payer" means any of the following that pays for or 529
processes a claim for payment for the provision of dangerous 530
drugs or pharmacy services: 531

(1) A health insuring corporation, as defined in section 532
1751.01 of the Revised Code; 533

(2) A person authorized to engage in the business of 534
sickness and accident insurance under Title XXXIX of the Revised 535
Code; 536

(3) A person or government entity providing coverage of 537
dangerous drugs or pharmacy services to individuals on a self- 538
insurance basis; 539

(4) A group health plan, as defined in 29 U.S.C. 1167; 540

(5) A service benefit plan, as referenced in 42 U.S.C. 541
1396a(a)(25); 542

~~(6) A medicaid managed care organization that has entered- 543
into a contract with the department of medicaid pursuant to- 544
section 5167.10 of the Revised Code; 545~~

~~(7) Any other person or government entity that is, by law, 546
contract, or agreement, responsible for paying for or processing 547
a claim for payment for the provision of dangerous drugs or 548
pharmacy services. 549~~

(F) "Pharmacy audit" means a review of one or more 550
pharmacy records conducted by an auditing entity, one purpose of 551
which is to identify discrepancies in claims for payment for the 552
provision of dangerous drugs or pharmacy services. "Pharmacy 553
audit" does not include concurrent review. 554

(G) "Pharmacy benefit manager" means a person that 555
provides administrative services related to the processing of 556
claims for payment for the provision of dangerous drugs or 557
pharmacy services, including performing pharmacy audit 558
compliance, negotiating pharmaceutical rebate agreements, 559
developing and managing drug formularies and preferred drug 560
lists, and administering programs for payers' prior 561
authorization of claims for payment for the provision of 562
dangerous drugs or pharmacy services. 563

(H) "Pharmacy record" means any record stored 564
electronically or as a hard copy by a pharmacy that relates to 565

the provision of dangerous drugs or pharmacy services or any 566
other component of pharmacist care that is included in the 567
practice of pharmacy. 568

Sec. 3902.70. As used in this section and section 3902.71 569
of the Revised Code: 570

(A) "340B covered entity" means an entity described in 571
section 340B(a) (4) of the "Public Health Service Act," 42 U.S.C. 572
256b(a) (4) and includes any pharmacy under contract with the 573
entity to dispense drugs on behalf of the entity. 574

(B) "Terminal distributor of dangerous drugs" has the same 575
meaning as in section 4729.01 of the Revised Code. 576

(C) "Third-party administrator" has the same meaning as in 577
section ~~5167.01~~ 4729.49 of the Revised Code. 578

Sec. 3903.14. (A) The superintendent of insurance as 579
rehabilitator may appoint one or more special deputies, who 580
shall have all the powers and responsibilities of the 581
rehabilitator granted under this section, and the superintendent 582
may employ such clerks and assistants as considered necessary. 583
The compensation of the special deputies, clerks, and assistants 584
and all expenses of taking possession of the insurer and of 585
conducting the proceedings shall be fixed by the superintendent, 586
with the approval of the court and shall be paid out of the 587
funds or assets of the insurer. The persons appointed under this 588
section shall serve at the pleasure of the superintendent. In 589
the event that the property of the insurer does not contain 590
sufficient cash or liquid assets to defray the costs incurred, 591
the superintendent may advance the costs so incurred out of any 592
appropriation for the maintenance of the department of 593
insurance. Any amounts so advanced for expenses of 594

administration shall be repaid to the superintendent for the use 595
of the department out of the first available money of the 596
insurer. 597

(B) The rehabilitator may take such action as the 598
rehabilitator considers necessary or appropriate to reform and 599
revitalize the insurer. The rehabilitator shall have all the 600
powers of the directors, officers, and managers, whose authority 601
shall be suspended, except as they are redelegated by the 602
rehabilitator. The rehabilitator shall have full power to direct 603
and manage, to hire and discharge employees subject to any 604
contract rights they may have, and to deal with the property and 605
business of the insurer. 606

(C) If it appears to the rehabilitator that there has been 607
criminal or tortious conduct, or breach of any contractual or 608
fiduciary obligation detrimental to the insurer by any officer, 609
manager, agent, director, trustee, broker, employee, or other 610
person, the rehabilitator may pursue all appropriate legal 611
remedies on behalf of the insurer. 612

(D) If the rehabilitator determines that reorganization, 613
consolidation, conversion, reinsurance, merger, or other 614
transformation of the insurer is appropriate, the rehabilitator 615
shall prepare a plan to effect such changes. Upon application of 616
the rehabilitator for approval of the plan, and after such 617
notice and hearings as the court may prescribe, the court may 618
either approve or disapprove the plan proposed, or may modify it 619
and approve it as modified. Any plan approved under this section 620
shall be, in the judgment of the court, fair and equitable to 621
all parties concerned. If the plan is approved, the 622
rehabilitator shall carry out the plan. In the case of a life 623
insurer, the plan proposed may include the imposition of liens 624

upon the policies of the company, if all rights of shareholders 625
are first relinquished. A plan for a life insurer may also 626
propose imposition of a moratorium upon loan and cash surrender 627
rights under policies, for such period and to such an extent as 628
may be necessary. 629

~~(E) In the case of a medicaid health insuring corporation 630
that has posted a bond or deposited securities in accordance 631
with section 1751.271 of the Revised Code, the plan proposed 632
under division (D) of this section may include the use of the 633
proceeds of the bond or securities to first pay the claims of 634
contracted providers for covered health care services provided 635
to medicaid recipients, then next to pay other claimants with 636
any remaining funds, consistent with the priorities set forth in 637
sections 3903.421 and 3903.42 of the Revised Code. 638~~

~~(F) The rehabilitator shall have the power under sections 639
3903.26 and 3903.27 of the Revised Code to avoid fraudulent 640
transfers. 641~~

~~(G) As used in this section: 642~~

~~(1) "Contracted provider" means a provider with a contract 643
with a medicaid health insuring corporation to provide covered 644
health care services to medicaid recipients. 645~~

~~(2) "Medicaid recipient" means a person enrolled in the 646
medicaid program. 647~~

Sec. 3903.42. The priority of distribution of claims from 648
the insurer's estate shall be in accordance with the order in 649
which each class of claims is set forth in this section. Every 650
claim in each class shall be paid in full or adequate funds 651
retained for such payment before the members of the next class 652
receive any payment. No subclasses shall be established within 653

any class. The order of distribution of claims shall be: 654

(A) Class 1. The costs and expenses of administration, 655
including but not limited to the following: 656

(1) The actual and necessary costs of preserving or 657
recovering the assets of the insurer; 658

(2) Compensation for all services rendered in the 659
liquidation; 660

(3) Any necessary filing fees; 661

(4) The fees and mileage payable to witnesses; 662

(5) Reasonable attorney's fees; 663

(6) The reasonable expenses of a guaranty association or 664
foreign guaranty association in handling claims. 665

(B) Class 2. All claims under policies for losses 666
incurred, including third party claims, ~~all claims of contracted~~ 667
~~providers against a medicaid health insuring corporation for~~ 668
~~covered health care services provided to medicaid recipients,~~ 669
all claims against the insurer for liability for bodily injury 670
or for injury to or destruction of tangible property that are 671
not under policies, and all claims of a guaranty association or 672
foreign guaranty association. All claims under life insurance, 673
annuity policies, and funding agreements, whether for death 674
proceeds, annuity proceeds, investment values, principal, or 675
interest, shall be treated as loss claims. That portion of any 676
loss, indemnification for which is provided by other benefits or 677
advantages recovered by the claimant, shall not be included in 678
this class, other than benefits or advantages recovered or 679
recoverable in discharge of familial obligations of support or 680
by way of succession at death or as proceeds of life insurance, 681

or as gratuities. No payment by an employer to an employee shall 682
be treated as a gratuity. Claims under nonassessable policies 683
for unearned premium or other premium refunds. 684

(C) Class 3. Claims of the federal government. 685

(D) Class 4. Debts due to employees for services performed 686
to the extent that they do not exceed one thousand dollars and 687
represent payment for services performed within one year before 688
the filing of the complaint for liquidation. Officers and 689
directors shall not be entitled to the benefit of this priority. 690
Such priority shall be in lieu of any other similar priority 691
that may be authorized by law as to wages or compensation of 692
employees. 693

(E) Class 5. Claims of general creditors. 694

(F) Class 6. Claims of any state or local government. 695
Claims, including those of any state or local governmental body 696
for a penalty or forfeiture, shall be allowed in this class only 697
to the extent of the pecuniary loss sustained from the act, 698
transaction, or proceeding out of which the penalty or 699
forfeiture arose, with reasonable and actual costs occasioned 700
thereby. The remainder of such claims shall be postponed to the 701
class of claims under division (J) of this section. 702

(G) Class 7. Claims filed late or any other claims other 703
than claims under divisions (H), (I), and (J) of this section. 704

(H) Class 8. Surplus or contribution notes, or similar 705
obligations, and premium refunds on assessable policies. 706
Payments to members of domestic mutual insurance companies shall 707
be limited in accordance with law. 708

(I) Class 9. Interest at the legal rate compounded 709
annually on all claims in the classes prescribed in divisions 710

(A) to (H) of this section, except for claims of the federal 711
government, from the date of the order for liquidation or the 712
date on which the claim becomes due, whichever is later, until 713
the date on which the interest or dividend is declared, 714
according to the terms of a plan proposed by the liquidator and 715
approved by the court supervising the liquidation. The 716
liquidator, with the approval of the court, may make reasonable 717
approximate computations of interest to be paid under this 718
division. 719

(J) Class 10. The claims of shareholders or other owners. 720

If any provision of this section or the application of any 721
provision of this section to any person or circumstance is held 722
invalid, the invalidity does not affect other provisions or 723
applications of this section, and to this end the provisions are 724
severable. 725

(K) As used in sections 3903.42 and 3903.421 of the 726
Revised Code, "contracted provider" and "medicaid recipient" 727
have the same meanings as in section 3903.14 of the Revised 728
Code. 729

Sec. 3959.01. As used in this chapter: 730

(A) "Administration fees" means any amount charged a 731
covered person for services rendered. "Administration fees" 732
includes commissions earned or paid by any person relative to 733
services performed by an administrator. 734

(B) "Administrator" means any person who adjusts or 735
settles claims on, residents of this state in connection with 736
life, dental, health, prescription drugs, or disability 737
insurance or self-insurance programs. "Administrator" includes a 738
pharmacy benefit manager. "Administrator" does not include any 739

of the following: 740

(1) An insurance agent or solicitor licensed in this state 741
whose activities are limited exclusively to the sale of 742
insurance and who does not provide any administrative services; 743

(2) Any person who administers or operates the workers' 744
compensation program of a self-insuring employer under Chapter 745
4123. of the Revised Code; 746

(3) Any person who administers pension plans for the 747
benefit of the person's own members or employees or administers 748
pension plans for the benefit of the members or employees of any 749
other person; 750

(4) Any person that administers an insured plan or a self- 751
insured plan that provides life, dental, health, or disability 752
benefits exclusively for the person's own members or employees; 753

(5) Any health insuring corporation holding a certificate 754
of authority under Chapter 1751. of the Revised Code or an 755
insurance company that is authorized to write life or sickness 756
and accident insurance in this state. 757

(C) "Aggregate excess insurance" means that type of 758
coverage whereby the insurer agrees to reimburse the insured 759
employer or trust for all benefits or claims paid during an 760
agreement period on behalf of all covered persons under the plan 761
or trust which exceed a stated deductible amount and subject to 762
a stated maximum. 763

(D) "Contracted pharmacy" or "pharmacy" means a pharmacy 764
located in this state participating in either the network of a 765
pharmacy benefit manager or in a health care or pharmacy benefit 766
plan through a direct contract or through a contract with a 767
pharmacy services administration organization, group purchasing 768

organization, or another contracting agent. 769

(E) "Contributions" means any amount collected from a 770
covered person to fund the self-insured portion of any plan in 771
accordance with the plan's provisions, summary plan 772
descriptions, and contracts of insurance. 773

(F) "Drug product reimbursement" means the amount paid by 774
a pharmacy benefit manager to a contracted pharmacy for the cost 775
of the drug dispensed to a patient and does not include a 776
dispensing or professional fee. 777

(G) "Fiduciary" has the meaning set forth in section 778
1002(21) (A) of the "Employee Retirement Income Security Act of 779
1974," 88 Stat. 829, 29 U.S.C. 1001, as amended. 780

(H) "Fiscal year" means the twelve-month accounting period 781
commencing on the date the plan is established and ending twelve 782
months following that date, and each corresponding twelve-month 783
accounting period thereafter as provided for in the summary plan 784
description. 785

(I) "Insurer" means an entity authorized to do the 786
business of insurance in this state or, for the purposes of this 787
section, a health insuring corporation authorized to issue 788
health care plans in this state. 789

(J) "Managed care organization" means an entity that 790
provides medical management and cost containment services ~~and~~ 791
~~includes a medicaid managed care organization, as defined in~~ 792
~~section 5167.01 of the Revised Code.~~ 793

(K) "Maximum allowable cost" means a maximum drug product 794
reimbursement for an individual drug or for a group of 795
therapeutically and pharmaceutically equivalent multiple source 796
drugs that are listed in the United States food and drug 797

administration's approved drug products with therapeutic 798
equivalence evaluations, commonly referred to as the orange 799
book. 800

(L) "Maximum allowable cost list" means a list of the 801
drugs for which a pharmacy benefit manager imposes a maximum 802
allowable cost. 803

(M) "Multiple employer welfare arrangement" has the same 804
meaning as in section 1739.01 of the Revised Code. 805

(N) "Pharmacy benefit manager" means an entity that 806
contracts with pharmacies on behalf of an employer, a multiple 807
employer welfare arrangement, public employee benefit plan, 808
state agency, insurer, managed care organization, or other 809
third-party payer to provide pharmacy health benefit services or 810
administration. ~~"Pharmacy benefit manager" includes the state~~ 811
~~pharmacy benefit manager selected under section 5167.24 of the~~ 812
~~Revised Code.~~ 813

(O) "Plan" means any arrangement in written form for the 814
payment of life, dental, health, or disability benefits to 815
covered persons defined by the summary plan description and 816
includes a drug benefit plan administered by a pharmacy benefit 817
manager. 818

(P) "Plan sponsor" means the person who establishes the 819
plan. 820

(Q) "Self-insurance program" means a program whereby an 821
employer provides a plan of benefits for its employees without 822
involving an intermediate insurance carrier to assume risk or 823
pay claims. "Self-insurance program" includes but is not limited 824
to employer programs that pay claims up to a prearranged limit 825
beyond which they purchase insurance coverage to protect against 826

unpredictable or catastrophic losses. 827

(R) "Specific excess insurance" means that type of 828
coverage whereby the insurer agrees to reimburse the insured 829
employer or trust for all benefits or claims paid during an 830
agreement period on behalf of a covered person in excess of a 831
stated deductible amount and subject to a stated maximum. 832

(S) "Summary plan description" means the written document 833
adopted by the plan sponsor which outlines the plan of benefits, 834
conditions, limitations, exclusions, and other pertinent details 835
relative to the benefits provided to covered persons thereunder. 836

(T) "Third-party payer" has the same meaning as in section 837
3901.38 of the Revised Code. 838

Sec. 3963.06. (A) If a provider, upon the oral or written 839
request of a contracting entity to submit a credentialing form, 840
submits a credentialing form that is not complete, the 841
contracting entity that receives the form shall notify the 842
provider of the deficiency electronically, by facsimile, or by 843
certified mail, return receipt requested, not later than twenty- 844
one days after the contracting entity receives the form. 845

(B) If a contracting entity receives any information that 846
is inconsistent with the information given by the provider in 847
the credentialing form, the contracting entity may request the 848
provider to submit a written clarification of the inconsistency. 849
The contracting entity shall send the request described in this 850
division electronically, by facsimile, or by certified mail, 851
return receipt requested. 852

(C) (1) ~~Except as otherwise provided in division (C) (2) of~~ 853
~~this section, the~~ The credentialing process under this section 854
starts when a provider initially submits a credentialing form 855

upon the oral or written request of a contracting entity, and 856
the provider shall submit the credentialing form to the 857
contracting entity electronically, by facsimile, or by certified 858
mail, return receipt requested. Subject to division ~~(C) (3)~~ (C) (2) 859
of this section, a contracting entity shall complete the 860
credentialing process not later than ninety days after the 861
contracting entity receives that credentialing form from the 862
provider. The contracting entity shall allow the provider to 863
submit a credentialing application prior to the provider's 864
employment. A contracting entity that does not complete the 865
credentialing process within the ninety-day period specified in 866
this division is liable for either a civil penalty payable to 867
the provider in the amount of five hundred dollars per day, 868
including weekend days, starting at the expiration of that 869
ninety-day period until the provider's credentialing application 870
is granted or denied or retroactive reimbursement to the 871
provider according to the terms of the contract for any basic 872
health care services, specialty health care services, or 873
supplemental health care services the provider provided to 874
enrollees starting at the expiration of that ninety-day period 875
until the provider's credentialing application is granted or 876
denied. When the credentialing process of the contracting entity 877
exceeds the ninety-day period, the contracting entity shall 878
select the liability to which the contracting entity is subject 879
and shall inform the provider of the contracting entity's 880
selection. 881

~~(2) The credentialing process for a medicaid managed care~~ 882
~~plan starts when the provider submits a credentialing form and~~ 883
~~the provider's national provider number issued by the centers~~ 884
~~for medicare and medicaid services.~~ 885

~~(3)~~ The requirement that the credentialing process be 886

completed within the ninety-day period specified in division (C) 887
(1) of this section does not apply to a contracting entity if a 888
provider that submits a credentialing form to the contracting 889
entity under that division is a hospital. 890

(D) Any communication between the provider and the 891
contracting entity shall be electronically, by facsimile, or by 892
certified mail, return receipt requested. 893

(E) If the state medical board or its agent has primary 894
source verified the medical education, graduate medical 895
education, and examination history of the physician, or the 896
status of the physician with the educational commission for 897
foreign medical graduates, if applicable, the contracting entity 898
may accept the documentation of primary source verification from 899
the state medical board's web site or from its agent and is not 900
required to perform primary source verification of the medical 901
education, graduate medical education, and examination history 902
of the physician or the status of the physician with the 903
educational commission for foreign medical graduates, if 904
applicable, as a condition for initially credentialing or 905
recredentialing the physician. 906

Sec. 4121.50. Not later than July 1, 2012, the 907
administrator of workers' compensation shall adopt rules in 908
accordance with Chapter 119. of the Revised Code to implement a 909
coordinated services program for claimants under this chapter or 910
Chapter 4123., 4127., or 4131. of the Revised Code who are found 911
to have obtained prescription drugs that were reimbursed 912
pursuant to an order of the administrator or of the industrial 913
commission or by a self-insuring employer but were obtained at a 914
frequency or in an amount that is not medically necessary. The 915
program shall be implemented in a manner that is substantially 916

similar to the coordinated services programs established for the 917
medicaid program under ~~sections~~ section 5164.758 ~~and 5167.13~~ of 918
the Revised Code. 919

Sec. 4729.20. As used in this section, "medication 920
synchronization" means a pharmacy service that synchronizes the 921
filling or refilling of prescriptions in a manner that allows 922
the dispensed drugs to be obtained on the same date each month. 923

A pharmacist may dispense a drug in a manner that varies 924
from the prescription for the drug by dispensing a quantity or 925
amount of the drug that is less than a thirty-day supply, if the 926
pharmacist's action is taken solely for the purpose of 927
medication synchronization pursuant to section 1751.68, 928
3923.602, or 5164.7511, ~~or 5167.12~~ of the Revised Code. 929

Sec. 4729.49. (A) As used in this section: 930

(1) "340B covered entity" has the same meaning as in 931
section 3902.70 of the Revised Code. 932

(2) ~~"Medicaid managed care organization," and "third-party~~ 933
~~"Third-party administrator" have the same meanings as in section~~ 934
~~5167.01 of the Revised Code~~means any person who adjusts or 935
settles claims on behalf of an insuring entity in connection 936
with life, dental, health, prescription drugs, or disability 937
insurance or self-insurance programs and includes a pharmacy 938
benefit manager. 939

(B) A contract between a terminal distributor of dangerous 940
drugs and a 340B covered entity shall require the terminal 941
distributor to comply with division (C) of this section. 942

(C) When paying a 340B covered entity for a dangerous drug 943
dispensed to a patient, a terminal distributor shall pay to the 944
340B covered entity the full reimbursement amount the terminal 945

distributor receives from the patient and the patient's health 946
insurer, including a third-party administrator ~~or medicaid-~~ 947
~~managed care organization,~~ except that the terminal distributor 948
may deduct from the full reimbursement amount a fee agreed on in 949
writing by the terminal distributor and the 340B covered entity. 950

Sec. 4729.80. (A) If the state board of pharmacy 951
establishes and maintains a drug database pursuant to section 952
4729.75 of the Revised Code, the board is authorized or required 953
to provide information from the database only as follows: 954

(1) On receipt of a request from a designated 955
representative of a government entity responsible for the 956
licensure, regulation, or discipline of health care 957
professionals with authority to prescribe, administer, or 958
dispense drugs, the board may provide to the representative 959
information from the database relating to the professional who 960
is the subject of an active investigation being conducted by the 961
government entity or relating to a professional who is acting as 962
an expert witness for the government entity in such an 963
investigation. 964

(2) On receipt of a request from a federal officer, or a 965
state or local officer of this or any other state, whose duties 966
include enforcing laws relating to drugs, the board shall 967
provide to the officer information from the database relating to 968
the person who is the subject of an active investigation of a 969
drug abuse offense, as defined in section 2925.01 of the Revised 970
Code, being conducted by the officer's employing government 971
entity. 972

(3) Pursuant to a subpoena issued by a grand jury, the 973
board shall provide to the grand jury information from the 974
database relating to the person who is the subject of an 975

investigation being conducted by the grand jury. 976

(4) Pursuant to a subpoena, search warrant, or court order 977
in connection with the investigation or prosecution of a 978
possible or alleged criminal offense, the board shall provide 979
information from the database as necessary to comply with the 980
subpoena, search warrant, or court order. 981

(5) On receipt of a request from a prescriber or the 982
prescriber's delegate approved by the board, the board shall 983
provide to the prescriber a report of information from the 984
database relating to a patient who is either a current patient 985
of the prescriber or a potential patient of the prescriber based 986
on a referral of the patient to the prescriber, if all of the 987
following conditions are met: 988

(a) The prescriber certifies in a form specified by the 989
board that it is for the purpose of providing medical treatment 990
to the patient who is the subject of the request; 991

(b) The prescriber has not been denied access to the 992
database by the board. 993

(6) On receipt of a request from a pharmacist or the 994
pharmacist's delegate approved by the board, the board shall 995
provide to the pharmacist information from the database relating 996
to a current patient of the pharmacist, if the pharmacist 997
certifies in a form specified by the board that it is for the 998
purpose of the pharmacist's practice of pharmacy involving the 999
patient who is the subject of the request and the pharmacist has 1000
not been denied access to the database by the board. 1001

(7) On receipt of a request from an individual seeking the 1002
individual's own database information in accordance with the 1003
procedure established in rules adopted under section 4729.84 of 1004

the Revised Code, the board may provide to the individual the 1005
individual's own prescription history. 1006

~~(8) On receipt of a request from a medical director or a 1007
pharmacy director of a managed care organization that has 1008
entered into a contract with the department of medicaid under 1009
section 5167.10 of the Revised Code and a data security 1010
agreement with the board required by section 5167.14 of the 1011
Revised Code, the board shall provide to the medical director or 1012
the pharmacy director information from the database relating to 1013
a medicaid recipient enrolled in the managed care organization, 1014
including information in the database related to prescriptions 1015
for the recipient that were not covered or reimbursed under a 1016
program administered by the department of medicaid. 1017~~

~~(9)~~ On receipt of a request from the medicaid director, 1018
the board shall provide to the director information from the 1019
database relating to a recipient of a program administered by 1020
the department of medicaid, including information in the 1021
database related to prescriptions for the recipient that were 1022
not covered or paid by a program administered by the department. 1023

~~(10)~~ (9) On receipt of a request from a medical director of 1024
a managed care organization that has entered into a contract 1025
with the administrator of workers' compensation under division 1026
(B) (4) of section 4121.44 of the Revised Code and a data 1027
security agreement with the board required by section 4121.447 1028
of the Revised Code, the board shall provide to the medical 1029
director information from the database relating to a claimant 1030
under Chapter 4121., 4123., 4127., or 4131. of the Revised Code 1031
assigned to the managed care organization, including information 1032
in the database related to prescriptions for the claimant that 1033
were not covered or reimbursed under Chapter 4121., 4123., 1034

4127., or 4131. of the Revised Code, if the administrator of 1035
workers' compensation confirms, upon request from the board, 1036
that the claimant is assigned to the managed care organization. 1037

~~(11)~~(10) On receipt of a request from the administrator of 1038
workers' compensation, the board shall provide to the 1039
administrator information from the database relating to a 1040
claimant under Chapter 4121., 4123., 4127., or 4131. of the 1041
Revised Code, including information in the database related to 1042
prescriptions for the claimant that were not covered or 1043
reimbursed under Chapter 4121., 4123., 4127., or 4131. of the 1044
Revised Code. 1045

~~(12)~~(11) On receipt of a request from a prescriber or the 1046
prescriber's delegate approved by the board, the board shall 1047
provide to the prescriber information from the database relating 1048
to a patient's mother, if the prescriber certifies in a form 1049
specified by the board that it is for the purpose of providing 1050
medical treatment to a newborn or infant patient diagnosed as 1051
opioid dependent and the prescriber has not been denied access 1052
to the database by the board. 1053

~~(13)~~(12) On receipt of a request from the director of 1054
health, the board shall provide to the director information from 1055
the database relating to the duties of the director or the 1056
department of health in implementing the Ohio violent death 1057
reporting system established under section 3701.93 of the 1058
Revised Code. 1059

~~(14)~~(13) On receipt of a request from a requestor 1060
described in division (A) (1), (2), (5), or (6) of this section 1061
who is from or participating with another state's prescription 1062
monitoring program, the board may provide to the requestor 1063
information from the database, but only if there is a written 1064

agreement under which the information is to be used and 1065
disseminated according to the laws of this state. 1066

~~(15)~~(14) On receipt of a request from a delegate of a 1067
retail dispensary licensed under Chapter 3796. of the Revised 1068
Code who is approved by the board to serve as the dispensary's 1069
delegate, the board shall provide to the delegate a report of 1070
information from the database pertaining only to a patient's use 1071
of medical marijuana, if both of the following conditions are 1072
met: 1073

(a) The delegate certifies in a form specified by the 1074
board that it is for the purpose of dispensing medical marijuana 1075
for use in accordance with Chapter 3796. of the Revised Code. 1076

(b) The retail dispensary or delegate has not been denied 1077
access to the database by the board. 1078

~~(16)~~(15) On receipt of a request from a judge of a program 1079
certified by the Ohio supreme court as a specialized docket 1080
program for drugs, the board shall provide to the judge, or an 1081
employee of the program who is designated by the judge to 1082
receive the information, information from the database that 1083
relates specifically to a current or prospective program 1084
participant. 1085

~~(17)~~(16) On receipt of a request from a coroner, deputy 1086
coroner, or coroner's delegate approved by the board, the board 1087
shall provide to the requestor information from the database 1088
relating to a deceased person about whom the coroner is 1089
conducting or has conducted an autopsy or investigation. 1090

~~(18)~~(17) On receipt of a request from a prescriber, the 1091
board may provide to the prescriber a summary of the 1092
prescriber's prescribing record if such a record is created by 1093

the board. Information in the summary is subject to the 1094
confidentiality requirements of this chapter. 1095

~~(19)~~(18) On receipt of a request from a pharmacy's 1096
responsible person designated under section 4729.54 of the 1097
Revised Code, the board may provide to the responsible person a 1098
summary of the pharmacy's dispensing record if such a record is 1099
created by the board. Information in the summary is subject to 1100
the confidentiality requirements of this chapter. 1101

~~(20)~~(19) The board may provide information from the 1102
database without request to a prescriber or pharmacist who is 1103
authorized to use the database pursuant to this chapter. 1104

~~(21)~~(a) (20) (a) On receipt of a request from a prescriber 1105
or pharmacist, or the prescriber's or pharmacist's delegate, who 1106
is a designated representative of a peer review committee, the 1107
board shall provide to the committee information from the 1108
database relating to a prescriber who is subject to the 1109
committee's evaluation, supervision, or discipline if the 1110
information is to be used for one of those purposes. The board 1111
shall provide only information that it determines, in accordance 1112
with rules adopted under section 4729.84 of the Revised Code, is 1113
appropriate to be provided to the committee. 1114

(b) As used in division ~~(A) (21) (a)~~ (A) (20) (a) of this 1115
section, "peer review committee" has the same meaning as in 1116
section 2305.25 of the Revised Code, except that it includes 1117
only a peer review committee of a hospital or a peer review 1118
committee of a nonprofit health care corporation that is a 1119
member of the hospital or of which the hospital is a member. 1120

~~(22)~~(21) On receipt of a request from a requestor 1121
described in division (A) (5) or (6) of this section who is from 1122

or participating with a prescription monitoring program that is 1123
operated by a federal agency and approved by the board, the 1124
board may provide to the requestor information from the 1125
database, but only if there is a written agreement under which 1126
the information is to be used and disseminated according to the 1127
laws of this state. 1128

~~(23)~~ (22) Any personal health information submitted to the 1129
board pursuant to section 4729.772 of the Revised Code may be 1130
provided by the board only as authorized by the submitter of the 1131
information and in accordance with rules adopted under section 1132
4729.84 of the Revised Code. 1133

~~(24)~~ (23) On receipt of a request from a person described 1134
in division (A) (5), (6), or ~~(17)~~ (16) of this section who is 1135
participating in a drug overdose fatality review committee 1136
described in section 307.631 of the Revised Code, the board may 1137
provide to the requestor information from the database, but only 1138
if there is a written agreement under which the information is 1139
to be used and disseminated according to the laws of this state. 1140

~~(25)~~ (24) On receipt of a request from a person described 1141
in division (A) (5), (6), or ~~(17)~~ (16) of this section who is 1142
participating in a suicide fatality review committee described 1143
in section 307.641 of the Revised Code, the board may provide to 1144
the requestor information from the database, but only if there 1145
is a written agreement under which the information is to be used 1146
and disseminated according to the laws of this state. 1147

~~(26)~~ (25) On receipt of a request from a designated 1148
representative of the division of cannabis control in the 1149
department of commerce, the board shall provide to the 1150
representative information from the database relating to an 1151
individual who, or entity that, is the subject of an active 1152

investigation being conducted by the division. 1153

(B) The state board of pharmacy shall maintain a record of 1154
each individual or entity that requests information from the 1155
database pursuant to this section. In accordance with rules 1156
adopted under section 4729.84 of the Revised Code, the board may 1157
use the records to document and report statistics and law 1158
enforcement outcomes. 1159

The board may provide records of an individual's requests 1160
for database information only to the following: 1161

(1) A designated representative of a government entity 1162
that is responsible for the licensure, regulation, or discipline 1163
of health care professionals with authority to prescribe, 1164
administer, or dispense drugs who is involved in an active 1165
criminal or disciplinary investigation being conducted by the 1166
government entity of the individual who submitted the requests 1167
for database information; 1168

(2) A federal officer, or a state or local officer of this 1169
or any other state, whose duties include enforcing laws relating 1170
to drugs and who is involved in an active investigation being 1171
conducted by the officer's employing government entity of the 1172
individual who submitted the requests for database information; 1173

(3) A designated representative of the department of 1174
medicaid regarding a prescriber who is treating or has treated a 1175
recipient of a program administered by the department and who 1176
submitted the requests for database information. 1177

(C) Information contained in the database and any 1178
information obtained from it is confidential and is not a public 1179
record. Information contained in the records of requests for 1180
information from the database is confidential and is not a 1181

public record. Information contained in the database that does 1182
not identify a person, including any licensee or registrant of 1183
the board or other entity, may be released in summary, 1184
statistical, or aggregate form. 1185

(D) A pharmacist or prescriber shall not be held liable in 1186
damages to any person in any civil action for injury, death, or 1187
loss to person or property on the basis that the pharmacist or 1188
prescriber did or did not seek or obtain information from the 1189
database. 1190

Sec. 4729.84. For purposes of establishing and maintaining 1191
a drug database pursuant to section 4729.75 of the Revised Code, 1192
the state board of pharmacy shall adopt rules in accordance with 1193
Chapter 119. of the Revised Code to carry out and enforce 1194
sections 4729.75 to 4729.83 of the Revised Code. The rules shall 1195
specify all of the following: 1196

(A) A means of identifying each patient, each terminal 1197
distributor of dangerous drugs, each purchase at wholesale of 1198
dangerous drugs, and each retail dispensary licensed under 1199
Chapter 3796. of the Revised Code about which information is 1200
entered into the drug database; 1201

(B) Requirements for the transmission of information from 1202
terminal distributors of dangerous drugs, manufacturers of 1203
dangerous drugs, outsourcing facilities, repackagers of 1204
dangerous drugs, wholesale distributors of dangerous drugs, 1205
prescribers, and retail dispensaries; 1206

(C) An electronic format for the submission of information 1207
from persons identified in division (B) of this section; 1208

(D) A procedure whereby a person unable to submit 1209
information electronically may obtain a waiver to submit 1210

information in another format; 1211

(E) A procedure whereby the board may grant a request from 1212
a law enforcement agency or a government entity responsible for 1213
the licensure, regulation, or discipline of licensed health 1214
professionals authorized to prescribe drugs that information 1215
that has been stored for three years be retained when the 1216
information pertains to an open investigation being conducted by 1217
the agency or entity; 1218

(F) A procedure whereby a person identified in division 1219
(B) of this section may apply for an extension to the time by 1220
which information must be transmitted to the board; 1221

(G) A procedure whereby a person or government entity to 1222
which the board is authorized to provide information may submit 1223
a request to the board for the information and the board may 1224
verify the identity of the requestor; 1225

(H) Standards for determining what information is 1226
appropriate to be provided under division ~~(A) (21)~~ (A) (20) of 1227
section 4729.80 of the Revised Code; 1228

(I) A procedure whereby the board can use the database 1229
request records required by division (B) of section 4729.80 of 1230
the Revised Code to document and report statistics and law 1231
enforcement outcomes; 1232

(J) A procedure whereby an individual may request the 1233
individual's own database information and the board may verify 1234
the identity of the requestor; 1235

(K) A reasonable fee that the board may charge under 1236
section 4729.83 of the Revised Code for providing an individual 1237
with the individual's own database information pursuant to 1238
section 4729.80 of the Revised Code; 1239

(L) The other specific dangerous drugs that, in addition 1240
to controlled substances, must be included in the database; 1241

(M) The types of pharmacies licensed as terminal 1242
distributors of dangerous drugs that are required to submit 1243
prescription information to the board pursuant to section 1244
4729.77 of the Revised Code; 1245

(N) Additional data fields, recognized by the American 1246
society for automation in pharmacy, that licensed terminal 1247
distributors of dangerous drugs must submit to the board 1248
pursuant to section 4729.77 of the Revised Code; 1249

(O) The information regarding medical marijuana dispensed 1250
to a patient that a retail dispensary is required to submit to 1251
the board pursuant to section 4729.771 of the Revised Code; 1252

(P) Requirements for the transmission of information 1253
pursuant to section 4729.772 of the Revised Code and 1254
requirements for the release of such information by the board. 1255

Sec. 4729.86. If the state board of pharmacy establishes 1256
and maintains a drug database pursuant to section 4729.75 of the 1257
Revised Code, all of the following apply: 1258

(A) (1) No person identified in divisions (A) (1) to ~~(13)~~ 1259
(12), ~~(15)~~ (14) to ~~(26)~~ (25), or (B) of section 4729.80 of the 1260
Revised Code shall disseminate any written or electronic 1261
information the person receives from the drug database or 1262
otherwise provide another person access to the information that 1263
the person receives from the database, except as follows: 1264

(a) When necessary in the investigation or prosecution of 1265
a possible or alleged criminal offense; 1266

(b) When a person provides the information to the 1267

prescriber, pharmacist, or retail dispensary licensed under 1268
Chapter 3796. of the Revised Code for whom the person is 1269
approved by the board to serve as a delegate of the prescriber, 1270
pharmacist, or retail dispensary for purposes of requesting and 1271
receiving information from the drug database under division (A) 1272
(5), (6), or ~~(15)~~(14) of section 4729.80 of the Revised Code; 1273

(c) When a prescriber, pharmacist, or retail dispensary 1274
licensed under Chapter 3796. of the Revised Code provides the 1275
information to a person who is approved by the board to serve as 1276
such a delegate of the prescriber, pharmacist, or retail 1277
dispensary; 1278

(d) When a prescriber or pharmacist includes the 1279
information in a medical record, as defined in section 3701.74 1280
of the Revised Code. 1281

(2) No person shall provide false information to the state 1282
board of pharmacy with the intent to obtain or alter information 1283
contained in the drug database. 1284

(3) No person shall obtain drug database information by 1285
any means except as provided under section 4729.80 or 4729.81 of 1286
the Revised Code. 1287

(B) A person shall not use information obtained pursuant 1288
to division (A) of section 4729.80 of the Revised Code as 1289
evidence in any civil or administrative proceeding. 1290

(C) (1) Except as provided in division (C) (2) of this 1291
section, after providing notice and affording an opportunity for 1292
a hearing in accordance with Chapter 119. of the Revised Code, 1293
the board may restrict a person from obtaining further 1294
information from the drug database if any of the following is 1295
the case: 1296

(a) The person violates division (A) (1), (2), or (3) of 1297
this section; 1298

(b) The person is a requestor identified in division (A) 1299
~~(14)~~(13) or ~~(22)~~(21) of section 4729.80 of the Revised Code and 1300
the board determines that the person's actions in another state 1301
would have constituted a violation of division (A) (1), (2), or 1302
(3) of this section; 1303

(c) The person fails to comply with division (B) of this 1304
section, regardless of the jurisdiction in which the failure to 1305
comply occurred; 1306

(d) The person creates, by clear and convincing evidence, 1307
a threat to the security of information contained in the 1308
database. 1309

(2) If the board determines that allegations regarding a 1310
person's actions warrant restricting the person from obtaining 1311
further information from the drug database without a prior 1312
hearing, the board may summarily impose the restriction. A 1313
telephone conference call may be used for reviewing the 1314
allegations and taking a vote on the summary restriction. The 1315
summary restriction shall remain in effect, unless removed by 1316
the board, until the board's final adjudication order becomes 1317
effective. 1318

(3) The board shall determine the extent to which the 1319
person is restricted from obtaining further information from the 1320
database. 1321

Sec. 5160.01. As used in this chapter: 1322

(A) "Dual eligible individual" has the same meaning as in 1323
the "Social Security Act," section 1915(h) (2) (B), 42 U.S.C. 1324
1396n(h) (2) (B). A dual eligible individual is a medicare- 1325

medicaid enrollee (MME). 1326

(B) "Exchange" has the same meaning as in 45 C.F.R. 1327
155.20. 1328

(C) "Federal financial participation" means the federal 1329
government's share of expenditures made by an entity in 1330
implementing a medical assistance program. 1331

(D) "Medical assistance program" means all of the 1332
following: 1333

(1) The medicaid program; 1334

(2) The children's health insurance program; 1335

(3) The refugee medical assistance program; 1336

(4) Any other program that provides medical assistance and 1337
state statutes authorize the department of medicaid to 1338
administer. 1339

(E) "Medical assistance recipient" means a recipient of a 1340
medical assistance program. To the extent appropriate in the 1341
context, "medical assistance recipient" includes an individual 1342
applying for a medical assistance program, a former medical 1343
assistance recipient, or both. 1344

~~(F) "Medicaid managed care organization" has the same 1345~~
~~meaning as in section 5167.01 of the Revised Code. 1346~~

~~(G) "Refugee medical assistance program" means the program 1347~~
~~that the department of medicaid administers pursuant to section 1348~~
~~5160.50 of the Revised Code. 1349~~

Sec. 5160.34. (A) As used in this section: 1350

(1) "Chronic condition" means a medical condition that has 1351
persisted after reasonable efforts have been made to relieve or 1352

cure its cause and has continued, either continuously or 1353
episodically, for longer than six continuous months. 1354

(2) "Clinical peer" means a health care provider in the 1355
same, or in a similar, specialty that typically manages the 1356
medical condition, procedure, or treatment under review. 1357

(3) "Emergency services" has the same meaning as in 1358
section 1753.28 of the Revised Code. 1359

(4) "Prior authorization requirement" means any practice 1360
implemented by a medical assistance program in which coverage of 1361
a health care service, device, or drug is dependent upon a 1362
medical assistance recipient or a health care provider, 1363
receiving approval from the department of medicaid or its 1364
~~designee, including a medicaid managed care organization,~~ prior 1365
to the service, device, or drug being performed, received, or 1366
prescribed, as applicable. "Prior authorization" includes 1367
prospective or utilization review procedures conducted prior to 1368
providing a health care service, device, or drug. 1369

(5) "Urgent care services" means a medical care or other 1370
service for a condition where application of the timeframe for 1371
making routine or non-life threatening care determinations is 1372
either of the following: 1373

(a) Could seriously jeopardize the life, health, or safety 1374
of the recipient or others due to the recipient's psychological 1375
state; 1376

(b) In the opinion of a practitioner with knowledge of the 1377
recipient's medical or behavioral condition, would subject the 1378
recipient to adverse health consequences without the care or 1379
treatment that is the subject of the request. 1380

(6) "Utilization review" and "utilization review 1381

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 1410
contractual arrangement under which the department or its 1411
designee agrees to process prior authorization requests that are 1412
not submitted electronically because of the financial hardship 1413
that electronic submission of prior authorization requests would 1414
create for the provider or if internet connectivity is limited 1415
or unavailable where the provider is located. 1416

(4) (a) On or before January 1, 2018, if the health care 1417
provider submits the request for prior authorization 1418
electronically as described in divisions (B) (1) and (2) of this 1419
section, respond to all prior authorization requests within 1420
forty-eight hours for urgent care services, or ten calendar days 1421
for any prior authorization request that is not for an urgent 1422
care service, of the time the request is received by the 1423
department or its designee. Division (B) (4) of this section does 1424
not apply to emergency services. 1425

(b) The response required under division (B) (4) (a) of this 1426
section shall indicate whether the request is approved or 1427
denied. If the prior authorization is denied, the department or 1428
its designee shall provide the specific reason for the denial. 1429

(c) If the prior authorization request is incomplete, the 1430
department or its designee shall indicate the specific 1431
additional information that is required to process the request. 1432

(5) (a) On or before January 1, 2018, if a health care 1433
provider submits a prior authorization request as described in 1434
divisions (B) (1) and (2) of this section, the department or its 1435
designee shall provide an electronic receipt to the health care 1436
provider acknowledging that the prior authorization request was 1437
received. 1438

(b) On or before January 1, 2018, if the department or its 1439
designee requests additional information that is required to 1440
process a prior authorization request as described in division 1441
(B) (4) (c) of this section, the health care provider shall 1442
provide an electronic receipt to the department or its designee 1443
acknowledging that the request for additional information was 1444
received. 1445

(6) (a) On or before January 1, 2017, honor a prior 1446
authorization approval for an approved drug for the lesser of 1447
the following from the date of approval: 1448

(i) Twelve months; 1449

(ii) The last day of the medical assistance recipient's 1450
eligibility for the medical assistance program. 1451

(b) The duration of all other prior authorization 1452
approvals shall be dictated by the medical assistance program. 1453

(c) The department or its designee, in relation to prior 1454
approval under division (B) (6) (a) of this section, may require a 1455
health care provider to submit information to the department or 1456
its designee indicating that the patient's chronic condition has 1457
not changed. 1458

(i) The request for information by the department or its 1459
designee and the response by the health care provider shall be 1460
in an electronic format, which may be by electronic mail or 1461
other electronic communication. 1462

(ii) The frequency of the submission of requested 1463
information shall be consistent with medical or scientific 1464
evidence as defined in section 3922.01 of the Revised Code, but 1465
shall not be required more frequently than quarterly. 1466

(iii) If the health care provider does not respond within 1467
five calendar days from the date the request was received, the 1468
insurer or plan may terminate the twelve-month approval. 1469

(d) A twelve-month approval provided under division (B) (6) 1470
(a) of this section is no longer valid and automatically 1471
terminates if there are changes to federal or state laws or 1472
federal regulatory guidance or compliance information 1473
prescribing that the drug in question is no longer approved or 1474
safe for the intended purpose. 1475

(e) A twelve-month approval provided under division (B) (6) 1476
(a) of this section does not apply to and is not required for 1477
any of the following: 1478

(i) Medications that are prescribed for a non-maintenance 1479
condition; 1480

(ii) Medications that have a typical treatment of less 1481
than one year; 1482

(iii) Medications that require an initial trial period to 1483
determine effectiveness and tolerability, beyond which a one- 1484
year, or greater, prior authorization period will be given; 1485

(iv) Medications where there is medical or scientific 1486
evidence as defined in section 3922.01 of the Revised Code that 1487
do not support a twelve-month prior approval; 1488

(v) Medications that are a schedule I or II controlled 1489
substance or any opioid analgesic or benzodiazepine, as defined 1490
in section 3719.01 of the Revised Code; 1491

(vi) Medications that are not prescribed by an in-network 1492
provider as part of a care management program. 1493

(7) On or before January 1, 2017, the department or its 1494

designee may, but is not required to, provide the twelve-month 1495
approval prescribed in division (B) (6) (a) of this section for a 1496
prescription drug that meets either of the following: 1497

(a) The drug is prescribed or administered to treat a rare 1498
medical condition and pursuant to medical or scientific evidence 1499
as defined in section 3922.01 of the Revised Code. 1500

(b) Medications that are controlled substances not 1501
included in division (B) (6) (e) (v) of this section. 1502

For purposes of division (B) (7) of this section, "rare 1503
medical condition" means any disease or condition that affects 1504
fewer than two-hundred thousand individuals in the United 1505
States. 1506

(8) Nothing in division (B) (6) or (7) of this section 1507
prohibits the substitution, in accordance with section 4729.38 1508
of the Revised Code, of any drug that has received a twelve- 1509
month approval under division (B) (6) (a) of this section when 1510
there is a release of either of the following: 1511

(a) A United States food and drug administration approved 1512
comparable brand product or a generic counterpart of a brand 1513
product that is listed as therapeutically equivalent in the 1514
United States food and drug administration's publication titled 1515
approved drug products with therapeutic equivalence evaluations; 1516

(b) An interchangeable biological product, as defined in 1517
section 3715.01 of the Revised Code. 1518

(9) (a) On or after January 1, 2017, upon written request, 1519
the department or its designee shall permit a retrospective 1520
review for a claim that is submitted for a service where prior 1521
authorization was required, but not obtained if the service in 1522
question meets all of the following: 1523

(i) The service is directly related to another service for 1524
which prior approval has already been obtained and that has 1525
already been performed. 1526

(ii) The new service was not known to be needed at the 1527
time the original prior authorized service was performed. 1528

(iii) The need for the new service was revealed at the 1529
time the original authorized service was performed. 1530

(b) Once the written request and all necessary information 1531
is received, the department or its designee shall review the 1532
claim for coverage and medical necessity. The department or its 1533
designee shall not deny a claim for such a new service based 1534
solely on the fact that a prior authorization approval was not 1535
received for the new service in question. 1536

(10) (a) On or before January 1, 2017, disclose to all 1537
participating health care providers any new prior authorization 1538
requirement at least thirty days prior to the effective date of 1539
the new requirement. 1540

(b) The notice may be sent via electronic mail or standard 1541
mail and shall be conspicuously entitled "Notice of Changes to 1542
Prior Authorization Requirements." The notice is not required to 1543
contain a complete listing of all changes made to the prior 1544
authorization requirements, but shall include specific 1545
information on where the health care provider may locate the 1546
information on the department's or its designee's web site or, 1547
if applicable, the department's or its designee's portal. 1548

(c) All participating health care providers shall promptly 1549
notify the department or its designee of any changes to the 1550
health care provider's electronic mail or standard mail address. 1551

(11) (a) On or before January 1, 2017, make available to 1552

all participating health care providers on its web site or 1553
provider portal a listing of its prior authorization 1554
requirements, including specific information or documentation 1555
that a provider must submit in order for the prior authorization 1556
request to be considered complete. 1557

(b) Make available on its web site information about the 1558
medical assistance programs offered in this state that clearly 1559
identifies specific services, drugs, or devices to which a prior 1560
authorization requirement exists. 1561

(12) On or before January 1, 2018, establish a streamlined 1562
appeal process relating to adverse prior authorization 1563
determinations that shall include all of the following: 1564

(a) For urgent care services, the appeal shall be 1565
considered within forty-eight hours after the department or its 1566
designee receives the appeal. 1567

(b) For all other matters, the appeal shall be considered 1568
within ten calendar days after the department or its designee 1569
receives the appeal. 1570

(c) The appeal shall be between the health care provider 1571
requesting the service in question and a clinical peer appointed 1572
by or contracted by the department or the department's designee. 1573

(d) If the appeal does not resolve the disagreement, the 1574
appeal procedures shall permit the recipient to further appeal 1575
in accordance with section 5160.31 of the Revised Code. 1576

(C) Beginning January 1, 2017, except in cases of 1577
fraudulent or materially incorrect information, the department 1578
or its designee shall not retroactively deny a prior 1579
authorization for a health care service, drug, or device when 1580
all of the following are met: 1581

(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 1610
includes an unintentional error and the error results in a claim 1611
that does not match the information originally submitted by the 1612
health care provider in the approved prior authorization 1613
request, upon receiving a denial of services from the department 1614
or its designee, the health care provider may resubmit the claim 1615
pursuant to division (C) of this section with the information 1616
that matches the information included in the approved prior 1617
authorization. 1618

(D) Any provision of a contractual arrangement entered 1619
into between the department or its designee and a health care 1620
provider or recipient that is contrary to divisions (A) to (C) 1621
of this section is unenforceable. 1622

(E) The director of medicaid may adopt rules in accordance 1623
with Chapter 119. of the Revised Code as necessary to implement 1624
the provisions of this section. 1625

Sec. 5160.37. (A) A medical assistance recipient's 1626
enrollment in a medical assistance program gives an automatic 1627
right of recovery to the department of medicaid and a county 1628
department of job and family services against the liability of a 1629
third party for the cost of medical assistance paid on behalf of 1630
the recipient. When an action or claim is brought against a 1631
third party by a medical assistance recipient, any payment, 1632
settlement or compromise of the action or claim, or any court 1633
award or judgment, is subject to the recovery right of the 1634
department of medicaid or county department. ~~Except in the case~~ 1635
~~of a medical assistance recipient who receives medical~~ 1636
~~assistance through a medicaid managed care organization, the~~ The 1637
department's or county department's claim shall not exceed the 1638
amount of medical assistance paid by the department or county 1639

department on behalf of the recipient. A payment, settlement, 1640
compromise, judgment, or award that excludes the cost of medical 1641
assistance paid for by the department or county department shall 1642
not preclude a department from enforcing its rights under this 1643
section. 1644

~~(B) (1) In the case of a medical assistance recipient who 1645
receives medical assistance through a medicaid managed care 1646
organization that has a capitation agreement with a provider, 1647
the amount of the department's or county department's claim 1648
shall be the amount the medicaid managed care organization would 1649
have paid in the absence of a capitation agreement. 1650~~

~~(2) In the case of a medical assistance recipient who 1651
receives medical assistance through a medicaid managed care 1652
organization that does not have a capitation agreement with a 1653
provider, the amount of the department's or county department's 1654
claim shall be the amount the medicaid managed care organization 1655
pays for medical assistance rendered to the recipient, even if 1656
that amount is more than the amount the department or county 1657
department pays to the medicaid managed care organization for 1658
the recipient's medical assistance. 1659~~

~~(C)~~ (B) A medical assistance recipient, and the recipient's 1660
attorney, if any, shall cooperate with the departments. In 1661
furtherance of this requirement, the medical assistance 1662
recipient, or the recipient's attorney, if any, shall, not later 1663
than thirty days after initiating informal recovery activity or 1664
filing a legal recovery action against a third party, provide 1665
written notice of the activity or action to the department of 1666
medicaid or county department if it has paid for medical 1667
assistance under a medical assistance program. 1668

~~(D)~~ (C) The written notice that must be given under 1669

division ~~(C)~~(B) of this section shall disclose the identity and 1670
address of any third party against whom the medical assistance 1671
recipient has or may have a right of recovery. 1672

~~(E)~~(D) No settlement, compromise, judgment, or award or 1673
any recovery in any action or claim by a medical assistance 1674
recipient where the department or county department has a right 1675
of recovery shall be made final without first giving the 1676
department or county department written notice as described in 1677
division ~~(C)~~(B) of this section and a reasonable opportunity to 1678
perfect its rights of recovery. If the department or county 1679
department is not given the appropriate written notice, the 1680
medical assistance recipient and, if there is one, the 1681
recipient's attorney, are liable to reimburse the department or 1682
county department for the recovery received to the extent of 1683
medical assistance payments made by the department or county 1684
department. 1685

~~(F)~~(E) The department or county department shall be 1686
permitted to enforce its recovery rights against the third party 1687
even though it accepted prior payments in discharge of its 1688
rights under this section if, at the time the department or 1689
county department received such payments, it was not aware that 1690
additional medical expenses had been incurred but had not yet 1691
been paid by the department or county department. The third 1692
party becomes liable to the department or county department as 1693
soon as the third party is notified in writing of the valid 1694
claims for recovery under this section. 1695

~~(G)~~(1) ~~(F)~~(1) Subject to division ~~(G)~~(2) ~~(F)~~(2) of this 1696
section, the right of recovery of the department or county 1697
department does not apply to that portion of any judgment, 1698
award, settlement, or compromise of a claim, to the extent of 1699

attorneys' fees, costs, or other expenses incurred by a medical 1700
assistance recipient in securing the judgment, award, 1701
settlement, or compromise, or to the extent of medical, 1702
surgical, and hospital expenses paid by such recipient from the 1703
recipient's own resources. 1704

(2) Reasonable attorneys' fees, not to exceed one-third of 1705
the total judgment, award, settlement, or compromise, plus costs 1706
and other expenses incurred by the medical assistance recipient 1707
in securing the judgment, award, settlement, or compromise, 1708
shall first be deducted from the total judgment, award, 1709
settlement, or compromise. After fees, costs, and other expenses 1710
are deducted from the total judgment, award, settlement, or 1711
compromise, there shall be a rebuttable presumption that the 1712
department of medicaid or county department shall receive no 1713
less than one-half of the remaining amount, or the actual amount 1714
of medical assistance paid, whichever is less. A party may rebut 1715
the presumption in accordance with division ~~(L)~~ (K) (1), (2), 1716
or (3) of this section, as applicable. 1717

~~(H)~~ (G) A right of recovery created by this section may be 1718
enforced separately or jointly by the department of medicaid or 1719
county department. To enforce its recovery rights, the 1720
department or county department may do any of the following: 1721

(1) Intervene or join in any action or proceeding brought 1722
by the medical assistance recipient or on the recipient's behalf 1723
against any third party who may be liable for the cost of 1724
medical assistance paid; 1725

(2) Institute and pursue legal proceedings against any 1726
third party who may be liable for the cost of medical assistance 1727
paid; 1728

(3) Initiate legal proceedings in conjunction with any 1729
injured, diseased, or disabled medical assistance recipient or 1730
the recipient's attorney or representative. 1731

~~(I)~~ (H) A medical assistance recipient shall not assess 1732
attorney fees, costs, or other expenses against the department 1733
of medicaid or a county department when the department or county 1734
department enforces its right of recovery created by this 1735
section. 1736

~~(J)~~ (I) The right of recovery given to the department under 1737
this section includes payments made by a third party under 1738
contract with a person having a duty to support. 1739

~~(K)~~ (J) The department of medicaid may assign to a medical 1740
assistance provider the right of recovery given to the 1741
department under this section with respect to any claim for 1742
which the department has notified the provider that the 1743
department intends to recoup the department's prior payment for 1744
the claim. 1745

~~(L)~~ ~~(1)~~ (K) (1) Prior to any payment to the department or a 1746
county department pursuant to the department's or county 1747
department's right of recovery under this section, a party that 1748
desires to rebut the presumption in division ~~(G)~~ (F) of this 1749
section shall submit to the department or county department a 1750
request for a hearing in accordance with the procedure the 1751
department establishes in rules required by division ~~(O)~~ (N) of 1752
this section. The amount sought by the department or county 1753
department shall be held in escrow or in an interest on lawyers' 1754
trust account until the hearing examiner renders a decision or 1755
the case is otherwise concluded. A party successfully rebuts the 1756
presumption by a showing of clear and convincing evidence that a 1757
different allocation is warranted. 1758

(2) A medical assistance recipient who has repaid money, 1759
on or after September 29, 2007, to the department or a county 1760
department pursuant to the department's or county department's 1761
right of recovery under this section, section 5160.38 of the 1762
Revised Code, or former section 5101.58 or 5101.59 of the 1763
Revised Code may request a hearing to rebut the presumption in 1764
division ~~(G)~~(F) of this section. The request shall be made in 1765
accordance with the procedure the department establishes for 1766
this purpose in rules required by division ~~(O)~~(N) of this 1767
section. It must be made not later than one hundred eighty days 1768
after September 29, 2015, or ninety days after the payment is 1769
made, whichever is later. A party successfully rebuts the 1770
presumption by a showing of clear and convincing evidence that a 1771
different allocation is warranted. 1772

(3) A medical assistance recipient who has repaid money, 1773
between April 6, 2007 and September 28, 2007, to the department 1774
or a county department pursuant to the department's or county 1775
department's right of recovery under this section, section 1776
5160.38 of the Revised Code, or former section 5101.58 or 1777
5101.59 of the Revised Code may request a hearing to rebut the 1778
presumption in division ~~(G)~~(F) of this section. The request 1779
shall be made not later than one hundred eighty days after ~~the~~ 1780
~~effective date of this amendment~~ September 30, 2025, in 1781
accordance with the procedure the department establishes for 1782
this purpose in rules required by division ~~(O)~~(N) of this 1783
section. The presumption is successfully rebutted if the 1784
requestor demonstrates by clear and convincing evidence that a 1785
different allocation is warranted. 1786

(4) With respect to a hearing requested under division ~~(I)~~ 1787
~~(I)~~(K) (1), (2), or (3) of this section, all of the following are 1788
the case: 1789

(a) The hearing examiner may consider, but is not bound by 1790
the allocation of, medical expenses specified in a settlement 1791
agreement between the medical assistance recipient and the 1792
relevant third party; 1793

(b) The department or county department may raise 1794
affirmative defenses during the hearing, including the existence 1795
of a prior settlement with the medical assistance recipient, the 1796
doctrine of accord and satisfaction, or the common law principle 1797
of res judicata; 1798

(c) If the parties agree, live testimony shall not be 1799
presented at the hearing; 1800

(d) The hearing may be governed by rules adopted under 1801
section 5160.02 of the Revised Code. If such rules are adopted, 1802
Chapter 119. of the Revised Code applies to the hearing only to 1803
the extent specified in those rules; 1804

(e) The hearing examiner's decision is binding on the 1805
department or county department and the medical assistance 1806
recipient unless the decision is reversed or modified on appeal 1807
to the medicaid director as described in division ~~(M)~~ (L) of this 1808
section; 1809

(f) A request for a hearing may be submitted by any of the 1810
following: 1811

(i) The medical assistance recipient; 1812

(ii) The medical assistance recipient's authorized 1813
representative; 1814

(iii) The executor or administrator of a medical 1815
assistance recipient's estate authorized to make or pursue a 1816
request; 1817

(iv) A court-appointed guardian; 1818

(v) An attorney who has been directly retained by the 1819
medical assistance recipient, or the recipient's parent, legal 1820
guardian, or court-appointed guardian. 1821

~~(M)~~ ~~(1)~~ (L) (1) A medical assistance recipient who disagrees 1822
with a hearing examiner's decision under division ~~(L)~~ (K) of this 1823
section may file an administrative appeal with the medicaid 1824
director in accordance with the procedure the department 1825
establishes for this purpose in rules required by division ~~(O)~~ 1826
(N) of this section. A hearing is not required during the 1827
administrative appeal, but the director or the director's 1828
designee shall review the hearing examiner's decision and any 1829
prior relevant administrative action. After the review, the 1830
director or the director's designee shall affirm, modify, 1831
remand, or reverse the hearing decision. A decision made under 1832
this division is final and binding on the department or county 1833
department and the medical assistance recipient unless it is 1834
reversed or modified on appeal to a court of common pleas as 1835
described in division ~~(N)~~ (M) of this section. 1836

(2) An administrative appeal may be governed by rules 1837
adopted under section 5160.02 of the Revised Code. If such rules 1838
are adopted, Chapter 119. of the Revised Code applies to an 1839
administrative appeal only to the extent specified in those 1840
rules. 1841

~~(N)~~ (M) A party to an administrative appeal described in 1842
division ~~(M)~~ (L) of this section may file an appeal with a court 1843
of common pleas in accordance with section 119.12 of the Revised 1844
Code. 1845

~~(O)~~ (N) The medicaid director shall adopt rules under 1846

section 5160.02 of the Revised Code as necessary to implement 1847
this section, including rules establishing procedures a party 1848
may use to request a hearing under division ~~(L)~~ (K) (1), (2), 1849
or (3) of this section or an administrative appeal under 1850
division ~~(M)~~ (L) (1) of this section. The rules shall be 1851
adopted in accordance with Chapter 119. of the Revised Code. 1852

~~(P)~~ (O) Divisions ~~(L)~~ (K) to ~~(N)~~ (M) of this section are 1853
remedial in nature and shall be liberally construed by the 1854
courts of this state in accordance with section 1.11 of the 1855
Revised Code. Those divisions specify the sole remedy available 1856
to a party who claims the department or a county department has 1857
received or is to receive more money than entitled to receive 1858
under this section, section 5160.38 of the Revised Code, or 1859
former section 5101.58 or 5101.59 of the Revised Code. 1860

Sec. 5160.371. In addition to the requirement of division 1861
~~(C)~~ (B) of section 5160.37 of the Revised Code to cooperate with 1862
the department of medicaid and county department of job and 1863
family services, a medical assistance recipient and the 1864
recipient's attorney, if any, shall cooperate with each medical 1865
provider of the recipient. Cooperation with a medical provider 1866
shall consist of disclosing to the provider all information the 1867
recipient and attorney, if any, possess that would assist the 1868
provider in determining each third party that is responsible for 1869
the payment or processing of a claim for medical assistance 1870
provided to the recipient. If disclosure is not made in 1871
accordance with this section, the recipient and the recipient's 1872
attorney, if any, are liable to reimburse the department or 1873
county department for the amount that would have been paid by a 1874
third party had the third party been disclosed to the provider 1875
by the recipient or the recipient's attorney. 1876

Sec. 5160.40. (A) As used in this section, "business day" 1877
means any day of the week excluding Saturday, Sunday, and a 1878
legal holiday, as defined in section 1.14 of the Revised Code. 1879

(B) Subject to ~~divisions~~ division (C) ~~and (D)~~ of this 1880
section, a third party shall do all of the following: 1881

(1) Accept the department of medicaid's right of recovery 1882
under section 5160.37 of the Revised Code and the assignment of 1883
rights to the department that are described in section 5160.38 1884
of the Revised Code; 1885

(2) Respond to an inquiry by the department regarding a 1886
claim for payment of a medical item or service that was 1887
submitted to the third party not later than six years after the 1888
date of the provision of such medical item or service; 1889

(3) Respond to the department's request for payment of a 1890
claim described in division (B) (2) of this section not later 1891
than sixty business days after receipt of written proof of the 1892
claim, either by paying the claim or issuing a written denial to 1893
the department; 1894

(4) Not charge a fee to do either of the following for a 1895
claim described in division (B) (2) of this section: 1896

(a) Determine whether the claim should be paid; 1897

(b) Process the claim. 1898

(5) Pay a claim described in division (B) (2) of this 1899
section; 1900

(6) Not deny a claim submitted by the department solely on 1901
the basis of the date of submission of the claim, type or format 1902
of the claim form, or a failure by the medical assistance 1903
recipient who is the subject of the claim to present proper 1904

documentation of coverage at the time of service, if both of the 1905
following have occurred: 1906

(a) The claim was submitted by the department not later 1907
than six years after the date of the provision of the medical 1908
item or service. 1909

(b) An action by the department to enforce its right of 1910
recovery under section 5160.37 of the Revised Code on the claim 1911
was commenced not later than six years after the department's 1912
submission of the claim. 1913

(7) Consider the department's payment of a claim for a 1914
medical item or service to be the equivalent of the medical 1915
assistance recipient having obtained prior authorization for the 1916
item or service from the third party; 1917

(8) Not deny a claim described in division (B) (7) of this 1918
section that is submitted by the department solely on the basis 1919
of the medical assistance recipient's failure to obtain prior 1920
authorization for the medical item or service. 1921

~~(C) For purposes of the requirements in division (B) of~~ 1922
~~this section, a third party shall treat a medicaid managed care~~ 1923
~~organization as the department for a claim if the individual who~~ 1924
~~is the subject of the claim received a medical item or service~~ 1925
~~through a medicaid managed care organization and the department~~ 1926
~~has assigned its right of recovery for the claim to the medicaid~~ 1927
~~managed care organization. Even if the department assigned its~~ 1928
~~right of recovery to a medicaid managed care organization, the~~ 1929
~~department may, beginning one year from the date the~~ 1930
~~organization paid the claim, recoup from a third party an amount~~ 1931
~~that was assigned to the organization but not collected.~~ 1932

~~(D)~~ If the department of medicaid, as permitted by 1933

division ~~(K)~~(J) of section 5160.37 of the Revised Code, assigns 1934
to a medical assistance provider the department's right of 1935
recovery for a claim for which it has notified the provider that 1936
it intends to recoup its prior payment for a claim, a third 1937
party shall treat the provider as the department and shall pay 1938
the provider the greater of the following: 1939

(1) The amount the department intends to recoup from the 1940
provider for the claim. 1941

(2) If the third party and the provider have an agreement 1942
that requires the third party to pay the provider at the time 1943
the provider presents the claim to the third party, the amount 1944
that is to be paid under that agreement. 1945

~~(E)~~(D) The time limitations associated with the 1946
requirements in divisions (B)(2) and (6) of this section apply 1947
only to submissions of claims to, and payments of claims by, a 1948
health insurer to which the "Social Security Act," section 1949
1902(a)(25)(I), 42 U.S.C. 1396a(a)(25)(I), applies. 1950

Sec. 5162.01. (A) As used in the Revised Code: 1951

(1) "Medicaid" and "medicaid program" mean the program of 1952
medical assistance established by Title XIX of the "Social 1953
Security Act," 42 U.S.C. 1396 et seq., including any medical 1954
assistance provided under the medicaid state plan or a federal 1955
medicaid waiver granted by the United States secretary of health 1956
and human services. 1957

(2) "Medicare" and "medicare program" mean the federal 1958
health insurance program established by Title XVIII of the 1959
"Social Security Act," 42 U.S.C. 1395 et seq. 1960

(B) As used in this chapter: 1961

- (1) "Exchange" has the same meaning as in 45 C.F.R. 1962
155.20. 1963
- (2) "Expansion eligibility group" has the same meaning as 1964
in section 5163.01 of the Revised Code. 1965
- (3) "Federal financial participation" has the same meaning 1966
as in section 5160.01 of the Revised Code. 1967
- (4) "Federal poverty line" means the official poverty line 1968
defined by the United States office of management and budget 1969
based on the most recent data available from the United States 1970
bureau of the census and revised by the United States secretary 1971
of health and human services pursuant to the "Omnibus Budget 1972
Reconciliation Act of 1981," section 673(2), 42 U.S.C. 9902(2). 1973
- (5) "Healthcheck" has the same meaning as in section 1974
5164.01 of the Revised Code. 1975
- (6) "Healthy start component" means the component of the 1976
medicaid program that covers pregnant women and children and is 1977
identified in rules adopted under section 5162.02 of the Revised 1978
Code as the healthy start component. 1979
- (7) "Home and community-based services" means services 1980
provided under a home and community-based services medicaid 1981
waiver component. 1982
- (8) "Home and community-based services medicaid waiver 1983
component" has the same meaning as in section 5166.01 of the 1984
Revised Code. 1985
- (9) "ICF/IID" has the same meaning as in section 5124.01 1986
of the Revised Code. 1987
- (10) "Individualized education program" has the same 1988
meaning as in section 3323.011 of the Revised Code. 1989

(11) "Medicaid managed care organization" ~~has the same~~ 1990
~~meaning as in section 5167.01 of the Revised Code~~ means a managed 1991
care organization that, on the effective date of this amendment, 1992
is under contract with the department of medicaid to administer 1993
medicaid benefits to medicaid recipients. 1994

(12) ~~"Medicaid MCO plan" has the same meaning as in~~ 1995
~~section 5167.01 of the Revised Code.~~ 1996

~~(13)~~ "Medicaid provider" has the same meaning as in 1997
section 5164.01 of the Revised Code. 1998

~~(14)~~ (13) "Medicaid services" has the same meaning as in 1999
section 5164.01 of the Revised Code. 2000

~~(15)~~ (14) "Medicaid waiver component" has the same meaning 2001
as in section 5166.01 of the Revised Code; 2002

~~(16)~~ (15) "Nursing facility" and "nursing facility 2003
services" have the same meanings as in section 5165.01 of the 2004
Revised Code. 2005

~~(17)~~ (16) "Ordering or referring only provider" means a 2006
medicaid provider who orders, prescribes, refers, or certifies a 2007
service or item reported on a claim for medicaid payment but 2008
does not bill for medicaid services. 2009

~~(18)~~ (17) "Political subdivision" means a municipal 2010
corporation, township, county, school district, or other body 2011
corporate and politic responsible for governmental activities 2012
only in a geographical area smaller than that of the state. 2013

~~(19)~~ (18) "Prescribed drug" has the same meaning as in 2014
section 5164.01 of the Revised Code. 2015

~~(20)~~ (19) "Provider agreement" has the same meaning as in 2016
section 5164.01 of the Revised Code. 2017

~~(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 2047
race and ethnic group: 2048

(1) The estimated number of pregnant women, infants, and 2049
children eligible for the program; 2050

(2) The actual number of eligible persons enrolled in the 2051
program; 2052

(3) The actual number of enrolled pregnant women 2053
categorized by estimated gestational age at time of enrollment; 2054

(4) The average number of days between ~~the following~~ 2055
~~events:~~ 2056

~~(a) A pregnant woman's application for medicaid and 2057~~
~~enrollment in the fee-for-service component of medicaid;~~ 2058

~~(b) A pregnant woman's application for enrollment in a 2059~~
~~medicaid managed care organization and enrollment in the managed 2060~~
~~care organization program.~~ 2061

The information described in ~~divisions (A) (4) (a) and~~ 2062
~~(b) division (A) (4)~~ of this section shall also be delineated by 2063
county and the urban and rural communities specified in rules 2064
adopted under section 3701.142 of the Revised Code. 2065

(5) The number of prenatal, postpartum, and child health 2066
visits; 2067

(6) The estimated number of enrolled women of child- 2068
bearing age who use a tobacco product; 2069

(7) The estimated number of enrolled women of child- 2070
bearing age who participate in a tobacco cessation program or 2071
who use a tobacco cessation product; 2072

(8) The rates at which enrolled pregnant women receive 2073

addiction or mental health services, progesterone therapy, and 2074
any other service specified by the department; 2075

(9) A report on birth outcomes, including a comparison of 2076
low-birthweight births and infant mortality rates of medicaid 2077
recipients with the general female child-bearing and infant 2078
population in this state; 2079

(10) A comparison of the prenatal, delivery, and child 2080
health costs of the program with such costs of similar programs 2081
in other states, where available; 2082

(11) A report on performance data generated by the 2083
component of the state innovation model (SIM) grant pertaining 2084
to episode-based payments for perinatal care that was awarded to 2085
this state by the center for medicare and medicaid innovation in 2086
the United States centers for medicare and medicaid services; 2087

(12) A report on funds allocated for infant mortality 2088
reduction initiatives in the urban and rural communities 2089
specified in rules adopted under section 3701.142 of the Revised 2090
Code; 2091

(13) A report on the results of client responses to 2092
questions related to pregnancy services and healthcheck that are 2093
asked by the personnel of county departments of job and family 2094
services; 2095

(14) ~~A comparison of the performance of the fee-for-~~ 2096
~~service component of medicaid with the performance of each~~ 2097
~~medicaid managed care organization on perinatal health metrics;~~ 2098

~~(15)~~ A report demonstrating cost savings resulting from 2099
program investments; 2100

~~(16)~~ (15) Beginning two years after April 30, 2024, a 2101

report on the medicaid coverage of doula services required by 2102
section 5164.071 of the Revised Code, including: 2103

(a) Outcomes related to maternal health and maternal 2104
morbidity; 2105

(b) Infant health outcomes; 2106

(c) The average costs of providing doula services to 2107
mothers and infants; 2108

(d) Estimated cost increases or savings as a result of 2109
providing doula coverage. 2110

(B) The department shall submit the report to the general 2111
assembly in accordance with section 101.68 of the Revised Code. 2112
The department also shall make the report available to the 2113
public. 2114

(C) The department shall provide to the legislative 2115
service commission a copy of the data used to calculate the 2116
information required in the report under division ~~(A) (16)~~ (A) (15) 2117
of this section. 2118

Sec. 5162.1310. (A) The department of medicaid shall 2119
periodically evaluate the success that members of the expansion 2120
eligibility group have with the following: 2121

(1) Obtaining employer-sponsored health insurance 2122
coverage; 2123

(2) Improving health conditions that would otherwise 2124
prevent or inhibit stable employment; 2125

(3) Improving the conditions of their employment, 2126
including duration and hours of employment. 2127

(B) ~~For the purpose of aiding the department's evaluations~~ 2128

~~under this section, medicaid managed care organizations shall~~ 2129
~~collect and submit to the department relevant data about members~~ 2130
~~of the expansion eligibility group who are enrolled in the~~ 2131
~~organizations' medicaid MCO plans. The department may request~~ 2132
~~that a medicaid managed care organization collect and submit to~~ 2133
~~the department additional data the department needs for the~~ 2134
~~evaluation.~~ 2135

~~(C)~~ The department shall complete a report for each 2136
evaluation conducted under this section. The director shall 2137
provide a copy of the report to the general assembly in 2138
accordance with section 101.68 of the Revised Code. 2139

Sec. 5162.73. (A) As used in this section: 2140

(1) "Administrative services organization" or "ASO" means 2141
an entity contracted by the department of medicaid to perform 2142
administrative functions related to the medicaid program, 2143
including claims processing, prior authorization review, 2144
provider credentialing and recruitment, customer service and 2145
grievance resolution, and data analytics and utilization 2146
monitoring. An "administrative services organization" or "ASO" 2147
is not a managed care organization and is a nonfinancial risk- 2148
bearing entity. 2149

(2) "Care coordination" means a set of services provided 2150
by physicians, nurses, community health workers, behavioral 2151
health providers, and other licensed health care providers to 2152
ensure that patients receive appropriate, timely, and culturally 2153
responsive care across the continuum of health services. 2154

(3) "Financial risk-bearing medicaid managed care 2155
organization" means a medicaid managed care organization that 2156
contracts with the department of medicaid to provide 2157

administrative services on a financial risk-bearing basis which 2158
entails payment on a capitated basis and incentivizes the 2159
organization to maximize internal profit by restricting care at 2160
the expense of medicaid recipients. 2161

(4) "Managed fee-for-service" means a medicaid delivery 2162
model that combines direct payment to medicaid providers for 2163
each encounter or service provided to a medicaid recipient with 2164
periodic capitated payments for a range of additional indirect 2165
services, including care coordination and quality improvement. 2166

(B) (1) Not later than thirty days after the effective date 2167
of this section, the medicaid director shall convene a workgroup 2168
to establish a transition plan concerning the termination of the 2169
care management system established under the former version of 2170
section 5167.03 of the Revised Code that existed immediately 2171
prior to the effective date of this section. 2172

(2) The workgroup shall consist of medicaid recipients; 2173
medicaid providers, including dentists, hospital 2174
representatives, and nursing home representatives; 2175
representatives of the Ohio association of community health 2176
centers; representatives of the Ohio association of area 2177
agencies on aging; and other stakeholders as determined by the 2178
director. Workgroup members shall be evenly distributed from the 2179
following regions of this state as follows: 2180

(a) Region 1: Ashtabula, Cuyahoga, Geauga, Lake, Lorain; 2181

(b) Region 2: Allen, Auglaize, Defiance, Erie, Fulton, 2182
Hancock, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, 2183
Sandusky, Seneca, Van Wert, Williams, Wood; 2184

(c) Region 3: Athens, Belmont, Coshocton, Gallia, 2185
Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, 2186

Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, 2187
Scioto, Vinton, Washington; 2188

(d) Region 4: Adams, Brown, Butler, Clermont, Clinton, 2189
Hamilton, Highland, Warren; 2190

(e) Region 5: Crawford, Delaware, Fairfield, Fayette, 2191
Franklin, Hardin, Knox, Licking, Logan, Madison, Marion, Morrow, 2192
Pickaway, Union, Wyandot; 2193

(f) Region 6: Ashland, Carroll, Columbiana, Holmes, 2194
Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, 2195
Tuscarawas, Wayne; 2196

(g) Region 7: Champaign, Clark, Darke, Greene, Miami, 2197
Montgomery, Preble, Shelby. 2198

(3) The workgroup shall meet to establish recommendations 2199
for terminating the care management system and transitioning 2200
medicaid recipients to an ASO-based model. In establishing 2201
recommendations for the transition, the workgroup shall consider 2202
all of the following: 2203

(a) The number of administrative services organizations 2204
the department of medicaid should contract with to perform 2205
administrative functions related to the medicaid program 2206
following termination of the care management system; 2207

(b) The medicaid program responsibilities that will be 2208
overseen by administrative services organizations; 2209

(c) The medicaid payment rate for services provided by 2210
medicaid providers under the managed fee-for-service component 2211
of the medicaid program, including whether providers should 2212
receive medicaid payment in an amount that equals one hundred 2213
per cent of the medicare payment rate for similar services; 2214

(d) How cost savings realized from the termination of the 2215
care management system will be redistributed within the medicaid 2216
program; 2217

(e) How to structure the care coordination component of 2218
the medicaid program, including how to transition care 2219
coordination from medicaid managed care organizations to 2220
medicaid providers and how to provide providers with requisite 2221
training. In considering the structure of the care coordination 2222
component of the medicaid program, the workgroup shall delineate 2223
the scope of care coordination activities that primary care 2224
providers will be responsible for overseeing and determine a 2225
capitated payment rate for care coordination services provided 2226
by medicaid providers. 2227

(f) How to structure and monitor office-based quality 2228
improvement activities. In considering quality improvement 2229
activities, the workgroup shall consider including a mechanism 2230
for determining high-impact clinical goals for improvement, 2231
creation of metrics to measure quality improvements, and 2232
establishing incentives for provider participation in quality 2233
improvement activities that include capitated payments, 2234
compensation for achieving intended outcomes, and continuing 2235
medical education credits. 2236

(4) Not later than twelve months after the workgroup is 2237
convened, the workgroup shall submit a report to the medicaid 2238
director detailing the workgroup's recommendations for 2239
terminating the care management system. 2240

(C) Upon receipt of the report submitted by the workgroup, 2241
the director shall do all of the following: 2242

(1) Adopt rules in accordance with Chapter 119. of the 2243

Revised Code to implement this section; 2244

(2) Through a procurement process, select one or more 2245
administrative services organizations as a replacement for the 2246
care management system. As part of the procurement process, the 2247
director shall do all of the following: 2248

(a) Accept applications from entities seeking to become an 2249
administrative services organization; 2250

(b) Establish eligibility criteria an entity must meet in 2251
order to become an administrative services organization; 2252

(c) Not later than one hundred eighty days after receipt 2253
of the workgroup's report, select and contract with one or more 2254
administrative services organizations. 2255

(3) Not later than one hundred eighty days after receipt 2256
of the workgroup's report, seek all necessary federal approval 2257
from the United States centers for medicare and medicaid 2258
services to implement this section. 2259

(D) Beginning on the first day of the fiscal biennium that 2260
begins after the medicaid director enters into contracts with 2261
selected administrative services organizations under division 2262
(C) (2) of this section, the director shall not renew any 2263
existing contracts or agreements between the department of 2264
medicaid and a financial risk-bearing medicaid managed care 2265
organization or enter into a new contract or agreement with a 2266
financial risk-bearing medicaid managed care organization. 2267

(E) (1) As soon as practicable after the first day of that 2268
fiscal biennium, the department shall transition all medicaid 2269
recipients enrolled in financial risk-bearing medicaid managed 2270
care organization plans to the fee-for-service component of the 2271
medicaid program or to the managed fee-for-service component in 2272

accordance with the rules adopted under division (C) (1) of this 2273
section. 2274

(2) The department shall prepare and distribute guidance 2275
materials to assist individuals transitioning from a medicaid 2276
managed care organization as described in division (E) (1) of 2277
this section. 2278

(F) Upon completing the transition described in division 2279
(E) of this section, the medicaid director shall terminate all 2280
contracts or agreements entered into between the department and 2281
financial risk-bearing medicaid managed care organizations. The 2282
director shall provide financial risk-bearing medicaid managed 2283
care organizations with at least thirty days' notice prior to 2284
terminating a contract or agreement under this section. Each 2285
financial risk-bearing medicaid managed care organization shall 2286
ensure that medicaid providers receive payment for incurred but 2287
not reported expenses prior to the financial risk-bearing 2288
medicaid managed care organization's termination from 2289
participation in the care management system. 2290

(G) The medicaid director shall prepare and submit an 2291
annual report to the general assembly and the governor detailing 2292
the actions the department of medicaid takes in accordance with 2293
this section. The report shall include all of the following: 2294

(1) Medicaid program financial performance metrics related 2295
to the transition from the care management system, including the 2296
amount of total savings experienced by the medicaid program as a 2297
result of the transition; 2298

(2) Clinical outcomes for and resource utilization by 2299
medicaid recipients who transition from the care management 2300
system to the ASO system; 2301

(3) Any other information that the director considers 2302
relevant regarding the transition. 2303

(H) The medicaid director shall ensure that one hundred 2304
per cent of all cost savings realized as a result of terminating 2305
the care management system are reinvested into the medicaid 2306
program. 2307

(I) In enacting this section, it is the intent of the 2308
general assembly to terminate the care management system 2309
established under the former version of section 5167.03 of the 2310
Revised Code that existed immediately prior to the effective 2311
date of this section. 2312

Sec. ~~5162.73~~ 5162.74. (A) The ~~Department~~department of 2313
~~Medicaid~~medicaid may establish and administer a program to 2314
provide dental services to pregnant ~~Medicaid~~medicaid 2315
recipients. If the program is established, all of the following 2316
shall apply: 2317

(1) Medicaid recipients who are members of the group 2318
described in section 5163.06 of the Revised Code shall be 2319
eligible to receive two dental cleanings per year. 2320

(2) The ~~Department~~department shall give priority to those 2321
~~Medicaid~~medicaid recipients residing in areas of the state with 2322
high preterm birth rates. 2323

(3) The ~~Department~~department shall inform ~~Medicaid~~medicaid 2324
recipients about the program and market the program to 2325
~~Medicaid~~medicaid recipients. 2326

(B) The ~~Department~~department of ~~Medicaid~~medicaid shall 2327
establish reimbursement rates for entities that educate ~~Medicaid~~medicaid 2328
recipients about the importance of prenatal and 2329
postnatal dental care as part of the program described in 2330

section 3701.615 of the Revised Code, including reimbursement 2331
rates for all or part of the costs associated with developing 2332
and distributing educational materials related to the importance 2333
of prenatal and postnatal dental care. 2334

Sec. 5164.01. As used in this chapter: 2335

(A) "Adjudication" has the same meaning as in section 2336
119.01 of the Revised Code. 2337

(B) "Behavioral health redesign" means revisions to the 2338
medicaid program's coverage of community behavioral health 2339
services beginning July 1, 2017, including revisions that update 2340
medicaid billing codes and payment rates for community 2341
behavioral health services. 2342

(C) "Clean claim" has the same meaning as in 42 C.F.R. 2343
447.45(b) . 2344

(D) "Community behavioral health services" means both of 2345
the following: 2346

(1) Alcohol and drug addiction services provided by a 2347
community addiction services provider, as defined in section 2348
5119.01 of the Revised Code; 2349

(2) Mental health services provided by a community mental 2350
health services provider, as defined in section 5119.01 of the 2351
Revised Code. 2352

(E) "Early and periodic screening, diagnostic, and 2353
treatment services" has the same meaning as in the "Social 2354
Security Act," section 1905(r), 42 U.S.C. 1396d(r) . 2355

(F) "Federal financial participation" has the same meaning 2356
as in section 5160.01 of the Revised Code. 2357

(G) "Federal poverty line" has the same meaning as in 2358
section 5162.01 of the Revised Code. 2359

(H) "Healthcheck" means the component of the medicaid 2360
program that provides early and periodic screening, diagnostic, 2361
and treatment services. 2362

(I) "Home and community-based services medicaid waiver 2363
component" has the same meaning as in section 5166.01 of the 2364
Revised Code. 2365

(J) "Hospital" has the same meaning as in section 3727.01 2366
of the Revised Code. 2367

(K) "ICDS participant" means a dual eligible individual 2368
who participates in the integrated care delivery system. 2369

(L) "ICF/IID" has the same meaning as in section 5124.01 2370
of the Revised Code. 2371

(M) "Integrated care delivery system" and "ICDS" mean the 2372
demonstration project authorized by section 5164.91 of the 2373
Revised Code. 2374

(N) "Mandatory services" means the health care services 2375
and items that must be covered by the medicaid state plan as a 2376
condition of the state receiving federal financial participation 2377
for the medicaid program. 2378

(O) ~~"Medicaid managed care organization" has the same~~ 2379
~~meaning as in section 5167.01 of the Revised Code.~~ 2380

~~(P)~~ "Medicaid provider" means a person or government 2381
entity with a valid provider agreement to provide medicaid 2382
services to medicaid recipients. To the extent appropriate in 2383
the context, "medicaid provider" includes a person or government 2384
entity applying for a provider agreement, a former medicaid 2385

provider, or both. 2386

~~(Q)~~(P) "Medicaid services" means either or both of the 2387
following: 2388

(1) Mandatory services; 2389

(2) Optional services that the medicaid program covers. 2390

~~(R)~~(Q) "Nursing facility" has the same meaning as in 2391
section 5165.01 of the Revised Code. 2392

~~(S)~~(R) "Optional services" means the health care services 2393
and items that may be covered by the medicaid state plan or a 2394
federal medicaid waiver and for which the medicaid program 2395
receives federal financial participation. 2396

~~(T)~~(S) "Prescribed drug" has the same meaning as in 42 2397
C.F.R. 440.120. 2398

~~(U)~~(T) "Provider agreement" means an agreement to which 2399
all of the following apply: 2400

(1) It is between a medicaid provider and the department 2401
of medicaid; 2402

(2) It provides for the medicaid provider to provide 2403
medicaid services to medicaid recipients; 2404

(3) It complies with 42 C.F.R. 431.107(b). 2405

~~(V)~~(U) "State plan home and community-based services" 2406
means home and community-based services that, as authorized by 2407
section 1915(i) of the "Social Security Act," 42 U.S.C. 2408
1396n(i), may be covered by the medicaid program pursuant to an 2409
amendment to the medicaid state plan. 2410

~~(W)~~(V) "Terminal distributor of dangerous drugs" has the 2411
same meaning as in section 4729.01 of the Revised Code. 2412

Sec. 5164.38. (A) As used in this section:	2413
(1) "Party" has the same meaning as in division (G) of section 119.01 of the Revised Code.	2414 2415
(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.	2416 2417 2418 2419
(B) This section does not apply to either of the following:	2420 2421
(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;	2422 2423 2424 2425
(2) Any <u>any</u> 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.	2426 2427 2428
(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:	2429 2430 2431 2432
(1) Refuse to enter into a provider agreement with a medicaid provider;	2433 2434
(2) Refuse to revalidate a medicaid provider's provider agreement;	2435 2436
(3) Suspend or terminate a medicaid provider's provider agreement;	2437 2438
(4) Take any action based upon a final fiscal audit of a	2439

medicaid provider. 2440

(D) Any party who is adversely affected by the issuance of 2441
an adjudication order under division (C) of this section may 2442
appeal to the court of common pleas in accordance with section 2443
119.12 of the Revised Code. 2444

(E) The department is not required to comply with division 2445
(C) (1), (2), or (3) of this section whenever any of the 2446
following occur: 2447

(1) The terms of a provider agreement require the medicaid 2448
provider to hold a license, permit, or certificate or maintain a 2449
certification issued by an official, board, commission, 2450
department, division, bureau, or other agency of state or 2451
federal government other than the department of medicaid, and 2452
the license, permit, certificate, or certification has been 2453
denied, revoked, not renewed, suspended, or otherwise limited. 2454

(2) The terms of a provider agreement require the medicaid 2455
provider to hold a license, permit, or certificate or maintain 2456
certification issued by an official, board, commission, 2457
department, division, bureau, or other agency of state or 2458
federal government other than the department of medicaid, and 2459
the provider has not obtained the license, permit, certificate, 2460
or certification. 2461

(3) The medicaid provider's application for a provider 2462
agreement is denied, or the provider's provider agreement is 2463
terminated or not revalidated, because of or pursuant to any of 2464
the following: 2465

(a) The termination, refusal to renew, or denial of a 2466
license, permit, certificate, or certification by an official, 2467
board, commission, department, division, bureau, or other agency 2468

of this state other than the department of medicaid, 2469
notwithstanding the fact that the provider may hold a license, 2470
permit, certificate, or certification from an official, board, 2471
commission, department, division, bureau, or other agency of 2472
another state; 2473

(b) Division (D) or (E) of section 5164.35 of the Revised 2474
Code; 2475

(c) The provider's termination, suspension, or exclusion 2476
from the medicare program or from another state's medicaid 2477
program and, in either case, the termination, suspension, or 2478
exclusion is binding on the provider's participation in the 2479
medicaid program in this state; 2480

(d) The provider's pleading guilty to or being convicted 2481
of a criminal activity materially related to either the medicare 2482
or medicaid program; 2483

(e) The provider or its owner, officer, authorized agent, 2484
associate, manager, or employee having been convicted of one of 2485
the offenses that caused the provider's provider agreement to be 2486
suspended pursuant to section 5164.36 of the Revised Code; 2487

(f) The provider's failure to provide the department the 2488
national provider identifier assigned the provider by the 2489
national provider system pursuant to 45 C.F.R. 162.408. 2490

(4) The medicaid provider's application for a provider 2491
agreement is denied, or the provider's provider agreement is 2492
terminated or suspended, as a result of action by the United 2493
States department of health and human services and that action 2494
is binding on the provider's medicaid participation. 2495

(5) The medicaid provider's provider agreement and 2496
medicaid payments to the provider are suspended under section 2497

5164.36 or 5164.37 of the Revised Code. 2498

(6) The medicaid provider's application for a provider 2499
agreement is denied because the provider's application was not 2500
complete; 2501

(7) The medicaid provider's provider agreement is 2502
converted under section 5164.32 of the Revised Code from a 2503
provider agreement that is not time-limited to a provider 2504
agreement that is time-limited. 2505

(8) Unless the medicaid provider is a nursing facility or 2506
ICF/IID, the provider's provider agreement is not revalidated 2507
pursuant to division (B)(1) of section 5164.32 of the Revised 2508
Code. 2509

(9) The medicaid provider's provider agreement is 2510
suspended, terminated, or not revalidated because of either of 2511
the following: 2512

(a) Any reason authorized or required by one or more of 2513
the following: 42 C.F.R. 455.106, 455.23, 455.416, 455.434, or 2514
455.450; 2515

(b) The provider has not billed or otherwise submitted a 2516
medicaid claim for two years or longer. 2517

(F) In the case of a medicaid provider described in 2518
division (E)(3)(f), (6), (7), or (9)(b) of this section, the 2519
department may take its action by sending a notice explaining 2520
the action to the provider. The notice shall be sent to the 2521
medicaid provider's address on record with the department. The 2522
notice may be sent by regular mail. 2523

(G) The department may withhold payments for medicaid 2524
services rendered by a medicaid provider during the pendency of 2525

proceedings initiated under division (C) (1), (2), or (3) of this 2526
section. If the proceedings are initiated under division (C) (4) 2527
of this section, the department may withhold payments only to 2528
the extent that they equal amounts determined in a final fiscal 2529
audit as being due the state. This division does not apply if 2530
the department fails to comply with section 119.07 of the 2531
Revised Code, requests a continuance of the hearing, or does not 2532
issue a decision within thirty days after the hearing is 2533
completed. This division does not apply to nursing facilities 2534
and ICFs/IID. 2535

Sec. 5164.46. (A) As used in this section, "electronic 2536
claims submission process" means any of the following: 2537

- (1) Electronic interchange of data; 2538
- (2) Direct entry of data through an internet-based 2539
mechanism implemented by the department of medicaid; 2540
- (3) Any other process for the electronic submission of 2541
claims that is specified in rules adopted under section 5162.02 2542
of the Revised Code. 2543

(B) Not later than January 1, 2013, and except as provided 2544
in division (C) of this section, each medicaid provider shall do 2545
both of the following: 2546

- (1) Use only an electronic claims submission process to 2547
submit to the department of medicaid claims for medicaid payment 2548
for medicaid services provided to medicaid recipients; 2549
- (2) Arrange to receive medicaid payment from the 2550
department by means of electronic funds transfer. 2551

(C) Division (B) of this section does not apply to any of 2552
the following: 2553

(1) A nursing facility; 2554

(2) An ICF/IID; 2555

(3) ~~A medicaid managed care organization;~~ 2556

~~(4) Any other medicaid provider or type of medicaid~~ 2557
provider designated in rules adopted under section 5162.02 of 2558
the Revised Code. 2559

(D) The department shall not process a medicaid claim 2560
submitted on or after January 1, 2013, unless the claim is 2561
submitted through an electronic claims submission process in 2562
accordance with this section. 2563

Sec. 5164.74. The medicaid director shall adopt rules 2564
under section 5164.02 of the Revised Code governing the 2565
calculation and payment of, and the allocation of payments for, 2566
graduate medical education costs associated with medicaid 2567
services rendered to medicaid recipients. ~~Subject to section~~ 2568
~~5164.741 of the Revised Code, the rules shall provide for~~ 2569
~~payment of graduate medical education costs associated with~~ 2570
~~medicaid services rendered to medicaid recipients, including~~ 2571
~~recipients enrolled in a medicaid managed care organization,~~ 2572
that the department of medicaid determines are allowable and 2573
reasonable. 2574

Sec. 5164.751. (A) As used in this section, "state maximum 2575
allowable cost" means the per unit amount the medicaid program 2576
pays a terminal distributor of dangerous drugs for a prescribed 2577
drug included in the state maximum allowable cost program 2578
established under division (B) of this section. "State maximum 2579
allowable cost" excludes dispensing fees and copayments, 2580
coinsurance, or other cost-sharing charges, if any. 2581

(B) ~~Subject to section 5167.123 of the Revised Code, the~~ 2582

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	2611
section 5160.01 of the Revised Code.	2612
"Enrollee" has the same meaning as in section 5167.01 of	2613
the Revised Code.	2614
"Expansion eligibility group" has the same meaning as in	2615
section 5163.01 of the Revised Code.	2616
"Federal poverty line" has the same meaning as in section	2617
5162.01 of the Revised Code.	2618
"Home and community-based services medicaid waiver	2619
component" means a medicaid waiver component under which home	2620
and community-based services are provided as an alternative to	2621
hospital services, nursing facility services, or ICF/IID	2622
services.	2623
"Hospital" has the same meaning as in section 3727.01 of	2624
the Revised Code.	2625
"Hospital long-term care unit" has the same meaning as in	2626
section 5168.40 of the Revised Code.	2627
"ICDS participant" has the same meaning as in section	2628
5164.01 of the Revised Code.	2629
"ICF/IID" and "ICF/IID services" have the same meanings as	2630
in section 5124.01 of the Revised Code.	2631
"Integrated care delivery system" and "ICDS" have the same	2632
meanings as in section 5164.01 of the Revised Code.	2633
"Level of care determination" means a determination of	2634
whether an individual needs the level of care provided by a	2635
hospital, nursing facility, or ICF/IID and whether the	2636
individual, if determined to need that level of care, would	2637

receive hospital services, nursing facility services, or ICF/IID 2638
services if not for a home and community-based services medicaid 2639
waiver component. 2640

"Medicaid buy-in for workers with disabilities program" 2641
has the same meaning as in section 5163.01 of the Revised Code. 2642

~~"Medicaid MCO plan" has the same meaning as in section 2643~~
~~5167.01 of the Revised Code. 2644~~

"Medicaid provider" has the same meaning as in section 2645
5164.01 of the Revised Code. 2646

"Medicaid services" has the same meaning as in section 2647
5164.01 of the Revised Code. 2648

"Medicaid waiver component" means a component of the 2649
medicaid program authorized by a waiver granted by the United 2650
States department of health and human services under section 2651
1115 or 1915 of the "Social Security Act," 42 U.S.C. 1315 or 2652
1396n. "Medicaid waiver component" does not include the care 2653
management system or services delivered under a prepaid 2654
inpatient health plan, as defined in 42 C.F.R. 438.2. 2655

"Medically fragile child" means an individual who is under 2656
eighteen years of age, has intensive health care needs, and is 2657
considered blind or disabled under section 1614(a)(2) or (3) of 2658
the "Social Security Act," 42 U.S.C. 1382c(a)(2) or (3). 2659

"Nursing facility" and "nursing facility services" have 2660
the same meanings as in section 5165.01 of the Revised Code. 2661

"Ohio home care waiver program" means the home and 2662
community-based services medicaid waiver component that is known 2663
as Ohio home care and was created pursuant to section 5166.11 of 2664
the Revised Code. 2665

"Provider agreement" has the same meaning as in section 2666
5164.01 of the Revised Code. 2667

"Residential treatment facility" means a residential 2668
facility licensed by the department of ~~mental-behavioral~~ health 2669
~~and addiction services~~ under section 5119.34 of the Revised 2670
Code, or an institution certified by the department of children 2671
and youth under section 5103.03 of the Revised Code, that serves 2672
children and either has more than sixteen beds or is part of a 2673
campus of multiple facilities or institutions that, combined, 2674
have a total of more than sixteen beds. 2675

"Skilled nursing facility" has the same meaning as in 2676
section 5165.01 of the Revised Code. 2677

Sec. 5166.40. (A) As used in sections 5166.40 to 5166.409 2678
of the Revised Code: 2679

(1) "Adult" means an individual who is at least eighteen 2680
years of age. 2681

(2) "Buckeye account" means a modified health savings 2682
account established under section 5166.402 of the Revised Code. 2683

(3) "Contribution" means the amounts that an individual 2684
contributes to the individual's buckeye account and are 2685
contributed to the account on the individual's behalf under 2686
divisions (C) and (D) of section 5166.402 of the Revised Code. 2687
"Contribution" does not mean the portion of an individual's 2688
buckeye account that consists of medicaid funds deposited under 2689
division (B) of section 5166.402 of the Revised Code or section 2690
5166.404 of the Revised Code. 2691

(4) "Core portion" means the portion of a healthy Ohio 2692
program participant's buckeye account that consists of the 2693
following: 2694

(a) The amount of contributions to the account; 2695

(b) The amounts awarded to the account under divisions (C) 2696
and (D) of section 5166.404 of the Revised Code. 2697

(5) "Eligible employer-sponsored health plan" has the same 2698
meaning as in section 5000A(f) (2) of the "Internal Revenue Code 2699
of 1986," 26 U.S.C. 5000A(f) (2) . 2700

(6) "Healthy Ohio program" means the medicaid waiver 2701
component established under sections 5166.40 to 5166.409 of the 2702
Revised Code under which medicaid recipients specified in 2703
division (B) of this section enroll in comprehensive health 2704
plans and contribute to buckeye accounts. 2705

(7) "Healthy Ohio program debit swipe card" means a debit 2706
swipe card issued by a managed care organization to a healthy 2707
Ohio program participant under section 5166.403 of the Revised 2708
Code. 2709

(8) "Not-for-profit organization" means an organization 2710
that is exempt from federal income taxation under section 501(a) 2711
and (c) (3) of the "Internal Revenue Code of 1986," 26 U.S.C. 2712
501(a) and (c) (3) . 2713

(9) "Ward of the state" means an individual who is a ward, 2714
as defined in section 2111.01 of the Revised Code. 2715

(10) "Workforce development activity" and "local board" 2716
have the same meanings as in section 6301.01 of the Revised 2717
Code. 2718

(B) The medicaid director shall establish a medicaid 2719
waiver component to be known as the healthy Ohio program. Each 2720
adult medicaid recipient, other than a ward of the state, 2721
determined to be eligible for medicaid on the basis of either of 2722

the following shall participate in the healthy Ohio program: 2723

(1) On the basis of being included in the category 2724
identified by the department of medicaid as covered families and 2725
children; 2726

(2) On the basis of being included in the expansion 2727
eligibility group. 2728

(C) Except as provided in section 5166.406 of the Revised 2729
Code, a healthy Ohio program participant shall not receive 2730
medicaid services under the fee-for-service component of 2731
~~medicaid or participate in the care management system.~~ 2732

Sec. 5166.405. (A) A healthy Ohio program participant's 2733
participation in the program shall cease if any of the following 2734
applies: 2735

(1) Unless the participant is pregnant, a monthly 2736
installment payment to the participant's buckeye account is 2737
sixty days late. 2738

(2) The participant fails to submit documentation needed 2739
for a redetermination of the participant's eligibility for 2740
medicaid before the sixty-first day after the documentation is 2741
requested. 2742

(3) The participant becomes eligible for medicaid on a 2743
basis other than being included in the category identified by 2744
the department of medicaid as covered families and children or 2745
being included in the expansion eligibility group. 2746

(4) The participant becomes a ward of the state. 2747

(5) The participant ceases to be eligible for medicaid. 2748

(6) The participant exhausts the annual or lifetime payout 2749

limit specified in division (D) of section 5166.401 of the 2750
Revised Code. 2751

(7) The participant requests that the participant's 2752
participation be terminated. 2753

(B) A healthy Ohio program participant who ceases to 2754
participate in the program under division (A) (1) or (2) of this 2755
section may not resume participation until the former 2756
participant pays the full amount of the monthly installment 2757
payment or submits the documentation needed for the former 2758
participant's medicaid eligibility redetermination. The former 2759
participant shall not be transferred to the fee-for-service 2760
component of medicaid ~~or the care management system~~ as a result 2761
of ceasing to participate in the healthy Ohio program under 2762
division (A) (1) or (2) of this section. 2763

(C) Except as provided in section 5166.407 of the Revised 2764
Code, a healthy Ohio program participant who ceases to 2765
participate in the program shall be provided the contributions 2766
that are in the participant's buckeye account at the time the 2767
participant ceases participation. 2768

Sec. 5166.406. If a healthy Ohio program participant 2769
exhausts the annual or lifetime payout limits specified in 2770
division (D) of section 5166.401 of the Revised Code, the 2771
participant shall be transferred to the fee-for-service 2772
component of medicaid ~~or the care management system~~. A 2773
participant who exhausts the annual payout limit for a year 2774
shall resume participation in the healthy Ohio program at the 2775
beginning of the immediately following year if division (B) of 2776
section 5166.40 of the Revised Code continues to apply to the 2777
participant. 2778

Sec. 5168.75. As used in sections 5168.75 to 5168.86 of 2779
the Revised Code: 2780

(A) "Basic health care services" means all of the services 2781
listed in division (A)(1) of section 1751.01 of the Revised 2782
Code. 2783

~~(B) "Care management system" has the same meaning as in~~ 2784
~~section 5167.01 of the Revised Code.~~ 2785

~~(C)~~ "Dual eligible individual" has the same meaning as in 2786
section 5160.01 of the Revised Code. 2787

~~(D)~~ (C) "Franchise fee" means the fee imposed on health 2788
insuring corporation plans under section 5168.76 of the Revised 2789
Code. 2790

~~(E)~~ (D) "Health insuring corporation" has the same meaning 2791
as in section 1751.01 of the Revised Code, except it does not 2792
mean a corporation that, pursuant to a policy, contract, 2793
certificate, or agreement, pays for, reimburses, or provides, 2794
delivers, arranges for, or otherwise makes available, only 2795
supplemental health care services or only specialty health care 2796
services. 2797

~~(F)~~ (E) "Health insuring corporation plan" means a policy, 2798
contract, certificate, or agreement of a health insuring 2799
corporation under which the corporation pays for, reimburses, 2800
provides, delivers, arranges for, or otherwise makes available 2801
basic health care services. "Health insuring corporation plan" 2802
does not mean any of the following: 2803

(1) A policy, contract, certificate, or agreement under 2804
which a health insuring corporation pays for, reimburses, 2805
provides, delivers, arranges for, or otherwise makes available 2806
only supplemental health care services or only specialty health 2807

care services; 2808

(2) An approved health benefits plan described in 5 U.S.C. 2809
8903 or 8903a, if imposing the franchise fee on the plan would 2810
violate 5 U.S.C. 8909(f); 2811

(3) A medicare advantage plan authorized by Part C of 2812
Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-21 et 2813
seq. 2814

~~(G)~~ (F) "Indirect guarantee percentage" means the 2815
percentage specified in section 1903(w)(4)(C)(ii) of the "Social 2816
Security Act," 42 U.S.C. 1396b(w)(4)(C)(ii), that is to be used 2817
in determining whether a health care class is indirectly held 2818
harmless for any portion of the costs of a broad-based health- 2819
care-related tax. If the indirect guarantee percentage changes 2820
during a fiscal year, the indirect guarantee percentage is the 2821
following: 2822

(1) For the part of the fiscal year before the change 2823
takes effect, the percentage in effect before the change; 2824

(2) For the part of the fiscal year beginning with the 2825
date the indirect guarantee percentage changes, the new 2826
percentage. 2827

~~(H) "Medicaid managed care organization" has the same~~ 2828
~~meaning as in section 5167.01 of the Revised Code.~~ 2829

~~(I)~~ (G) "Medicaid provider" has the same meaning as in 2830
section 5164.01 of the Revised Code. 2831

~~(J)~~ (H) "Ohio medicaid member month" means a month in which 2832
a medicaid recipient residing in this state is enrolled in a 2833
health insuring corporation plan. 2834

~~(K)~~ (I) "Other Ohio member month" means a month in which a 2835

resident of this state who is not a medicaid recipient is 2836
enrolled in a health insuring corporation plan. 2837

~~(I)~~(J) "Rate year" means the fiscal year for which a 2838
franchise fee is imposed. 2839

Sec. 5168.76. (A) For the purposes specified in section 2840
5168.85 of the Revised Code and subject to sections 5168.82, 2841
5168.83, and 5168.84 of the Revised Code, a franchise fee is 2842
hereby imposed each month beginning with July 2017 on each 2843
health insuring corporation plan. The franchise fee shall have a 2844
component based on Ohio medicaid member months and another 2845
component based on other Ohio member months. 2846

(B) The department of medicaid shall determine the amount 2847
of the monthly franchise fee to be imposed on a health insuring 2848
corporation plan under the component based on Ohio medicaid 2849
member months. The determination shall be made as part of the 2850
process of determining the annual capitated payment rates to be 2851
paid to medicaid managed care organizations under the care 2852
management system, for so long as the department continues that 2853
system. The following rates shall be used as part of the 2854
determination: 2855
2856

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 2857
on a health insuring corporation plan under the component based 2858
on other Ohio member months shall be determined by multiplying 2859
the number of other Ohio member months that the health insuring 2860
corporation plan had for the month by the applicable rate or 2861
rates. The applicable rate or rates to be used in the 2862
calculation for a health insuring corporation plan for a month 2863
shall depend on the cumulative total number of other Ohio member 2864
months the health insuring corporation plan had for all of a 2865
rate year's months that ended before the beginning of the month 2866
in which the franchise fee is due. 2867

The following table shows the applicable rate or rates: 2868
2869

	1	2	
A	CUMULATIVE TOTAL NUMBER OF OTHER OHIO APPLICABLE RATE MEMBER MONTHS		
B	For the first 150,000	\$2	
C	For 150,001 and above	\$1	
			2870

Sec. 5739.01. As used in this chapter: 2871

(A) "Person" includes individuals, receivers, assignees, 2872
trustees in bankruptcy, estates, firms, partnerships, 2873
associations, joint-stock companies, joint ventures, clubs, 2874
societies, corporations, the state and its political 2875
subdivisions, and combinations of individuals of any form. 2876

(B) "Sale" and "selling" include all of the following 2877
transactions for a consideration in any manner, whether 2878

absolutely or conditionally, whether for a price or rental, in 2879
money or by exchange, and by any means whatsoever: 2880

(1) All transactions by which title or possession, or 2881
both, of tangible personal property, is or is to be transferred, 2882
or a license to use or consume tangible personal property is or 2883
is to be granted; 2884

(2) All transactions by which lodging by a hotel is or is 2885
to be furnished to transient guests; 2886

(3) All transactions by which: 2887

(a) An item of tangible personal property is or is to be 2888
repaired, except property, the purchase of which would not be 2889
subject to the tax imposed by section 5739.02 of the Revised 2890
Code; 2891

(b) An item of tangible personal property is or is to be 2892
installed, except property, the purchase of which would not be 2893
subject to the tax imposed by section 5739.02 of the Revised 2894
Code or property that is or is to be incorporated into and will 2895
become a part of a production, transmission, transportation, or 2896
distribution system for the delivery of a public utility 2897
service; 2898

(c) The service of washing, cleaning, waxing, polishing, 2899
or painting a motor vehicle is or is to be furnished; 2900

(d) Laundry and dry cleaning services are or are to be 2901
provided; 2902

(e) Automatic data processing, computer services, or 2903
electronic information services are or are to be provided for 2904
use in business when the true object of the transaction is the 2905
receipt by the consumer of automatic data processing, computer 2906

services, or electronic information services rather than the 2907
receipt of personal or professional services to which automatic 2908
data processing, computer services, or electronic information 2909
services are incidental or supplemental. Notwithstanding any 2910
other provision of this chapter, such transactions that occur 2911
between members of an affiliated group are not sales. An 2912
"affiliated group" means two or more persons related in such a 2913
way that one person owns or controls the business operation of 2914
another member of the group. In the case of corporations with 2915
stock, one corporation owns or controls another if it owns more 2916
than fifty per cent of the other corporation's common stock with 2917
voting rights. 2918

(f) Telecommunications service, including prepaid calling 2919
service, prepaid wireless calling service, or ancillary service, 2920
is or is to be provided, but not including coin-operated 2921
telephone service; 2922

(g) Landscaping and lawn care service is or is to be 2923
provided; 2924

(h) Private investigation and security service is or is to 2925
be provided; 2926

(i) Information services or tangible personal property is 2927
provided or ordered by means of a nine hundred telephone call; 2928

(j) Building maintenance and janitorial service is or is 2929
to be provided; 2930

(k) Exterminating service is or is to be provided; 2931

(l) Physical fitness facility service is or is to be 2932
provided; 2933

(m) Recreation and sports club service is or is to be 2934

provided; 2935

(n) Satellite broadcasting service is or is to be 2936
provided; 2937

(o) Personal care service is or is to be provided to an 2938
individual. As used in this division, "personal care service" 2939
includes skin care, the application of cosmetics, manicuring, 2940
pedicuring, hair removal, tattooing, body piercing, tanning, 2941
massage, and other similar services. "Personal care service" 2942
does not include a service provided by or on the order of a 2943
licensed physician, certified nurse-midwife, clinical nurse 2944
specialist, certified nurse practitioner, or chiropractor, or 2945
the cutting, coloring, or styling of an individual's hair. 2946

(p) The transportation of persons by motor vehicle or 2947
aircraft is or is to be provided, when the transportation is 2948
entirely within this state, except for transportation provided 2949
by an ambulance service, by a transit bus, as defined in section 2950
5735.01 of the Revised Code, and transportation provided by a 2951
citizen of the United States holding a certificate of public 2952
convenience and necessity issued under 49 U.S.C. 41102; 2953

(q) Motor vehicle towing service is or is to be provided. 2954
As used in this division, "motor vehicle towing service" means 2955
the towing or conveyance of a wrecked, disabled, or illegally 2956
parked motor vehicle. 2957

(r) Snow removal service is or is to be provided. As used 2958
in this division, "snow removal service" means the removal of 2959
snow by any mechanized means, but does not include the providing 2960
of such service by a person that has less than five thousand 2961
dollars in sales of such service during the calendar year. 2962

(s) Electronic publishing service is or is to be provided 2963

to a consumer for use in business, except that such transactions 2964
occurring between members of an affiliated group, as defined in 2965
division (B) (3) (e) of this section, are not sales. 2966

(4) All transactions by which printed, imprinted, 2967
overprinted, lithographic, multilithic, blueprinted, 2968
photostatic, or other productions or reproductions of written or 2969
graphic matter are or are to be furnished or transferred; 2970

(5) The production or fabrication of tangible personal 2971
property for a consideration for consumers who furnish either 2972
directly or indirectly the materials used in the production of 2973
fabrication work; and include the furnishing, preparing, or 2974
serving for a consideration of any tangible personal property 2975
consumed on the premises of the person furnishing, preparing, or 2976
serving such tangible personal property. Except as provided in 2977
section 5739.03 of the Revised Code, a construction contract 2978
pursuant to which tangible personal property is or is to be 2979
incorporated into a structure or improvement on and becoming a 2980
part of real property is not a sale of such tangible personal 2981
property. The construction contractor is the consumer of such 2982
tangible personal property, provided that the sale and 2983
installation of carpeting, the sale and installation of 2984
agricultural land tile, the sale and erection or installation of 2985
portable grain bins, or the provision of landscaping and lawn 2986
care service and the transfer of property as part of such 2987
service is never a construction contract. 2988

As used in division (B) (5) of this section: 2989

(a) "Agricultural land tile" means fired clay or concrete 2990
tile, or flexible or rigid perforated plastic pipe or tubing, 2991
incorporated or to be incorporated into a subsurface drainage 2992
system appurtenant to land used or to be used primarily in 2993

production by farming, agriculture, horticulture, or 2994
floriculture. The term does not include such materials when they 2995
are or are to be incorporated into a drainage system appurtenant 2996
to a building or structure even if the building or structure is 2997
used or to be used in such production. 2998

(b) "Portable grain bin" means a structure that is used or 2999
to be used by a person engaged in farming or agriculture to 3000
shelter the person's grain and that is designed to be 3001
disassembled without significant damage to its component parts. 3002

(6) All transactions in which all of the shares of stock 3003
of a closely held corporation are transferred, or an ownership 3004
interest in a pass-through entity, as defined in section 5733.04 3005
of the Revised Code, is transferred, if the corporation or pass- 3006
through entity is not engaging in business and its entire assets 3007
consist of boats, planes, motor vehicles, or other tangible 3008
personal property operated primarily for the use and enjoyment 3009
of the shareholders or owners; 3010

(7) All transactions in which a warranty, maintenance or 3011
service contract, or similar agreement by which the vendor of 3012
the warranty, contract, or agreement agrees to repair or 3013
maintain the tangible personal property of the consumer is or is 3014
to be provided; 3015

(8) The transfer of copyrighted motion picture films used 3016
solely for advertising purposes, except that the transfer of 3017
such films for exhibition purposes is not a sale; 3018

(9) All transactions by which tangible personal property 3019
is or is to be stored, except such property that the consumer of 3020
the storage holds for sale in the regular course of business; 3021

(10) All transactions in which "guaranteed auto 3022

protection" is provided whereby a person promises to pay to the 3023
consumer the difference between the amount the consumer receives 3024
from motor vehicle insurance and the amount the consumer owes to 3025
a person holding title to or a lien on the consumer's motor 3026
vehicle in the event the consumer's motor vehicle suffers a 3027
total loss under the terms of the motor vehicle insurance policy 3028
or is stolen and not recovered, if the protection and its price 3029
are included in the purchase or lease agreement; 3030

(11) (a) Except as provided in division (B) (11) (b) of this 3031
section, all transactions by which health care services are paid 3032
for, reimbursed, provided, delivered, arranged for, or otherwise 3033
made available by a medicaid health insuring corporation 3034
pursuant to the corporation's contract with the state. 3035

(b) If the centers for medicare and medicaid services of 3036
the United States department of health and human services 3037
determines that the taxation of transactions described in 3038
division (B) (11) (a) of this section constitutes an impermissible 3039
health care-related tax under the "Social Security Act," section 3040
1903(w), 42 U.S.C. 1396b(w), and regulations adopted thereunder, 3041
the medicaid director shall notify the tax commissioner of that 3042
determination. Beginning with the first day of the month 3043
following that notification, the transactions described in 3044
division (B) (11) (a) of this section are not sales for the 3045
purposes of this chapter or Chapter 5741. of the Revised Code. 3046
The tax commissioner shall order that the collection of taxes 3047
under sections 5739.02, 5739.021, 5739.023, 5739.026, 5741.02, 3048
5741.021, 5741.022, and 5741.023 of the Revised Code shall cease 3049
for transactions occurring on or after that date. 3050

(12) All transactions by which a specified digital product 3051
is provided for permanent use or less than permanent use, 3052

regardless of whether continued payment is required. 3053

(13) All transactions by a delivery network company for 3054
the company's delivery network services, provided the company 3055
has a waiver issued under section 5741.072 of the Revised Code. 3056

Except as provided in this section, "sale" and "selling" 3057
do not include transfers of interest in leased property where 3058
the original lessee and the terms of the original lease 3059
agreement remain unchanged, or professional, insurance, or 3060
personal service transactions that involve the transfer of 3061
tangible personal property as an inconsequential element, for 3062
which no separate charges are made. 3063

(C) "Vendor" means the person providing the service or by 3064
whom the transfer effected or license given by a sale is or is 3065
to be made or given and, for sales described in division (B)(3) 3066
(i) of this section, the telecommunications service vendor that 3067
provides the nine hundred telephone service; if two or more 3068
persons are engaged in business at the same place of business 3069
under a single trade name in which all collections on account of 3070
sales by each are made, such persons shall constitute a single 3071
vendor. 3072

Physicians, certified nurse-midwives, clinical nurse 3073
specialists, certified nurse practitioners, dentists, hospitals, 3074
and veterinarians who are engaged in selling tangible personal 3075
property as received from others, such as eyeglasses, 3076
mouthwashes, dentifrices, or similar articles, are vendors. 3077
Veterinarians who are engaged in transferring to others for a 3078
consideration drugs, the dispensing of which does not require an 3079
order of a licensed veterinarian, physician, certified nurse- 3080
midwife, clinical nurse specialist, or certified nurse 3081
practitioner under federal law, are vendors. 3082

The operator of any peer-to-peer car sharing program shall 3083
be considered to be the vendor. 3084

(D) (1) "Consumer" means the person for whom the service is 3085
provided, to whom the transfer effected or license given by a 3086
sale is or is to be made or given, to whom the service described 3087
in division (B) (3) (f) or (i) of this section is charged, or to 3088
whom the admission is granted. 3089

(2) Physicians, certified nurse-midwives, clinical nurse 3090
specialists, certified nurse practitioners, dentists, hospitals, 3091
and blood banks operated by nonprofit institutions and persons 3092
licensed to practice veterinary medicine, surgery, and dentistry 3093
are consumers of all tangible personal property and services 3094
purchased by them in connection with the practice of medicine, 3095
dentistry, the rendition of hospital or blood bank service, or 3096
the practice of veterinary medicine, surgery, and dentistry. In 3097
addition to being consumers of drugs administered by them or by 3098
their assistants according to their direction, veterinarians 3099
also are consumers of drugs that under federal law may be 3100
dispensed only by or upon the order of a licensed veterinarian, 3101
physician, certified nurse-midwife, clinical nurse specialist, 3102
or certified nurse practitioner, when transferred by them to 3103
others for a consideration to provide treatment to animals as 3104
directed by the veterinarian. 3105

(3) A person who performs a facility management, or 3106
similar service contract for a contractee is a consumer of all 3107
tangible personal property and services purchased for use in 3108
connection with the performance of such contract, regardless of 3109
whether title to any such property vests in the contractee. The 3110
purchase of such property and services is not subject to the 3111
exception for resale under division (E) of this section. 3112

(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. 3143

(7) In the case of a transaction for health care services 3144
under division (B) (11) of this section, a medicaid health 3145
insuring corporation is the consumer of such services. The 3146
purchase of such services by a medicaid health insuring 3147
corporation is not subject to the exception for resale under 3148
division (E) of this section or to the exemptions provided under 3149
divisions (B) (12), (18), (19), and (22) of section 5739.02 of 3150
the Revised Code. 3151

(E) "Retail sale" and "sales at retail" include all sales, 3152
except those in which the purpose of the consumer is to resell 3153
the thing transferred or benefit of the service provided, by a 3154
person engaging in business, in the form in which the same is, 3155
or is to be, received by the person. 3156

(F) "Business" includes any activity engaged in by any 3157
person with the object of gain, benefit, or advantage, either 3158
direct or indirect. "Business" does not include the activity of 3159
a person in managing and investing the person's own funds. 3160

(G) "Engaging in business" means commencing, conducting, 3161
or continuing in business, and liquidating a business when the 3162
liquidator thereof holds itself out to the public as conducting 3163
such business. Making a casual sale is not engaging in business. 3164

(H) (1) (a) "Price," except as provided in divisions (H) (2), 3165
(3), and (4) of this section, means the total amount of 3166
consideration, including cash, credit, property, and services, 3167
for which tangible personal property or services are sold, 3168
leased, or rented, valued in money, whether received in money or 3169
otherwise, without any deduction for any of the following: 3170

(i) The vendor's cost of the property sold; 3171

(ii) The cost of materials used, labor or service costs, 3172
interest, losses, all costs of transportation to the vendor, all 3173
taxes imposed on the vendor, including the tax imposed under 3174
Chapter 5751. of the Revised Code, and any other expense of the 3175
vendor; 3176

(iii) Charges by the vendor for any services necessary to 3177
complete the sale; 3178

(iv) Delivery charges. As used in this division, "delivery 3179
charges" means charges by the vendor for preparation and 3180
delivery to a location designated by the consumer of tangible 3181
personal property or a service, including transportation, 3182
shipping, postage, handling, crating, and packing. 3183

(v) Installation charges; 3184

(vi) Credit for any trade-in. 3185

(b) "Price" includes consideration received by the vendor 3186
from a third party, if the vendor actually receives the 3187
consideration from a party other than the consumer, and the 3188
consideration is directly related to a price reduction or 3189
discount on the sale; the vendor has an obligation to pass the 3190
price reduction or discount through to the consumer; the amount 3191
of the consideration attributable to the sale is fixed and 3192
determinable by the vendor at the time of the sale of the item 3193
to the consumer; and one of the following criteria is met: 3194

(i) The consumer presents a coupon, certificate, or other 3195
document to the vendor to claim a price reduction or discount 3196
where the coupon, certificate, or document is authorized, 3197
distributed, or granted by a third party with the understanding 3198
that the third party will reimburse any vendor to whom the 3199
coupon, certificate, or document is presented; 3200

(ii) The consumer identifies the consumer's self to the 3201
seller as a member of a group or organization entitled to a 3202
price reduction or discount. A preferred customer card that is 3203
available to any patron does not constitute membership in such a 3204
group or organization. 3205

(iii) The price reduction or discount is identified as a 3206
third party price reduction or discount on the invoice received 3207
by the consumer, or on a coupon, certificate, or other document 3208
presented by the consumer. 3209

(c) "Price" does not include any of the following: 3210

(i) Discounts, including cash, term, or coupons that are 3211
not reimbursed by a third party that are allowed by a vendor and 3212
taken by a consumer on a sale; 3213

(ii) Interest, financing, and carrying charges from credit 3214
extended on the sale of tangible personal property or services, 3215
if the amount is separately stated on the invoice, bill of sale, 3216
or similar document given to the purchaser; 3217

(iii) Any taxes legally imposed directly on the consumer 3218
that are separately stated on the invoice, bill of sale, or 3219
similar document given to the consumer. For the purpose of this 3220
division, the tax imposed under Chapter 5751. of the Revised 3221
Code is not a tax directly on the consumer, even if the tax or a 3222
portion thereof is separately stated. 3223

(iv) Notwithstanding divisions (H) (1) (b) (i) to (iii) of 3224
this section, any discount allowed by an automobile manufacturer 3225
to its employee, or to the employee of a supplier, on the 3226
purchase of a new motor vehicle from a new motor vehicle dealer 3227
in this state. 3228

(v) The dollar value of a gift card that is not sold by a 3229

vendor or purchased by a consumer and that is redeemed by the 3230
consumer in purchasing tangible personal property or services if 3231
the vendor is not reimbursed and does not receive compensation 3232
from a third party to cover all or part of the gift card value. 3233
For the purposes of this division, a gift card is not sold by a 3234
vendor or purchased by a consumer if it is distributed pursuant 3235
to an awards, loyalty, or promotional program. Past and present 3236
purchases of tangible personal property or services by the 3237
consumer shall not be treated as consideration exchanged for a 3238
gift card. 3239

(2) In the case of a sale of any new motor vehicle by a 3240
new motor vehicle dealer, as defined in section 4517.01 of the 3241
Revised Code, in which another motor vehicle is accepted by the 3242
dealer as part of the consideration received, "price" has the 3243
same meaning as in division (H)(1) of this section, reduced by 3244
the credit afforded the consumer by the dealer for the motor 3245
vehicle received in trade. 3246

(3) In the case of a sale of any watercraft or outboard 3247
motor by a watercraft dealer licensed in accordance with section 3248
1547.543 of the Revised Code, in which another watercraft, 3249
watercraft and trailer, or outboard motor is accepted by the 3250
dealer as part of the consideration received, "price" has the 3251
same meaning as in division (H)(1) of this section, reduced by 3252
the credit afforded the consumer by the dealer for the 3253
watercraft, watercraft and trailer, or outboard motor received 3254
in trade. As used in this division, "watercraft" includes an 3255
outdrive unit attached to the watercraft. 3256

(4) In the case of transactions for health care services 3257
under division (B)(11) of this section, "price" means the amount 3258
of managed care premiums received each month by a medicaid 3259

health insuring corporation. 3260

(I) "Receipts" means the total amount of the prices of the 3261
sales of vendors, provided that the dollar value of gift cards 3262
distributed pursuant to an awards, loyalty, or promotional 3263
program, and cash discounts allowed and taken on sales at the 3264
time they are consummated are not included, minus any amount 3265
deducted as a bad debt pursuant to section 5739.121 of the 3266
Revised Code. "Receipts" does not include the sale price of 3267
property returned or services rejected by consumers when the 3268
full sale price and tax are refunded either in cash or by 3269
credit. 3270

(J) "Place of business" means any location at which a 3271
person engages in business. 3272

(K) "Premises" includes any real property or portion 3273
thereof upon which any person engages in selling tangible 3274
personal property at retail or making retail sales and also 3275
includes any real property or portion thereof designated for, or 3276
devoted to, use in conjunction with the business engaged in by 3277
such person. 3278

(L) "Casual sale" means a sale of an item of tangible 3279
personal property, in person or online, that was obtained by the 3280
person making the sale, through purchase or otherwise, for the 3281
person's own use and was previously subject to any state's 3282
taxing jurisdiction on its sale or use, and includes such items 3283
acquired for the seller's use that are sold by an auctioneer 3284
employed directly by the person for such purpose, provided the 3285
location of such sales is not the auctioneer's physical 3286
permanent place of business. As used in this division, 3287
"permanent place of business" includes any physical location 3288
where such auctioneer has conducted more than two auctions 3289

during the year. 3290

(M) "Hotel" means every establishment kept, used, 3291
maintained, advertised, or held out to the public to be a place 3292
where sleeping accommodations are offered to guests, in which 3293
five or more rooms are used for the accommodation of such 3294
guests, whether the rooms are in one or several structures, 3295
except as otherwise provided in section 5739.091 of the Revised 3296
Code. 3297

(N) "Transient guests" means persons occupying a room or 3298
rooms for sleeping accommodations for less than thirty 3299
consecutive days. 3300

(O) "Making retail sales" means the effecting of 3301
transactions wherein one party is obligated to pay the price and 3302
the other party is obligated to provide a service or to transfer 3303
title to or possession of the item sold. "Making retail sales" 3304
does not include the preliminary acts of promoting or soliciting 3305
the retail sales, other than the distribution of printed matter 3306
which displays or describes and prices the item offered for 3307
sale, nor does it include delivery of a predetermined quantity 3308
of tangible personal property or transportation of property or 3309
personnel to or from a place where a service is performed. 3310

(P) "Used directly in the rendition of a public utility 3311
service" means that property that is to be incorporated into and 3312
will become a part of the consumer's production, transmission, 3313
transportation, or distribution system and that retains its 3314
classification as tangible personal property after such 3315
incorporation; fuel or power used in the production, 3316
transmission, transportation, or distribution system; and 3317
tangible personal property used in the repair and maintenance of 3318
the production, transmission, transportation, or distribution 3319

system, including only such motor vehicles as are specially 3320
designed and equipped for such use. Tangible personal property 3321
and services used primarily in providing highway transportation 3322
for hire are not used directly in the rendition of a public 3323
utility service. In this definition, "public utility" includes a 3324
citizen of the United States holding, and required to hold, a 3325
certificate of public convenience and necessity issued under 49 3326
U.S.C. 41102. 3327

(Q) "Refining" means removing or separating a desirable 3328
product from raw or contaminated materials by distillation or 3329
physical, mechanical, or chemical processes. 3330

(R) "Assembly" and "assembling" mean attaching or fitting 3331
together parts to form a product, but do not include packaging a 3332
product. 3333

(S) "Manufacturing operation" means a process in which 3334
materials are changed, converted, or transformed into a 3335
different state or form from which they previously existed and 3336
includes refining materials, assembling parts, and preparing raw 3337
materials and parts by mixing, measuring, blending, or otherwise 3338
committing such materials or parts to the manufacturing process. 3339
"Manufacturing operation" does not include packaging. 3340

(T) "Fiscal officer" means, with respect to a regional 3341
transit authority, the secretary-treasurer thereof, and with 3342
respect to a county that is a transit authority, the fiscal 3343
officer of the county transit board if one is appointed pursuant 3344
to section 306.03 of the Revised Code or the county auditor if 3345
the board of county commissioners operates the county transit 3346
system. 3347

(U) "Transit authority" means a regional transit authority 3348

created pursuant to section 306.31 of the Revised Code or a 3349
county in which a county transit system is created pursuant to 3350
section 306.01 of the Revised Code. For the purposes of this 3351
chapter, a transit authority must extend to at least the entire 3352
area of a single county. A transit authority that includes 3353
territory in more than one county must include all the area of 3354
the most populous county that is a part of such transit 3355
authority. County population shall be measured by the most 3356
recent census taken by the United States census bureau. 3357

(V) "Legislative authority" means, with respect to a 3358
regional transit authority, the board of trustees thereof, and 3359
with respect to a county that is a transit authority, the board 3360
of county commissioners. 3361

(W) "Territory of the transit authority" means all of the 3362
area included within the territorial boundaries of a transit 3363
authority as they from time to time exist. Such territorial 3364
boundaries must at all times include all the area of a single 3365
county or all the area of the most populous county that is a 3366
part of such transit authority. County population shall be 3367
measured by the most recent census taken by the United States 3368
census bureau. 3369

(X) "Providing a service" means providing or furnishing 3370
anything described in division (B) (3) of this section for 3371
consideration. 3372

(Y) (1) (a) "Automatic data processing" means processing of 3373
others' data, including keypunching or similar data entry 3374
services together with verification thereof, or providing access 3375
to computer equipment for the purpose of processing data. 3376

(b) "Computer services" means providing services 3377

consisting of specifying computer hardware configurations and 3378
evaluating technical processing characteristics, computer 3379
programming, and training of computer programmers and operators, 3380
provided in conjunction with and to support the sale, lease, or 3381
operation of taxable computer equipment or systems. 3382

(c) "Electronic information services" means providing 3383
access to computer equipment by means of telecommunications 3384
equipment for the purpose of either of the following: 3385

(i) Examining or acquiring data stored in or accessible to 3386
the computer equipment; 3387

(ii) Placing data into the computer equipment to be 3388
retrieved by designated recipients with access to the computer 3389
equipment. 3390

"Electronic information services" does not include 3391
electronic publishing. 3392

(d) "Automatic data processing, computer services, or 3393
electronic information services" shall not include personal or 3394
professional services. 3395

(2) As used in divisions (B) (3) (e) and (Y) (1) of this 3396
section, "personal and professional services" means all services 3397
other than automatic data processing, computer services, or 3398
electronic information services, including but not limited to: 3399

(a) Accounting and legal services such as advice on tax 3400
matters, asset management, budgetary matters, quality control, 3401
information security, and auditing and any other situation where 3402
the service provider receives data or information and studies, 3403
alters, analyzes, interprets, or adjusts such material; 3404

(b) Analyzing business policies and procedures; 3405

(c) Identifying management information needs;	3406
(d) Feasibility studies, including economic and technical analysis of existing or potential computer hardware or software needs and alternatives;	3407 3408 3409
(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;	3410 3411 3412 3413 3414
(f) Developing policies and procedures that document how business events and transactions are to be authorized, executed, and controlled;	3415 3416 3417
(g) Testing of business procedures;	3418
(h) Training personnel in business procedure applications;	3419
(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;	3420 3421 3422 3423 3424 3425 3426
(j) Providing debt collection services by any oral, written, graphic, or electronic means;	3427 3428
(k) Providing digital advertising services;	3429
(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	3430 3431 3432 3433

such individual income tax to such an entity. For the purpose of 3434
this division, "individual income tax" does not include federal, 3435
state, or local taxes withheld by an employer from an employee's 3436
compensation. 3437

The services listed in divisions (Y) (2) (a) to (l) of this 3438
section are not automatic data processing or computer services. 3439

(Z) "Highway transportation for hire" means the 3440
transportation of personal property belonging to others for 3441
consideration by any of the following: 3442

(1) The holder of a permit or certificate issued by this 3443
state or the United States authorizing the holder to engage in 3444
transportation of personal property belonging to others for 3445
consideration over or on highways, roadways, streets, or any 3446
similar public thoroughfare; 3447

(2) A person who engages in the transportation of personal 3448
property belonging to others for consideration over or on 3449
highways, roadways, streets, or any similar public thoroughfare 3450
but who could not have engaged in such transportation on 3451
December 11, 1985, unless the person was the holder of a permit 3452
or certificate of the types described in division (Z) (1) of this 3453
section; 3454

(3) A person who leases a motor vehicle to and operates it 3455
for a person described by division (Z) (1) or (2) of this 3456
section. 3457

"Highway transportation for hire" does not include 3458
delivery network services. 3459

(AA) (1) "Telecommunications service" means the electronic 3460
transmission, conveyance, or routing of voice, data, audio, 3461
video, or any other information or signals to a point, or 3462

between or among points. "Telecommunications service" includes 3463
such transmission, conveyance, or routing in which computer 3464
processing applications are used to act on the form, code, or 3465
protocol of the content for purposes of transmission, 3466
conveyance, or routing without regard to whether the service is 3467
referred to as voice-over internet protocol service or is 3468
classified by the federal communications commission as enhanced 3469
or value-added. "Telecommunications service" does not include 3470
any of the following: 3471

(a) Data processing and information services that allow 3472
data to be generated, acquired, stored, processed, or retrieved 3473
and delivered by an electronic transmission to a consumer where 3474
the consumer's primary purpose for the underlying transaction is 3475
the processed data or information; 3476

(b) Installation or maintenance of wiring or equipment on 3477
a customer's premises; 3478

(c) Tangible personal property; 3479

(d) Advertising, including directory advertising; 3480

(e) Billing and collection services provided to third 3481
parties; 3482

(f) Internet access service; 3483

(g) Radio and television audio and video programming 3484
services, regardless of the medium, including the furnishing of 3485
transmission, conveyance, and routing of such services by the 3486
programming service provider. Radio and television audio and 3487
video programming services include, but are not limited to, 3488
cable service, as defined in 47 U.S.C. 522(6), and audio and 3489
video programming services delivered by commercial mobile radio 3490
service providers, as defined in 47 C.F.R. 20.3; 3491

(h) Ancillary service;	3492
(i) Digital products delivered electronically, including	3493
software, music, video, reading materials, or ring tones.	3494
(2) "Ancillary service" means a service that is associated	3495
with or incidental to the provision of telecommunications	3496
service, including conference bridging service, detailed	3497
telecommunications billing service, directory assistance,	3498
vertical service, and voice mail service. As used in this	3499
division:	3500
(a) "Conference bridging service" means an ancillary	3501
service that links two or more participants of an audio or video	3502
conference call, including providing a telephone number.	3503
"Conference bridging service" does not include	3504
telecommunications services used to reach the conference bridge.	3505
(b) "Detailed telecommunications billing service" means an	3506
ancillary service of separately stating information pertaining	3507
to individual calls on a customer's billing statement.	3508
(c) "Directory assistance" means an ancillary service of	3509
providing telephone number or address information.	3510
(d) "Vertical service" means an ancillary service that is	3511
offered in connection with one or more telecommunications	3512
services, which offers advanced calling features that allow	3513
customers to identify callers and manage multiple calls and call	3514
connections, including conference bridging service.	3515
(e) "Voice mail service" means an ancillary service that	3516
enables the customer to store, send, or receive recorded	3517
messages. "Voice mail service" does not include any vertical	3518
services that the customer may be required to have in order to	3519
utilize the voice mail service.	3520

(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 3551
telecommunications service paid for by inserting money into a 3552
telephone accepting direct deposits of money to operate. 3553

(8) "Customer" has the same meaning as in section 5739.034 3554
of the Revised Code. 3555

(BB) "Laundry and dry cleaning services" means removing 3556
soil or dirt from towels, linens, articles of clothing, or other 3557
fabric items that belong to others and supplying towels, linens, 3558
articles of clothing, or other fabric items. "Laundry and dry 3559
cleaning services" does not include the provision of self- 3560
service facilities for use by consumers to remove soil or dirt 3561
from towels, linens, articles of clothing, or other fabric 3562
items. 3563

(CC) "Magazines distributed as controlled circulation 3564
publications" means magazines containing at least twenty-four 3565
pages, at least twenty-five per cent editorial content, issued 3566
at regular intervals four or more times a year, and circulated 3567
without charge to the recipient, provided that such magazines 3568
are not owned or controlled by individuals or business concerns 3569
which conduct such publications as an auxiliary to, and 3570
essentially for the advancement of the main business or calling 3571
of, those who own or control them. 3572

(DD) "Landscaping and lawn care service" means the 3573
services of planting, seeding, sodding, removing, cutting, 3574
trimming, pruning, mulching, aerating, applying chemicals, 3575
watering, fertilizing, and providing similar services to 3576
establish, promote, or control the growth of trees, shrubs, 3577
flowers, grass, ground cover, and other flora, or otherwise 3578
maintaining a lawn or landscape grown or maintained by the owner 3579
for ornamentation or other nonagricultural purpose. However, 3580

"landscaping and lawn care service" does not include the 3581
providing of such services by a person who has less than five 3582
thousand dollars in sales of such services during the calendar 3583
year. 3584

(EE) "Private investigation and security service" means 3585
the performance of any activity for which the provider of such 3586
service is required to be licensed pursuant to Chapter 4749. of 3587
the Revised Code, or would be required to be so licensed in 3588
performing such services in this state, and also includes the 3589
services of conducting polygraph examinations and of monitoring 3590
or overseeing the activities on or in, or the condition of, the 3591
consumer's home, business, or other facility by means of 3592
electronic or similar monitoring devices. "Private investigation 3593
and security service" does not include special duty services 3594
provided by off-duty police officers, deputy sheriffs, and other 3595
peace officers regularly employed by the state or a political 3596
subdivision. 3597

(FF) "Information services" means providing conversation, 3598
giving consultation or advice, playing or making a voice or 3599
other recording, making or keeping a record of the number of 3600
callers, and any other service provided to a consumer by means 3601
of a nine hundred telephone call, except when the nine hundred 3602
telephone call is the means by which the consumer makes a 3603
contribution to a recognized charity. 3604

(GG) "Research and development" means designing, creating, 3605
or formulating new or enhanced products, equipment, or 3606
manufacturing processes, and also means conducting scientific or 3607
technological inquiry and experimentation in the physical 3608
sciences with the goal of increasing scientific knowledge which 3609
may reveal the bases for new or enhanced products, equipment, or 3610

manufacturing processes. 3611

(HH) "Qualified research and development equipment" means 3612
either of the following: 3613

(1) Capitalized tangible personal property, and leased 3614
personal property that would be capitalized if purchased, used 3615
by a person primarily to perform research and development; 3616

(2) Any tangible personal property used by a megaproject 3617
operator primarily to perform research and development at the 3618
site of a megaproject that satisfies the criteria described in 3619
division (A) (11) (a) (ii) of section 122.17 of the Revised Code 3620
during the period that the megaproject operator has an agreement 3621
for such megaproject with the tax credit authority under 3622
division (D) of that section that remains in effect and has not 3623
expired or been terminated. 3624

"Qualified research and development equipment" does not 3625
include tangible personal property primarily used in testing, as 3626
defined in division (A) (4) of section 5739.011 of the Revised 3627
Code, or used for recording or storing test results, unless such 3628
property is primarily used by the consumer in testing the 3629
product, equipment, or manufacturing process being created, 3630
designed, or formulated by the consumer in the research and 3631
development activity or in recording or storing such test 3632
results. 3633

(II) "Building maintenance and janitorial service" means 3634
cleaning the interior or exterior of a building and any tangible 3635
personal property located therein or thereon, including any 3636
services incidental to such cleaning for which no separate 3637
charge is made. However, "building maintenance and janitorial 3638
service" does not include the providing of such service by a 3639

person who has less than five thousand dollars in sales of such 3640
service during the calendar year. As used in this division, 3641
"cleaning" does not include sanitation services necessary for an 3642
establishment described in 21 U.S.C. 608 to comply with rules 3643
and regulations adopted pursuant to that section. 3644

(JJ) "Exterminating service" means eradicating or 3645
attempting to eradicate vermin infestations from a building or 3646
structure, or the area surrounding a building or structure, and 3647
includes activities to inspect, detect, or prevent vermin 3648
infestation of a building or structure. 3649

(KK) "Physical fitness facility service" means all 3650
transactions by which a membership is granted, maintained, or 3651
renewed, including initiation fees, membership dues, renewal 3652
fees, monthly minimum fees, and other similar fees and dues, by 3653
a physical fitness facility such as an athletic club, health 3654
spa, or gymnasium, which entitles the member to use the facility 3655
for physical exercise. 3656

(LL) "Recreation and sports club service" means all 3657
transactions by which a membership is granted, maintained, or 3658
renewed, including initiation fees, membership dues, renewal 3659
fees, monthly minimum fees, and other similar fees and dues, by 3660
a recreation and sports club, which entitles the member to use 3661
the facilities of the organization. "Recreation and sports club" 3662
means an organization that has ownership of, or controls or 3663
leases on a continuing, long-term basis, the facilities used by 3664
its members and includes an aviation club, gun or shooting club, 3665
yacht club, card club, swimming club, tennis club, golf club, 3666
country club, riding club, amateur sports club, or similar 3667
organization. 3668

(MM) "Livestock" means farm animals commonly raised for 3669

food, food production, or other agricultural purposes, 3670
including, but not limited to, cattle, sheep, goats, swine, 3671
poultry, and captive deer. "Livestock" does not include 3672
invertebrates, amphibians, reptiles, domestic pets, animals for 3673
use in laboratories or for exhibition, or other animals not 3674
commonly raised for food or food production. 3675

(NN) "Livestock structure" means a building or structure 3676
used exclusively for the housing, raising, feeding, or 3677
sheltering of livestock, and includes feed storage or handling 3678
structures and structures for livestock waste handling. 3679

(OO) "Horticulture" means the growing, cultivation, and 3680
production of flowers, fruits, herbs, vegetables, sod, 3681
mushrooms, and nursery stock. As used in this division, "nursery 3682
stock" has the same meaning as in section 927.51 of the Revised 3683
Code. 3684

(PP) "Horticulture structure" means a building or 3685
structure used exclusively for the commercial growing, raising, 3686
or overwintering of horticultural products, and includes the 3687
area used for stocking, storing, and packing horticultural 3688
products when done in conjunction with the production of those 3689
products. 3690

(QQ) "Newspaper" means an unbound publication bearing a 3691
title or name that is regularly published, at least as 3692
frequently as biweekly, and distributed from a fixed place of 3693
business to the public in a specific geographic area, and that 3694
contains a substantial amount of news matter of international, 3695
national, or local events of interest to the general public. 3696

(RR) (1) "Feminine hygiene products" means tampons, panty 3697
liners, menstrual cups, sanitary napkins, and other similar 3698

tangible personal property designed for feminine hygiene in 3699
connection with the human menstrual cycle, but does not include 3700
grooming and hygiene products. 3701

(2) "Grooming and hygiene products" means soaps and 3702
cleaning solutions, shampoo, toothpaste, mouthwash, 3703
antiperspirants, and sun tan lotions and screens, regardless of 3704
whether any of these products are over-the-counter drugs. 3705

(3) "Over-the-counter drugs" means a drug that contains a 3706
label that identifies the product as a drug as required by 21 3707
C.F.R. 201.66, which label includes a drug facts panel or a 3708
statement of the active ingredients with a list of those 3709
ingredients contained in the compound, substance, or 3710
preparation. 3711

(SS) (1) "Lease" or "rental" means any transfer of the 3712
possession or control of tangible personal property for a fixed 3713
or indefinite term, for consideration. "Lease" or "rental" 3714
includes future options to purchase or extend, and agreements 3715
described in 26 U.S.C. 7701(h) (1) covering motor vehicles and 3716
trailers where the amount of consideration may be increased or 3717
decreased by reference to the amount realized upon the sale or 3718
disposition of the property. "Lease" or "rental" does not 3719
include: 3720

(a) A transfer of possession or control of tangible 3721
personal property under a security agreement or a deferred 3722
payment plan that requires the transfer of title upon completion 3723
of the required payments; 3724

(b) A transfer of possession or control of tangible 3725
personal property under an agreement that requires the transfer 3726
of title upon completion of required payments and payment of an 3727

option price that does not exceed the greater of one hundred 3728
dollars or one per cent of the total required payments; 3729

(c) Providing tangible personal property along with an 3730
operator for a fixed or indefinite period of time, if the 3731
operator is necessary for the property to perform as designed. 3732
For purposes of this division, the operator must do more than 3733
maintain, inspect, or set up the tangible personal property. 3734

(2) "Lease" and "rental," as defined in division (SS) of 3735
this section, shall not apply to leases or rentals that exist 3736
before June 26, 2003. 3737

(3) "Lease" and "rental" have the same meaning as in 3738
division (SS) (1) of this section regardless of whether a 3739
transaction is characterized as a lease or rental under 3740
generally accepted accounting principles, the Internal Revenue 3741
Code, Title XIII of the Revised Code, or other federal, state, 3742
or local laws. 3743

(TT) "Mobile telecommunications service" has the same 3744
meaning as in the "Mobile Telecommunications Sourcing Act," Pub. 3745
L. No. 106-252, 114 Stat. 631 (2000), 4 U.S.C.A. 124(7), as 3746
amended, and, on and after August 1, 2003, includes related fees 3747
and ancillary services, including universal service fees, 3748
detailed billing service, directory assistance, service 3749
initiation, voice mail service, and vertical services, such as 3750
caller ID and three-way calling. 3751

(UU) "Certified service provider" has the same meaning as 3752
in section 5740.01 of the Revised Code. 3753

(VV) "Satellite broadcasting service" means the 3754
distribution or broadcasting of programming or services by 3755
satellite directly to the subscriber's receiving equipment 3756

without the use of ground receiving or distribution equipment, 3757
except the subscriber's receiving equipment or equipment used in 3758
the uplink process to the satellite, and includes all service 3759
and rental charges, premium channels or other special services, 3760
installation and repair service charges, and any other charges 3761
having any connection with the provision of the satellite 3762
broadcasting service. 3763

(WW) "Tangible personal property" means personal property 3764
that can be seen, weighed, measured, felt, or touched, or that 3765
is in any other manner perceptible to the senses. For purposes 3766
of this chapter and Chapter 5741. of the Revised Code, "tangible 3767
personal property" includes motor vehicles, electricity, water, 3768
gas, steam, and prewritten computer software. 3769

(XX) "Municipal gas utility" means a municipal corporation 3770
that owns or operates a system for the distribution of natural 3771
gas. 3772

(YY) "Computer" means an electronic device that accepts 3773
information in digital or similar form and manipulates it for a 3774
result based on a sequence of instructions. 3775

(ZZ) "Computer software" means a set of coded instructions 3776
designed to cause a computer or automatic data processing 3777
equipment to perform a task. 3778

(AAA) "Delivered electronically" means delivery of 3779
computer software from the seller to the purchaser by means 3780
other than tangible storage media. 3781

(BBB) "Prewritten computer software" means computer 3782
software, including prewritten upgrades, that is not designed 3783
and developed by the author or other creator to the 3784
specifications of a specific purchaser. The combining of two or 3785

more prewritten computer software programs or prewritten 3786
portions thereof does not cause the combination to be other than 3787
prewritten computer software. "Prewritten computer software" 3788
includes software designed and developed by the author or other 3789
creator to the specifications of a specific purchaser when it is 3790
sold to a person other than the purchaser. If a person modifies 3791
or enhances computer software of which the person is not the 3792
author or creator, the person shall be deemed to be the author 3793
or creator only of such person's modifications or enhancements. 3794
Prewritten computer software or a prewritten portion thereof 3795
that is modified or enhanced to any degree, where such 3796
modification or enhancement is designed and developed to the 3797
specifications of a specific purchaser, remains prewritten 3798
computer software; provided, however, that where there is a 3799
reasonable, separately stated charge or an invoice or other 3800
statement of the price given to the purchaser for the 3801
modification or enhancement, the modification or enhancement 3802
shall not constitute prewritten computer software. 3803

(CCC) (1) "Food" means substances, whether in liquid, 3804
concentrated, solid, frozen, dried, or dehydrated form, that are 3805
sold for ingestion or chewing by humans and are consumed for 3806
their taste or nutritional value. "Food" does not include 3807
alcoholic beverages, dietary supplements, soft drinks, or 3808
tobacco. 3809

(2) As used in division (CCC) (1) of this section: 3810

(a) "Dietary supplements" means any product, other than 3811
tobacco, that is intended to supplement the diet and that is 3812
intended for ingestion in tablet, capsule, powder, softgel, 3813
gelcap, or liquid form, or, if not intended for ingestion in 3814
such a form, is not represented as conventional food for use as 3815

a sole item of a meal or of the diet; that is required to be 3816
labeled as a dietary supplement, identifiable by the "supplement 3817
facts" box found on the label, as required by 21 C.F.R. 101.36; 3818
and that contains one or more of the following dietary 3819
ingredients: 3820

(i) A vitamin; 3821

(ii) A mineral; 3822

(iii) An herb or other botanical; 3823

(iv) An amino acid; 3824

(v) A dietary substance for use by humans to supplement 3825
the diet by increasing the total dietary intake; 3826

(vi) A concentrate, metabolite, constituent, extract, or 3827
combination of any ingredient described in divisions (CCC) (2) (a) 3828
(i) to (v) of this section. 3829

(b) "Soft drinks" means nonalcoholic beverages that 3830
contain natural or artificial sweeteners. "Soft drinks" does not 3831
include beverages that contain milk or milk products, soy, rice, 3832
or similar milk substitutes, or that contains greater than fifty 3833
per cent vegetable or fruit juice by volume. 3834

(DDD) "Drug" means a compound, substance, or preparation, 3835
and any component of a compound, substance, or preparation, 3836
other than food, dietary supplements, or alcoholic beverages 3837
that is recognized in the official United States pharmacopoeia, 3838
official homeopathic pharmacopoeia of the United States, or 3839
official national formulary, and supplements to them; is 3840
intended for use in the diagnosis, cure, mitigation, treatment, 3841
or prevention of disease; or is intended to affect the structure 3842
or any function of the body. 3843

(EEE) "Prescription" means an order, formula, or recipe 3844
issued in any form of oral, written, electronic, or other means 3845
of transmission by a duly licensed practitioner authorized by 3846
the laws of this state to issue a prescription. 3847

(FFF) "Durable medical equipment" means equipment, 3848
including repair and replacement parts for such equipment, that 3849
can withstand repeated use, is primarily and customarily used to 3850
serve a medical purpose, generally is not useful to a person in 3851
the absence of illness or injury, and is not worn in or on the 3852
body. "Durable medical equipment" does not include mobility 3853
enhancing equipment. 3854

(GGG) "Mobility enhancing equipment" means equipment, 3855
including repair and replacement parts for such equipment, that 3856
is primarily and customarily used to provide or increase the 3857
ability to move from one place to another and is appropriate for 3858
use either in a home or a motor vehicle, that is not generally 3859
used by persons with normal mobility, and that does not include 3860
any motor vehicle or equipment on a motor vehicle normally 3861
provided by a motor vehicle manufacturer. "Mobility enhancing 3862
equipment" does not include durable medical equipment. 3863

(HHH) "Prosthetic device" means a replacement, corrective, 3864
or supportive device, including repair and replacement parts for 3865
the device, worn on or in the human body to artificially replace 3866
a missing portion of the body, prevent or correct physical 3867
deformity or malfunction, or support a weak or deformed portion 3868
of the body. As used in this division, before July 1, 2019, 3869
"prosthetic device" does not include corrective eyeglasses, 3870
contact lenses, or dental prosthesis. On or after July 1, 2019, 3871
"prosthetic device" does not include dental prosthesis but does 3872
include corrective eyeglasses or contact lenses. 3873

(III) (1) "Fractional aircraft ownership program" means a 3874
program in which persons within an affiliated group sell and 3875
manage fractional ownership program aircraft, provided that at 3876
least one hundred airworthy aircraft are operated in the program 3877
and the program meets all of the following criteria: 3878

(a) Management services are provided by at least one 3879
program manager within an affiliated group on behalf of the 3880
fractional owners. 3881

(b) Each program aircraft is owned or possessed by at 3882
least one fractional owner. 3883

(c) Each fractional owner owns or possesses at least a 3884
one-sixteenth interest in at least one fixed-wing program 3885
aircraft. 3886

(d) A dry-lease aircraft interchange arrangement is in 3887
effect among all of the fractional owners. 3888

(e) Multi-year program agreements are in effect regarding 3889
the fractional ownership, management services, and dry-lease 3890
aircraft interchange arrangement aspects of the program. 3891

(2) As used in division (III) (1) of this section: 3892

(a) "Affiliated group" has the same meaning as in division 3893
(B) (3) (e) of this section. 3894

(b) "Fractional owner" means a person that owns or 3895
possesses at least a one-sixteenth interest in a program 3896
aircraft and has entered into the agreements described in 3897
division (III) (1) (e) of this section. 3898

(c) "Fractional ownership program aircraft" or "program 3899
aircraft" means a turbojet aircraft that is owned or possessed 3900
by a fractional owner and that has been included in a dry-lease 3901

aircraft interchange arrangement and agreement under divisions 3902
(III) (1) (d) and (e) of this section, or an aircraft a program 3903
manager owns or possesses primarily for use in a fractional 3904
aircraft ownership program. 3905

(d) "Management services" means administrative and 3906
aviation support services furnished under a fractional aircraft 3907
ownership program in accordance with a management services 3908
agreement under division (III) (1) (e) of this section, and 3909
offered by the program manager to the fractional owners, 3910
including, at a minimum, the establishment and implementation of 3911
safety guidelines; the coordination of the scheduling of the 3912
program aircraft and crews; program aircraft maintenance; 3913
program aircraft insurance; crew training for crews employed, 3914
furnished, or contracted by the program manager or the 3915
fractional owner; the satisfaction of record-keeping 3916
requirements; and the development and use of an operations 3917
manual and a maintenance manual for the fractional aircraft 3918
ownership program. 3919

(e) "Program manager" means the person that offers 3920
management services to fractional owners pursuant to a 3921
management services agreement under division (III) (1) (e) of this 3922
section. 3923

(JJJ) "Electronic publishing" means providing access to 3924
one or more of the following primarily for business customers, 3925
including the federal government or a state government or a 3926
political subdivision thereof, to conduct research: news; 3927
business, financial, legal, consumer, or credit materials; 3928
editorials, columns, reader commentary, or features; photos or 3929
images; archival or research material; legal notices, identity 3930
verification, or public records; scientific, educational, 3931

instructional, technical, professional, trade, or other literary 3932
materials; or other similar information which has been gathered 3933
and made available by the provider to the consumer in an 3934
electronic format. Providing electronic publishing includes the 3935
functions necessary for the acquisition, formatting, editing, 3936
storage, and dissemination of data or information that is the 3937
subject of a sale. 3938

~~(KKK) "Medicaid health insuring corporation" means a~~ 3939
~~health insuring corporation that holds a certificate of~~ 3940
~~authority under Chapter 1751. of the Revised Code and is under~~ 3941
~~contract with the department of medicaid pursuant to section~~ 3942
~~5167.10 of the Revised Code.~~ 3943

~~(LLL)~~ "Managed care premium" means any premium, 3944
capitation, or other payment a medicaid health insuring 3945
corporation receives for providing or arranging for the 3946
provision of health care services to its members or enrollees 3947
residing in this state. 3948

~~(MMM)~~ (LLL) "Captive deer" means deer and other cervidae 3949
that have been legally acquired, or their offspring, that are 3950
privately owned for agricultural or farming purposes. 3951

~~(NNN)~~ (MMM) "Gift card" means a document, card, 3952
certificate, or other record, whether tangible or intangible, 3953
that may be redeemed by a consumer for a dollar value when 3954
making a purchase of tangible personal property or services. 3955

~~(OOO)~~ (NNN) "Specified digital product" means an 3956
electronically transferred digital audiovisual work, digital 3957
audio work, or digital book. 3958

As used in division ~~(OOO)~~ (NNN) of this section: 3959

(1) "Digital audiovisual work" means a series of related 3960

images that, when shown in succession, impart an impression of 3961
motion, together with accompanying sounds, if any. 3962

(2) "Digital audio work" means a work that results from 3963
the fixation of a series of musical, spoken, or other sounds, 3964
including digitized sound files that are downloaded onto a 3965
device and that may be used to alert the customer with respect 3966
to a communication. 3967

(3) "Digital book" means a work that is generally 3968
recognized in the ordinary and usual sense as a book. 3969

(4) "Electronically transferred" means obtained by the 3970
purchaser by means other than tangible storage media. 3971

~~(PPP)~~ (OOO) "Digital advertising services" means providing 3972
access, by means of telecommunications equipment, to computer 3973
equipment that is used to enter, upload, download, review, 3974
manipulate, store, add, or delete data for the purpose of 3975
electronically displaying, delivering, placing, or transferring 3976
promotional advertisements to potential customers about products 3977
or services or about industry or business brands. 3978

~~(QQQ)~~ (PPP) "Peer-to-peer car sharing program" has the same 3979
meaning as in section 4516.01 of the Revised Code. 3980

~~(RRR)~~ (QQQ) "Megaproject" and "megaproject operator" have 3981
the same meanings as in section 122.17 of the Revised Code. 3982

~~(SSS)~~ ~~(1)~~ (RRR) (1) "Diaper" means an absorbent garment worn 3983
by humans who are incapable of, or have difficulty, controlling 3984
their bladder or bowel movements. 3985

(2) "Children's diaper" means a diaper marketed to be worn 3986
by children. 3987

(3) "Adult diaper" means a diaper other than a children's 3988

diaper. 3989

~~(TTT)~~ (SSS) "Sales tax holiday" means three or more dates 3990
on which sales of all eligible tangible personal property are 3991
exempt from the taxes levied under sections 5739.02, 5739.021, 3992
5739.023, 5739.026, 5741.02, 5741.021, 5741.022, and 5741.023 of 3993
the Revised Code. 3994

~~(UUU)~~ (TTT) "Eligible tangible personal property" means any 3995
item of tangible personal property that meets both of the 3996
following requirements: 3997

(1) The price of the item does not exceed five hundred 3998
dollars; 3999

(2) The item is not a watercraft or outboard motor 4000
required to be titled pursuant to Chapter 1548. of the Revised 4001
Code, a motor vehicle, an alcoholic beverage, tobacco, a vapor 4002
product as defined in section 5743.01 of the Revised Code, or an 4003
item that contains marijuana as defined in section 3796.01 of 4004
the Revised Code. 4005

~~(VVV)~~ (UUU) "Alcoholic beverages" means beverages that are 4006
suitable for human consumption and contain one-half of one per 4007
cent or more of alcohol by volume. 4008

~~(WWW)~~ (VVV) "Tobacco" means cigarettes, cigars, chewing or 4009
pipe tobacco, or any other item that contains tobacco. 4010

~~(XXX)~~ (1) ~~(WWW)~~ (1) "Delivery network company" means a person 4011
that operates a business platform, including a web site or 4012
mobile application, to facilitate delivery network services. 4013

(2) "Delivery network courier" means an individual 4014
connected to a consumer through a delivery network company and 4015
who provides delivery network services to that consumer. 4016

(3) "Delivery network services" means both of the 4017
following when performed as part of a single transaction: 4018

(a) Pickup of a local product by a delivery network 4019
courier from a local merchant that is not under common ownership 4020
or control of the delivery network company through which the 4021
transaction was initiated, and which may include selection, 4022
collection, and purchase of the local product; 4023

(b) Delivery by the delivery network courier of that local 4024
product to a location designated by the consumer that is not 4025
more than seventy-five miles from the local merchant's place of 4026
business where the pickup described in division (XXX) (3) (a) of 4027
this section occurs. 4028

(4) "Local merchant" means a person engaged in selling 4029
local products from a temporary or fixed place of business in 4030
this state, including a kitchen, restaurant, grocery store, 4031
retail store, or convenience store. 4032

(5) "Local product" means any tangible personal property, 4033
including food, but excluding freight, mail, or a package to 4034
which postage is affixed. 4035

Sec. 5739.03. (A) Except as provided in section 5739.05 ~~or~~ 4036
~~section 5739.051~~ of the Revised Code, the tax imposed by or 4037
pursuant to section 5739.02, 5739.021, 5739.023, or 5739.026 of 4038
the Revised Code shall be paid by the consumer to the vendor, 4039
and each vendor shall collect from the consumer, as a trustee 4040
for the state of Ohio, the full and exact amount of the tax 4041
payable on each taxable sale, in the manner and at the times 4042
provided as follows: 4043

(1) If the price is, at or prior to the provision of the 4044
service or the delivery of possession of the thing sold to the 4045

consumer, paid in currency passed from hand to hand by the 4046
consumer or the consumer's agent to the vendor or the vendor's 4047
agent, the vendor or the vendor's agent shall collect the tax 4048
with and at the same time as the price; 4049

(2) If the price is otherwise paid or to be paid, the 4050
vendor or the vendor's agent shall, at or prior to the provision 4051
of the service or the delivery of possession of the thing sold 4052
to the consumer, charge the tax imposed by or pursuant to 4053
section 5739.02, 5739.021, 5739.023, or 5739.026 of the Revised 4054
Code to the account of the consumer, which amount shall be 4055
collected by the vendor from the consumer in addition to the 4056
price. Such sale shall be reported on and the amount of the tax 4057
applicable thereto shall be remitted with the return for the 4058
period in which the sale is made, and the amount of the tax 4059
shall become a legal charge in favor of the vendor and against 4060
the consumer. 4061

(B) (1) (a) If any sale is claimed to be exempt under 4062
division (E) of section 5739.01 of the Revised Code or under 4063
section 5739.02 of the Revised Code, with the exception of 4064
divisions (B) (1) to (11), (28), (48), (55), (59), or (62) of 4065
section 5739.02 of the Revised Code, the consumer must provide 4066
to the vendor, and the vendor must obtain from the consumer, a 4067
certificate specifying the reason that the sale is not legally 4068
subject to the tax. The certificate shall be in such form, and 4069
shall be provided either in a hard copy form or electronic form, 4070
as the tax commissioner prescribes. 4071

(b) A vendor that obtains a fully completed exemption 4072
certificate from a consumer is relieved of liability for 4073
collecting and remitting tax on any sale covered by that 4074
certificate. If it is determined the exemption was improperly 4075

claimed, the consumer shall be liable for any tax due on that 4076
sale under section 5739.02, 5739.021, 5739.023, or 5739.026 or 4077
Chapter 5741. of the Revised Code. Relief under this division 4078
from liability does not apply to any of the following: 4079

(i) A vendor that fraudulently fails to collect tax; 4080

(ii) A vendor that solicits consumers to participate in 4081
the unlawful claim of an exemption; 4082

(iii) A vendor that accepts an exemption certificate from 4083
a consumer that claims an exemption based on who purchases or 4084
who sells property or a service, when the subject of the 4085
transaction sought to be covered by the exemption certificate is 4086
actually received by the consumer at a location operated by the 4087
vendor in this state, and this state has posted to its web site 4088
an exemption certificate form that clearly and affirmatively 4089
indicates that the claimed exemption is not available in this 4090
state; 4091

(iv) A vendor that accepts an exemption certificate from a 4092
consumer who claims a multiple points of use exemption under 4093
division (D) of section 5739.033 of the Revised Code, if the 4094
item purchased is tangible personal property, other than 4095
prewritten computer software. 4096

(2) The vendor shall maintain records, including exemption 4097
certificates, of all sales on which a consumer has claimed an 4098
exemption, and provide them to the tax commissioner on request. 4099

(3) The tax commissioner may establish an identification 4100
system whereby the commissioner issues an identification number 4101
to a consumer that is exempt from payment of the tax. The 4102
consumer must present the number to the vendor, if any sale is 4103
claimed to be exempt as provided in this section. 4104

(4) If no certificate is provided or obtained within 4105
ninety days after the date on which such sale is consummated, it 4106
shall be presumed that the tax applies. Failure to have so 4107
provided or obtained a certificate shall not preclude a vendor, 4108
within one hundred twenty days after the tax commissioner gives 4109
written notice of intent to levy an assessment, from either 4110
establishing that the sale is not subject to the tax, or 4111
obtaining, in good faith, a fully completed exemption 4112
certificate. 4113

(5) Certificates need not be obtained nor provided where 4114
the identity of the consumer is such that the transaction is 4115
never subject to the tax imposed or where the item of tangible 4116
personal property sold or the service provided is never subject 4117
to the tax imposed, regardless of use, or when the sale is in 4118
interstate commerce. 4119

(6) If a transaction is claimed to be exempt under 4120
division (B)(13) of section 5739.02 of the Revised Code, the 4121
contractor shall obtain certification of the claimed exemption 4122
from the contractee. This certification shall be in addition to 4123
an exemption certificate provided by the contractor to the 4124
vendor. A contractee that provides a certification under this 4125
division shall be deemed to be the consumer of all items 4126
purchased by the contractor under the claim of exemption, if it 4127
is subsequently determined that the exemption is not properly 4128
claimed. The certification shall be in such form as the tax 4129
commissioner prescribes. 4130

(7) If a transaction is claimed to be exempt under 4131
division (B)(13) of section 5739.02 of the Revised Code, the 4132
person that leases a sports facility, as defined in section 4133
307.696 of the Revised Code, wholly owned by a county may 4134

provide and sign, on behalf of the county, an exemption 4135
certificate required under this section for that exemption. 4136

(C) As used in this division, "contractee" means a person 4137
who seeks to enter or enters into a contract or agreement with a 4138
contractor or vendor for the construction of real property or 4139
for the sale and installation onto real property of tangible 4140
personal property. 4141

Any contractor or vendor may request from any contractee a 4142
certification of what portion of the property to be transferred 4143
under such contract or agreement is to be incorporated into the 4144
realty and what portion will retain its status as tangible 4145
personal property after installation is completed. The 4146
contractor or vendor shall request the certification by 4147
certified mail delivered to the contractee, return receipt 4148
requested. Upon receipt of such request and prior to entering 4149
into the contract or agreement, the contractee shall provide to 4150
the contractor or vendor a certification sufficiently detailed 4151
to enable the contractor or vendor to ascertain the resulting 4152
classification of all materials purchased or fabricated by the 4153
contractor or vendor and transferred to the contractee. This 4154
requirement applies to a contractee regardless of whether the 4155
contractee holds a direct payment permit under section 5739.031 4156
of the Revised Code or provides to the contractor or vendor an 4157
exemption certificate as provided under this section. 4158

For the purposes of the taxes levied by this chapter and 4159
Chapter 5741. of the Revised Code, the contractor or vendor may 4160
in good faith rely on the contractee's certification. 4161
Notwithstanding division (B) of section 5739.01 of the Revised 4162
Code, if the tax commissioner determines that certain property 4163
certified by the contractee as tangible personal property 4164

pursuant to this division is, in fact, real property, the 4165
contractee shall be considered to be the consumer of all 4166
materials so incorporated into that real property and shall be 4167
liable for the applicable tax, and the contractor or vendor 4168
shall be excused from any liability on those materials. 4169

If a contractee fails to provide such certification upon 4170
the request of the contractor or vendor, the contractor or 4171
vendor shall comply with the provisions of this chapter and 4172
Chapter 5741. of the Revised Code without the certification. If 4173
the tax commissioner determines that such compliance has been 4174
performed in good faith and that certain property treated as 4175
tangible personal property by the contractor or vendor is, in 4176
fact, real property, the contractee shall be considered to be 4177
the consumer of all materials so incorporated into that real 4178
property and shall be liable for the applicable tax, and the 4179
construction contractor or vendor shall be excused from any 4180
liability on those materials. 4181

This division does not apply to any contract or agreement 4182
where the tax commissioner determines as a fact that a 4183
certification under this division was made solely on the 4184
decision or advice of the contractor or vendor. 4185

(D) Notwithstanding division (B) of section 5739.01 of the 4186
Revised Code, whenever the total rate of tax imposed under this 4187
chapter is increased after the date after a construction 4188
contract is entered into, the contractee shall reimburse the 4189
construction contractor for any additional tax paid on tangible 4190
property consumed or services received pursuant to the contract. 4191

(E) A vendor who files a petition for reassessment 4192
contesting the assessment of tax on sales for which the vendor 4193
obtained no valid exemption certificates and for which the 4194

vendor failed to establish that the sales were properly not 4195
subject to the tax during the one-hundred-twenty-day period 4196
allowed under division (B) of this section, may present to the 4197
tax commissioner additional evidence to prove that the sales 4198
were properly subject to a claim of exception or exemption. The 4199
vendor shall file such evidence within ninety days of the 4200
receipt by the vendor of the notice of assessment, except that, 4201
upon application and for reasonable cause, the period for 4202
submitting such evidence shall be extended thirty days. 4203

The commissioner shall consider such additional evidence 4204
in reaching the final determination on the assessment and 4205
petition for reassessment. 4206

(F) Whenever a vendor refunds the price, minus any 4207
separately stated delivery charge, of an item of tangible 4208
personal property on which the tax imposed under this chapter 4209
has been paid, the vendor shall also refund the amount of tax 4210
paid, minus the amount of tax attributable to the delivery 4211
charge. 4212

Section 2. That existing sections 126.021, 126.024, 4213
173.19, 1751.03, 3701.741, 3901.81, 3902.70, 3903.14, 3903.42, 4214
3959.01, 3963.06, 4121.50, 4729.20, 4729.49, 4729.80, 4729.84, 4215
4729.86, 5160.01, 5160.34, 5160.37, 5160.371, 5160.40, 5162.01, 4216
5162.021, 5162.13, 5162.1310, 5162.73, 5164.01, 5164.38, 4217
5164.46, 5164.74, 5164.751, 5166.01, 5166.40, 5166.405, 4218
5166.406, 5168.75, 5168.76, 5739.01, and 5739.03 of the Revised 4219
Code are hereby repealed. 4220

Section 3. That sections 1751.271, 3901.815, 3903.421, 4221
5164.741, 5167.01, 5167.02, 5167.03, 5167.031, 5167.04, 5167.05, 4222
5167.051, 5167.09, 5167.10, 5167.101, 5167.103, 5167.11, 4223
5167.12, 5167.122, 5167.123, 5167.13, 5167.14, 5167.15, 5167.16, 4224

5167.17, 5167.171, 5167.173, 5167.18, 5167.20, 5167.201, 4225
5167.21, 5167.22, 5167.221, 5167.24, 5167.241, 5167.243, 4226
5167.244, 5167.245, 5167.26, 5167.30, 5167.31, 5167.32, 5167.33, 4227
5167.34, 5167.35, 5167.40, 5167.41, 5167.45, 5167.47, and 4228
5739.051 of the Revised Code are hereby repealed. 4229

Section 4. This act shall be known as the Medicaid Savings 4230
Act. 4231