

As Introduced

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

H. B. No. 336

Representatives Lipps, West

A BILL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

pharmacy audit. 106

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

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

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

(a) Two hundred fifty prescriptions; 119

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

covered individual if left untreated. 188

~~(B) "Covered person," "health benefit plan," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.~~ 189
190
191

~~(C) "Stage four advanced metastatic cancer" means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.~~ 192
193
194
195

Sec. 3902.70. As used in this section and section 3902.71 of the Revised Code: 196
197

(A) "340B covered entity" and "third-party administrator" have the same meanings as in section 5167.01 of the Revised Code. 198
199
200

~~(B) "Health plan issuer" has the same meaning as in section 3922.01 of the Revised Code.~~ 201
202

~~(C) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.~~ 203
204

Sec. 3902.72. As used in sections 3902.72 to 3902.77 of the Revised Code: 205
206

(A) "Affiliated pharmacy" means a pharmacy in which a health plan issuer, either directly or indirectly through one or more intermediaries, has an investment or ownership interest or with which it shares common ownership. 207
208
209
210

(B) "Dispensing physician" means a physician who dispenses a "dangerous drug" as that term is defined in section 4729.01 of the Revised Code. 211
212
213

(C) Notwithstanding section 3902.50 of the Revised Code, 214

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

national drug shortage that has been reported to the United 329
States food and drug administration. 330

(B) A health plan issuer shall ensure that a covered 331
person can obtain a covered orally administered prescription 332
drug used to treat cancer within seventy-two hours following 333
submission of a clean claim or prior authorization request to 334
the health plan issuer, notwithstanding the prior authorization 335
time limits established in section 1751.72 or 3923.041 of the 336
Revised Code. If the health plan issuer is unable to do so by 337
requiring the covered person to use a pharmacy in the issuer's 338
pharmacy provider network or a dispensing physician in the 339
issuer's physician provider network, the issuer shall cover the 340
drug if purchased from an out-of-network pharmacy or out-of- 341
network dispensing physician to the same extent as it would if 342
the drug were dispensed by an in-network pharmacy or dispensing 343
physician. 344

(C) Within twenty-four hours of submission to a health 345
plan issuer of a clean claim or prior authorization request for 346
the drug, the health plan issuer shall confirm receipt of the 347
claim and notify the prescribing provider in writing of both of 348
the following: 349

(1) Whether the drug is covered; 350

(2) If the drug is covered, any delay in authorization or 351
coverage that would likely result in the covered person not 352
being able to receive the drug within seventy-two hours 353
following the initial submission of the claim. 354

(D) If it is likely that the drug will not be available to 355
a covered person within seventy-two hours of the initial 356
submission, the health plan issuer shall notify the covered 357

person that the covered person can use another pharmacy or 358
dispensing physician to obtain the drug, including a pharmacy or 359
dispensing physician that is not part of the health plan 360
issuer's pharmacy provider or physician provider network. The 361
notification shall be written in a clear, concise, and 362
intelligible manner. 363

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

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

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

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

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

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

addition to those of the state board of pharmacy; 414

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

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

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

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

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

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

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

(1) The process for determining the incentive payments and adjustments, including any performance criteria, shall be described in an express contract between the medicaid managed care organization and the pharmacy entered into not less than six months prior to the start of the period when the pharmacy's performance will be measured. 443
444
445
446
447
448

(2) The incentive payments and adjustments shall be based on the individual pharmacy's actual performance metrics under the performance criteria. 449
450
451

(3) The pharmacy's evaluation shall be based on actual data received from the pharmacy and not extrapolated from a sample of data. 452
453
454

(4) The pharmacy's evaluation shall be based on objective performance standards, not on its performance relative to other pharmacies. 455
456
457

(5) The pharmacy's performance shall be evaluated using only performance criteria over which the pharmacy has meaningful control and that appropriately correspond to the types of services offered by the pharmacy, including the dispensing of specialty drugs. 458
459
460
461
462

(6) The incentive payments and adjustments shall not favor the medicaid managed care organization's affiliated pharmacies or discriminate against nonaffiliated pharmacies. 463
464
465

(7) For each claim for which a pharmacy receives a decreased payment, the medicaid managed care organization shall provide to the pharmacy a written explanation detailing how the pharmacy failed to meet the applicable performance criteria and describing the steps it must take to improve its performance. The written explanation shall be provided at the time the 466
467
468
469
470
471

incentive payments or adjustments are applied, or as soon as 472
practicable thereafter. 473

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

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

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

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

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

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

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

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

(1) Whether the drug is covered; 506

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

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

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

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

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

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