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Representative Huffman

Cosponsors: Representatives DeGeeter, Seitz, McGregor, J., Schneider, Latta, Adams, Gibbs, Setzer, Oelslager, Uecker, McGregor, R., Stewart, J., Stebelton, Fessler, Barrett, Wagoner, Celeste, Reinhard, Widener, Blessing, Book, Carmichael, Lundy, Hughes, Core, Dodd, Batchelder, Boyd, Budish, Chandler, Collier, Distel, Driehaus, Dyer, Evans, Flowers, Goyal, Hagan, J., Healy, Koziura, Letson, Luckie, Otterman, Patton, Yuko
Senators Goodman, Seitz, Boccieri, Cafaro, Carey, Coughlin, Faber, Harris, Kearney, Miller, D., Miller, R., Morano, Mumper, Niehaus, Roberts, Spada, Fedor

—

A BILL

To amend sections 1751.13, 1753.01, 1753.07, 1753.09, 1
2317.54, 3701.741, 3702.51, and 5111.17, to enact 2
sections 3721.042, 3963.01 to 3963.11, and to 3
repeal sections 1753.03, 1753.04, 1753.05, and 4
1753.08 of the Revised Code to establish certain 5
uniform contract provisions between health care 6
providers and contracting entities, to establish 7
standardized credentialing, to require the 8
Department of Job and Family Services to allow 9
managed care plans to use providers to render 10
care, to modify the fees for electronic copies of 11
certain medical records and allow an authorized 12
person to obtain one copy of a patient's medical 13
record without charge, to exempt a nursing home 14
that is a converted county or district home from 15

administrative rules regarding the toilet rooms 16
and dining and recreation areas of nursing homes 17
if certain other requirements are met, to create a 18
Joint Legislative Study Commission on Most Favored 19
Nation Clauses in Health Care Contracts, and to 20
create an Advisory Committee on Eligibility and 21
Real Time Claim Adjudication. 22

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

Section 1. That sections 1751.13, 1753.01, 1753.07, 1753.09, 24
2317.54, 3701.741, 3702.51, and 5111.17 be amended and sections 25
3721.042, 3963.01, 3963.02, 3963.03, 3963.04, 3963.05, 3963.06, 26
3963.07, 3963.08, 3963.09, 3963.10, and 3963.11 of the Revised 27
Code be enacted to read as follows: 28

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, 29
either directly or indirectly, enter into contracts for the 30
provision of health care services with a sufficient number and 31
types of providers and health care facilities to ensure that all 32
covered health care services will be accessible to enrollees from 33
a contracted provider or health care facility. 34

(b) A health insuring corporation shall not refuse to 35
contract with a physician for the provision of health care 36
services or refuse to recognize a physician as a specialist on the 37
basis that the physician attended an educational program or a 38
residency program approved or certified by the American 39
osteopathic association. A health insuring corporation shall not 40
refuse to contract with a health care facility for the provision 41
of health care services on the basis that the health care facility 42
is certified or accredited by the American osteopathic association 43
or that the health care facility is an osteopathic hospital as 44

defined in section 3702.51 of the Revised Code. 45

(c) Nothing in division (A)(1)(b) of this section shall be construed to require a health insuring corporation to make a benefit payment under a closed panel plan to a physician or health care facility with which the health insuring corporation does not have a contract, provided that none of the bases set forth in that division are used as a reason for failing to make a benefit payment. 46 47 48 49 50 51 52

(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance. 53 54 55 56 57 58 59 60 61 62 63

(3) Nothing in this section shall prohibit a health insuring corporation from entering into contracts with out-of-state providers or health care facilities that are licensed, certified, accredited, or otherwise authorized in that state. 64 65 66 67

(B)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts with all providers and health care facilities through which health care services are provided to its enrollees. 68 69 70 71

(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers. 72 73 74

(C) A health insuring corporation shall file an annual 75

certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided contain the following: 76 77 78

(1) A description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facility will be responsible, including any limitations or conditions on such services; 79 80 81 82 83

(2) The specific hold harmless provision specifying protection of enrollees set forth as follows: 84 85

"[Provider/Health Care Facility] agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall [Provider/Health Care Facility] bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit [Provider/Health Care Facility] from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor." 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

(3) Provisions requiring the provider or health care facility to continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. The provisions shall require the provider or health care facility to continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the 101 102 103 104 105 106 107

time of the health insuring corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, the provisions may limit the required provision of covered health care services relating to that inpatient care in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also limit such required provision of covered health care services to the period ending thirty days after the health insuring corporation's insolvency or discontinuance of operations. 108 109 110 111 112 113 114 115 116 117 118 119

The provisions required by division (C)(3) of this section shall not require any provider or health care facility to continue to provide any covered health care service after the occurrence of any of the following: 120 121 122 123

(a) The end of the thirty-day period following the entry of a liquidation order under Chapter 3903. of the Revised Code; 124 125

(b) The end of the enrollee's period of coverage for a contractual prepayment or premium; 126 127

(c) The enrollee obtains equivalent coverage with another health insuring corporation or insurer, or the enrollee's employer obtains such coverage for the enrollee; 128 129 130

(d) The enrollee or the enrollee's employer terminates coverage under the contract; 131 132

(e) A liquidator effects a transfer of the health insuring corporation's obligations under the contract under division (A)(8) of section 3903.21 of the Revised Code. 133 134 135

(4) A provision clearly stating the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to 136 137 138

administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs; 139 140 141 142 143

(5) A provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records. 144 145 146 147 148 149 150 151 152 153 154 155 156

(6) A provision that states that contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health insuring corporation; 157 158 159 160

(7) A provision requiring the provider or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the provider or health care facility to notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage. 161 162 163 164 165 166 167

(8) A provision requiring the provider or health care facility to observe, protect, and promote the rights of enrollees as patients; 168 169 170

(9) A provision requiring the provider or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions. 171 172 173 174 175 176 177 178 179 180

(10) A provision containing the specifics of any obligation on the primary care provider to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week; 181 182 183 184

(11) A provision setting forth procedures for the resolution of disputes arising out of the contract; 185 186

(12) A provision stating that the hold harmless provision required by division (C)(2) of this section shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation; 187 188 189 190 191 192

(13) A provision requiring those terms that are used in the contract and that are defined by this chapter, be used in the contract in a manner consistent with those definitions. 193 194 195

This division does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of 196 197 198 199 200 201

beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the department of job and family services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services. 202 203 204 205 206 207 208 209 210

(D)(1) No health insuring corporation contract with a provider or health care facility shall contain any of the following: 211 212 213

(a) A provision that directly or indirectly offers an inducement to the provider or health care facility to reduce or limit medically necessary health care services to a covered enrollee; 214 215 216 217

(b) A provision that penalizes a provider or health care facility that assists an enrollee to seek a reconsideration of the health insuring corporation's decision to deny or limit benefits to the enrollee; 218 219 220 221

(c) A provision that limits or otherwise restricts the provider's or health care facility's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options; 222 223 224 225

(d) A provision that penalizes a provider or health care facility for principally advocating for medically necessary health care services; 226 227 228

(e) A provision that penalizes a provider or health care facility for providing information or testimony to a legislative or regulatory body or agency. This shall not be construed to prohibit a health insuring corporation from penalizing a provider 229 230 231 232

or health care facility that provides information or testimony that is libelous or slanderous or that discloses trade secrets which the provider or health care facility has no privilege or permission to disclose. 233 234 235 236

(f) A provision that violates Chapter 3963. of the Revised Code. 237 238

(2) Nothing in this division shall be construed to prohibit a health insuring corporation from doing either of the following: 239 240

(a) Making a determination not to reimburse or pay for a particular medical treatment or other health care service; 241 242

(b) Enforcing reasonable peer review or utilization review protocols, or determining whether a particular provider or health care facility has complied with these protocols. 243 244 245

(E) Any contract between a health insuring corporation and an intermediary organization shall clearly specify that the health insuring corporation must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts. 246 247 248 249 250

(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following: 251 252 253 254 255

(1) Contain the provisions required by divisions (C) and (G) of this section, as made applicable to an intermediary organization, without the inclusion of inducements or penalties described in division (D) of this section; 256 257 258 259

(2) Acknowledge that the health insuring corporation is a third-party beneficiary to the agreement; 260 261

(3) Acknowledge the health insuring corporation's role in 262

approving the participation of the provider or health care facility, pursuant to division (E) of this section. 263 264

(G) Any provider contract or contract with a health care facility shall clearly specify the health insuring corporation's statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees. 265 266 267 268

(H)(1) A health insuring corporation shall maintain its provider contracts and its contracts with health care facilities at one or more of its places of business in this state, and shall provide copies of these contracts to facilitate regulatory review upon written notice by the superintendent of insurance. 269 270 271 272 273

(2) Any contract with an intermediary organization that accepts compensation shall include provisions requiring the intermediary organization to provide the superintendent with regulatory access to all books, records, financial information, and documents related to the provision of health care services to subscribers and enrollees under the contract. The contract shall require the intermediary organization to maintain such books, records, financial information, and documents at its principal place of business in this state and to preserve them for at least three years in a manner that facilitates regulatory review. 274 275 276 277 278 279 280 281 282 283

(I)(1) A health insuring corporation shall notify its affected enrollees of the termination of a contract for the provision of health care services between the health insuring corporation and a primary care physician or hospital, by mail, within thirty days after the termination of the contract. 284 285 286 287 288

(a) Notice shall be given to subscribers of the termination of a contract with a primary care physician if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from the primary care physician within the previous twelve months or if the subscriber or 289 290 291 292 293

dependent has selected the physician as the subscriber's or 294
dependent's primary care physician within the previous twelve 295
months. 296

(b) Notice shall be given to subscribers of the termination 297
of a contract with a hospital if the subscriber, or a dependent 298
covered under the subscriber's health care coverage, has received 299
health care services from that hospital within the previous twelve 300
months. 301

(2) The health insuring corporation shall pay, in accordance 302
with the terms of the contract, for all covered health care 303
services rendered to an enrollee by a primary care physician or 304
hospital between the date of the termination of the contract and 305
five days after the notification of the contract termination is 306
mailed to a subscriber at the subscriber's last known address. 307

(J) Divisions (A) and (B) of this section do not apply to any 308
health insuring corporation that, on June 4, 1997, holds a 309
certificate of authority or license to operate under Chapter 1740. 310
of the Revised Code. 311

(K) Nothing in this section shall restrict the governing body 312
of a hospital from exercising the authority granted it pursuant to 313
section 3701.351 of the Revised Code. 314

Sec. 1753.01. As used in this chapter~~:~~ 315

~~(A) "Economic profiling" means a health insuring~~ 316
~~corporation's use of economic performance data and economic~~ 317
~~information in determining whether to contract with a provider for~~ 318
~~the provision of covered health care services to enrollees as a~~ 319
~~participating provider.~~ 320

~~(B) "Basic~~, "basic health care services," "enrollee," "health 321
care facility," "health care services," "health insuring 322
corporation," "medical record," "person," "primary care provider," 323

"provider," "specialty health care services," "subscriber," and "supplemental health care services" have the same meanings as in section 1751.01 of the Revised Code.

Sec. 1753.07. (A)(1) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose basic information regarding its programs and procedures to the provider~~, upon the provider's request~~. The information shall include all of the following:

~~(1)~~(a) How a participating provider is reimbursed for the participating provider's services, including the range and structure of any financial risk sharing arrangements, a description of any incentive plans, and, if reimbursed according to a type of fee-for-service arrangement, the level of reimbursement for the participating provider's services;

~~(2)~~(b) Insofar as division (A)(1) of section 3963.03 of the Revised Code is applicable, all of the information that is described in that division and is not included in division (A)(1)(a) of this section.

(2) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose the following information upon the provider's request:

(a) How referrals to other participating providers or to nonparticipating providers are made;

~~(3)~~(b) The availability of dispute resolution procedures and the potential for cost to be incurred;

~~(4)~~(c) How a participating provider's name and address will be used in marketing materials.

(B) A health insuring corporation shall provide all of the

following to a participating provider: 354

(1) Any material incorporated by reference into the participation contract, that is not otherwise available as a public record, if such material affects the participating provider; 355 356 357 358

(2) Administrative manuals related to provider participation, if any; 359 360

(3) Insofar as division (B) of section 3963.03 of the Revised Code is applicable, the summary disclosure form with the disclosures required under that division; 361 362 363

(4) A signed and dated copy of the final participation contract. 364 365

(C) Nothing in this section requires a health insuring corporation providing specialty health care services or supplemental health care services to disclose the health insuring corporation's aggregate maximum allowable fee table used to determine providers' fees or fee schedules. 366 367 368 369 370

Sec. 1753.09. (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the 371 372 373 374 375 376 377 378 379 380 381 382 383

participation of the provider. 384

(B)(1) A participating provider whose participation has been terminated under division (A) of this section may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director shall give the participating provider an opportunity to discuss with the medical director the reason or reasons for the termination. 385 386 387 388 389 390

(2) If a satisfactory resolution of a participating provider's appeal cannot be reached under division (B)(1) of this section, the participating provider may appeal the termination to a panel composed of participating providers who have comparable or higher levels of education and training than the participating provider making the appeal. A representative of the participating provider's specialty shall be a member of the panel, if possible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty days after holding the hearing. The recommendation shall be presented to the medical director and to the participating provider. 391 392 393 394 395 396 397 398 399 400 401

(3) The medical director shall review and consider the panel's recommendation before making a decision. The decision rendered by the medical director shall be final. 402 403 404

(C) A provider's status as a participating provider shall remain in effect during the appeal process set forth in division (B) of this section unless the termination was based on any of the reasons listed in division (D) of this section. 405 406 407 408

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, 409 410 411 412 413 414

or loss of authority to practice in the participating provider's 415
field; or if a governmental action has impaired the participating 416
provider's ability to practice. 417

(E) Divisions (A) to (D) of this section apply only to 418
providers who are natural persons. 419

(F)(1) Nothing in this section prohibits a health insuring 420
corporation from rejecting a provider's application for 421
participation, or from terminating a participating provider's 422
contract, if the health insuring corporation determines that the 423
health care needs of its enrollees are being met and no need 424
exists for the provider's or participating provider's services. 425

(2) Nothing in this section shall be construed as prohibiting 426
a health insuring corporation from terminating a participating 427
provider who does not meet the terms and conditions of the 428
participating provider's contract. 429

(3) Nothing in this section shall be construed as prohibiting 430
a health insuring corporation from terminating a participating 431
provider's contract pursuant to any provision of the contract 432
described in division (E)(2) of section 3963.02 of the Revised 433
Code, except that, notwithstanding any provision of a contract 434
described in that division, this section applies to the 435
termination of a participating provider's contract for any of the 436
causes described in divisions (A), (D), and (F)(1) and (2) of this 437
section. 438

(G) The superintendent of insurance may adopt rules as 439
necessary to implement and enforce sections ~~1753.04 to~~ 1753.06, 440
1753.07, and 1753.09 of the Revised Code. Such rules shall be 441
adopted in accordance with Chapter 119. of the Revised Code. The 442
director of health may make recommendations to the superintendent 443
for rules necessary to implement and enforce sections ~~1753.04 to~~ 444
1753.06, 1753.07, and 1753.09 of the Revised Code. In adopting any 445

rules pursuant to this division, the superintendent shall consider the recommendations of the director. 446 447

Sec. 2317.54. No hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program shall be held liable for a physician's failure to obtain an informed consent from the physician's patient prior to a surgical or medical procedure or course of procedures, unless the physician is an employee of the hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program. 448 449 450 451 452 453 454

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent. 455 456 457 458 459 460 461 462 463 464 465 466 467

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures. 468 469 470 471 472 473

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a 474 475 476

satisfactory manner. 477

(C) The consent is signed by the patient for whom the 478
procedure is to be performed, or, if the patient for any reason 479
including, but not limited to, competence, ~~infancy~~ minority, or 480
the fact that, at the latest time that the consent is needed, the 481
patient is under the influence of alcohol, hallucinogens, or 482
drugs, lacks legal capacity to consent, by a person who has legal 483
authority to consent on behalf of such patient in such 484
circumstances, including either of the following: 485

(1) The parent, whether the parent is an adult or a minor, of 486
the parent's minor child; 487

(2) An adult whom the parent of the minor child has given 488
written authorization to consent to a surgical or medical 489
procedure or course of procedures for the parent's minor child. 490

Any use of a consent form that fulfills the requirements 491
stated in divisions (A), (B), and (C) of this section has no 492
effect on the common law rights and liabilities, including the 493
right of a physician to obtain the oral or implied consent of a 494
patient to a medical procedure, that may exist as between 495
physicians and patients on July 28, 1975. 496

As used in this section the term "hospital" has the same 497
meaning as in section 2305.113 of the Revised Code; "home health 498
agency" has the same meaning as in section 5101.61 of the Revised 499
Code; "ambulatory surgical facility" has the meaning as in 500
division (A) of section 3702.30 of the Revised Code; and "hospice 501
care program" has the same meaning as in section 3712.01 of the 502
Revised Code. The provisions of this division apply to hospitals, 503
doctors of medicine, doctors of osteopathic medicine, and doctors 504
of podiatric medicine. 505

Sec. 3701.741. (A) ~~Through December 31, 2008, each~~ Each 506

health care provider and medical records company shall provide 507
copies of medical records in accordance with this section. 508

(B) Except as provided in divisions (C) and (E) of this 509
section, a health care provider or medical records company that 510
receives a request for a copy of a patient's medical record shall 511
charge not more than the amounts set forth in this section. 512

(1) If the request is made by the patient or the patient's 513
personal representative, total costs for copies and all services 514
related to those copies shall not exceed the sum of the following: 515

(a) ~~With~~ Except as provided in division (B)(1)(b) of this 516
section, with respect to data recorded on paper or electronically, 517
the following amounts: 518

(i) Two dollars and ~~fifty~~ seventy-four cents per page for the 519
first ten pages; 520

(ii) ~~Fifty-one~~ Fifty-seven cents per page for pages eleven 521
through fifty; 522

(iii) ~~Twenty~~ Twenty-three cents per page for pages fifty-one 523
and higher; 524

(b) With respect to data resulting from an x-ray, magnetic 525
resonance imaging (MRI), or computed axial tomography (CAT) scan 526
and recorded ~~other than~~ on paper or film, one dollar and ~~seventy~~ 527
eighty-seven cents per page; 528

(c) The actual cost of any related postage incurred by the 529
health care provider or medical records company. 530

(2) If the request is made other than by the patient or the 531
patient's personal representative, total costs for copies and all 532
services related to those copies shall not exceed the sum of the 533
following: 534

(a) An initial fee of ~~fifteen~~ sixteen dollars and ~~thirty-five~~ 535
eighty-four cents, which shall compensate for the records search; 536

(b) ~~With~~ Except as provided in division (B)(2)(c) of this section, with respect to data recorded on paper or electronically, the following amounts:

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

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

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

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

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

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

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

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

(c) The department of job and family services or a county department of job and family services, in accordance with Chapters 5101. and 5111. of the Revised Code and the rules adopted under those chapters;

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

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

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

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

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

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

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

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

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the Revised Code: 597 598

(A) "Applicant" means any person that submits an application for a certificate of need and who is designated in the application as the applicant. 599 600 601

(B) "Person" means any individual, corporation, business trust, estate, firm, partnership, association, joint stock company, insurance company, government unit, or other entity. 602 603 604

(C) "Certificate of need" means a written approval granted by the director of health to an applicant to authorize conducting a reviewable activity. 605 606 607

(D) "Health service area" means a geographic region designated by the director of health under section 3702.58 of the Revised Code. 608 609 610

(E) "Health service" means a clinically related service, such as a diagnostic, treatment, rehabilitative, or preventive service. 611 612

(F) "Health service agency" means an agency designated to serve a health service area in accordance with section 3702.58 of the Revised Code. 613 614 615

(G) "Health care facility" means: 616

(1) A hospital registered under section 3701.07 of the Revised Code; 617 618

(2) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code; 619 620 621

(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended; 622 623 624 625

(4) A freestanding dialysis center; 626

(5) A freestanding inpatient rehabilitation facility; 627

(6) An ambulatory surgical facility; 628

(7) A freestanding cardiac catheterization facility; 629

(8) A freestanding birthing center; 630

(9) A freestanding or mobile diagnostic imaging center; 631

(10) A freestanding radiation therapy center. 632

A health care facility does not include the offices of 633
private physicians and dentists whether for individual or group 634
practice, residential facilities licensed under section 5123.19 of 635
the Revised Code, or an institution for the sick that is operated 636
exclusively for patients who use spiritual means for healing and 637
for whom the acceptance of medical care is inconsistent with their 638
religious beliefs, accredited by a national accrediting 639
organization, exempt from federal income taxation under section 640
501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 641
U.S.C.A. 1, as amended, and providing twenty-four hour nursing 642
care pursuant to the exemption in division (E) of section 4723.32 643
of the Revised Code from the licensing requirements of Chapter 644
4723. of the Revised Code. 645

(H) "Medical equipment" means a single unit of medical 646
equipment or a single system of components with related functions 647
that is used to provide health services. 648

(I) "Third-party payer" means a health insuring corporation 649
licensed under Chapter 1751. of the Revised Code, a health 650
maintenance organization as defined in division (K) of this 651
section, an insurance company that issues sickness and accident 652
insurance in conformity with Chapter 3923. of the Revised Code, a 653
state-financed health insurance program under Chapter 3701., 654
4123., or 5111. of the Revised Code, or any self-insurance plan. 655

(J) "Government unit" means the state and any county, municipal corporation, township, or other political subdivision of the state, or any department, division, board, or other agency of the state or a political subdivision.

(K) "Health maintenance organization" means a public or private organization organized under the law of any state that is qualified under section 1310(d) of Title XIII of the "Public Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9.

(L) "Existing health care facility" means either of the following:

(1) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, is staffed and equipped to provide health care services, and is actively providing health services;

(2) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or that has beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds and has provided services for at least three hundred sixty-five consecutive days within the twenty-four months immediately preceding the date a certificate of need application is filed with the director of health.

(M) "State" means the state of Ohio, including, but not limited to, the general assembly, the supreme court, the offices of all elected state officers, and all departments, boards,

offices, commissions, agencies, institutions, and other instrumentalities of the state of Ohio. "State" does not include political subdivisions. 687 688 689

(N) "Political subdivision" means a municipal corporation, township, county, school district, and all other bodies corporate and politic responsible for governmental activities only in geographic areas smaller than that of the state to which the sovereign immunity of the state attaches. 690 691 692 693 694

(O) "Affected person" means: 695

(1) An applicant for a certificate of need, including an applicant whose application was reviewed comparatively with the application in question; 696 697 698

(2) The person that requested the reviewability ruling in question; 699 700

(3) Any person that resides or regularly uses health care facilities within the geographic area served or to be served by the health care services that would be provided under the certificate of need or reviewability ruling in question; 701 702 703 704

(4) Any health care facility that is located in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question; 705 706 707

(5) Third-party payers that reimburse health care facilities for services in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question; 708 709 710 711

(6) Any other person who testified at a public hearing held under division (B) of section 3702.52 of the Revised Code or submitted written comments in the course of review of the certificate of need application in question. 712 713 714 715

(P) "Osteopathic hospital" means a hospital registered under 716

section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following: 717 718 719

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician; 720 721 722 723

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians; 724 725

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members. 726 727

(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code. 728 729

(R) Except as otherwise provided in division (T) of this section, and until the termination date specified in section 3702.511 of the Revised Code, "reviewable activity" means any of the following: 730 731 732 733

(1) The addition by any person of any of the following health services, regardless of the amount of operating costs or capital expenditures: 734 735 736

(a) A heart, heart-lung, lung, liver, kidney, bowel, pancreas, or bone marrow transplantation service, a stem cell harvesting and reinfusion service, or a service for transplantation of any other organ unless transplantation of the organ is designated by public health council rule not to be a reviewable activity; 737 738 739 740 741 742

(b) A cardiac catheterization service; 743

(c) An open-heart surgery service; 744

(d) Any new, experimental medical technology that is designated by rule of the public health council. 745 746

(2) The acceptance of high-risk patients, as defined in rules adopted under section 3702.57 of the Revised Code, by any cardiac catheterization service that was initiated without a certificate of need pursuant to division (R)(3)(b) of the version of this section in effect immediately prior to April 20, 1995; 747 748 749 750 751

(3)(a) The establishment, development, or construction of a new health care facility other than a new long-term care facility or a new hospital; 752 753 754

(b) The establishment, development, or construction of a new hospital or the relocation of an existing hospital; 755 756

(c) The relocation of hospital beds, other than long-term care, perinatal, or pediatric intensive care beds, into or out of a rural area. 757 758 759

(4)(a) The replacement of an existing hospital; 760

(b) The replacement of an existing hospital obstetric or newborn care unit or freestanding birthing center. 761 762

(5)(a) The renovation of a hospital that involves a capital expenditure, obligated on or after June 30, 1995, of five million dollars or more, not including expenditures for equipment, staffing, or operational costs. For purposes of division (R)(5)(a) of this section, a capital expenditure is obligated: 763 764 765 766 767

(i) When a contract enforceable under Ohio law is entered into for the construction, acquisition, lease, or financing of a capital asset; 768 769 770

(ii) When the governing body of a hospital takes formal action to commit its own funds for a construction project undertaken by the hospital as its own contractor; 771 772 773

(iii) In the case of donated property, on the date the gift is completed under applicable Ohio law. 774 775

(b) The renovation of a hospital obstetric or newborn care 776

unit or freestanding birthing center that involves a capital expenditure of five million dollars or more, not including expenditures for equipment, staffing, or operational costs. 777 778 779

(6) Any change in the health care services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need was granted, if the change is made prior to the date the activity for which the certificate was issued ceases to be a reviewable activity; 780 781 782 783 784 785

(7) Any of the following changes in perinatal bed capacity or pediatric intensive care bed capacity: 786 787

(a) An increase in bed capacity; 788

(b) A change in service or service-level designation of newborn care beds or obstetric beds in a hospital or freestanding birthing center, other than a change of service that is provided within the service-level designation of newborn care or obstetric beds as registered by the department of health; 789 790 791 792 793

(c) A relocation of perinatal or pediatric intensive care beds from one physical facility or site to another, excluding the relocation of beds within a hospital or freestanding birthing center or the relocation of beds among buildings of a hospital or freestanding birthing center at the same site. 794 795 796 797 798

(8) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need; 799 800

(9) Any transfer of a certificate of need issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of a certificate of need issued prior to that date upon completion of the project, and any transfer of the controlling interest in an entity that holds a certificate of need issued prior to that date. 801 802 803 804 805 806 807

However, the transfer of a certificate of need issued prior to that date or agreement to transfer such a certificate of need from the person to whom the certificate of need was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for the purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need. 808 809 810 811 812 813 814 815

(10)(a) The acquisition by any person of any of the following medical equipment, regardless of the amount of operating costs or capital expenditure: 816 817 818

(i) A cobalt radiation therapy unit; 819

(ii) A linear accelerator; 820

(iii) A gamma knife unit. 821

(b) The acquisition by any person of medical equipment with a cost of two million dollars or more. The cost of acquiring medical equipment includes the sum of the following: 822 823 824

(i) The greater of its fair market value or the cost of its lease or purchase; 825 826

(ii) The cost of installation and any other activities essential to the acquisition of the equipment and its placement into service. 827 828 829

(11) The addition of another cardiac catheterization laboratory to an existing cardiac catheterization service. 830 831

(S) Except as provided in division (T) of this section, "reviewable activity" also means any of the following activities, none of which are subject to a termination date: 832 833 834

(1) The establishment, development, or construction of a new long-term care facility; 835 836

(2) The replacement of an existing long-term care facility; 837

(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs; 838 839 840 841

(4) Any of the following changes in long-term care bed capacity: 842 843

(a) An increase in bed capacity; 844

(b) A relocation of beds from one physical facility or site to another, excluding the relocation of beds within a long-term care facility or among buildings of a long-term care facility at the same site; 845 846 847 848

(c) A recategorization of hospital beds registered under section 3701.07 of the Revised Code from another registration category to skilled nursing beds or long-term care beds. 849 850 851

(5) Any change in the health services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need concerning long-term care beds was granted, if the change is made within five years after the implementation of the reviewable activity for which the certificate was granted; 852 853 854 855 856 857

(6) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need concerning long-term care beds; 858 859 860

(7) Any transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of such a certificate of need upon completion of the project, and any transfer of the controlling interest in an entity that holds such a certificate of need. However, the transfer of a certificate of need that concerns 861 862 863 864 865 866 867 868

long-term care beds and was issued prior to April 20, 1995, or agreement to transfer such a certificate of need from the person to whom the certificate was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need. 869 870 871 872 873 874 875

(T) "Reviewable activity" does not include any of the following activities: 876 877

(1) Acquisition of computer hardware or software; 878

(2) Acquisition of a telephone system; 879

(3) Construction or acquisition of parking facilities; 880

(4) Correction of cited deficiencies that are in violation of federal, state, or local fire, building, or safety laws and rules and that constitute an imminent threat to public health or safety; 881 882 883

(5) Acquisition of an existing health care facility that does not involve a change in the number of the beds, by service, or in the number or type of health services; 884 885 886

(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association; 887 888 889 890

(7) Acquisition of medical equipment to replace the same or similar equipment for which a certificate of need has been issued if the replaced equipment is removed from service; 891 892 893

(8) Mergers, consolidations, or other corporate reorganizations of health care facilities that do not involve a change in the number of beds, by service, or in the number or type of health services; 894 895 896 897

(9) Construction, repair, or renovation of bathroom 898

facilities; 899

(10) Construction of laundry facilities, waste disposal facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of medical office buildings used exclusively for physician services; 900 901 902 903

(11) Acquisition of medical equipment to conduct research required by the United States food and drug administration or clinical trials sponsored by the national institute of health. Use of medical equipment that was acquired without a certificate of need under division (T)(11) of this section and for which premarket approval has been granted by the United States food and drug administration to provide services for which patients or reimbursement entities will be charged shall be a reviewable activity. 904 905 906 907 908 909 910 911 912

(12) Removal of asbestos from a health care facility. 913

Only that portion of a project that meets the requirements of division (T) of this section is not a reviewable activity. 914 915

(U) "Small rural hospital" means a hospital that is located within a rural area, has fewer than one hundred beds, and to which fewer than four thousand persons were admitted during the most recent calendar year. 916 917 918 919

(V) "Children's hospital" means any of the following: 920

(1) A hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age; 921 922 923 924 925

(2) A distinct portion of a hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, has a total of at least one hundred 926 927 928

fifty registered pediatric special care and pediatric acute care beds, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age; 929 930 931 932

(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (V)(1) of this section. 933 934 935 936

(W) "Long-term care facility" means any of the following: 937

(1) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code; 938 939 940

(2) The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act"; 941 942 943 944

(3) The portion of any hospital that contains beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds. 945 946 947

(X) "Long-term care bed" means a bed in a long-term care facility. 948 949

(Y) "Perinatal bed" means a bed in a hospital that is registered under section 3701.07 of the Revised Code as a newborn care bed or obstetric bed, or a bed in a freestanding birthing center. 950 951 952 953

(Z) "Freestanding birthing center" means any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus of another health care facility, and which is not licensed under Chapter 3711. of the Revised Code as a level one, two, or three maternity unit or a limited 954 955 956 957 958

maternity unit.

(AA)(1) "Reviewability ruling" means a ruling issued by the director of health under division (A) of section 3702.52 of the Revised Code as to whether a particular proposed project is or is not a reviewable activity.

(2) "Nonreviewability ruling" means a ruling issued under that division that a particular proposed project is not a reviewable activity.

(BB)(1) "Metropolitan statistical area" means an area of this state designated a metropolitan statistical area or primary metropolitan statistical area in United States office of management and budget bulletin ~~No.~~ no. 93-17, June 30, 1993, and its attachments.

(2) "Rural area" means any area of this state not located within a metropolitan statistical area.

(CC) "County nursing home" has the same meaning as in section 5155.31 of the Revised Code.

Sec. 3721.042. The director of health may not deny a nursing home license to a facility seeking a license under this chapter as a nursing home on the grounds that the facility does not satisfy a requirement established in rules adopted under section 3721.04 of the Revised Code regarding the toilet rooms and dining and recreational areas of nursing homes if all of the following requirements are met:

(A) The facility seeks a license under this chapter because it is a county home or district home being sold under section 5155.31 of the Revised Code to a person who may not operate the facility without a nursing home license under this chapter.

(B) The requirement would not have applied to the facility had the facility been a nursing home first licensed under this

chapter before October 20, 2001. 989

(C) The facility was a nursing facility, as defined in section 5111.20 of the Revised Code, on the date immediately preceding the date the facility is sold to the person seeking the license. 990 991 992 993

Sec. 3963.01. As used in this chapter: 994

(A) "Affiliate" means any person or entity that has ownership or control of a contracting entity, is owned or controlled by a contracting entity, or is under common ownership or control with a contracting entity. 995 996 997 998

(B) "Basic health care services" has the same meaning as in division (A) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home. 999 1000 1001 1002

(C) "Contracting entity" means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services. 1003 1004 1005

(D) "Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a contracting entity to provide basic health care services, specialty health care services, or supplemental health care services to enrollees. 1006 1007 1008 1009 1010

(E) "Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in any of the following: 1011 1012 1013

(1) Payment for some, but not all of the procedure codes originally billed by a participating provider; 1014 1015

(2) Payment for a different procedure code than the procedure code originally billed by a participating provider; 1016 1017

(3) A reduced payment as a result of services provided to an enrollee that are claimed under more than one procedure code on the same service date. 1018 1019 1020

(F) "Electronic claims transport" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States department of health and human services pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator. 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031

(G) "Enrollee" means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of medicaid under Chapter 5111. of the Revised Code, and includes all of the following terms: 1032 1033 1034 1035

(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code; 1036 1037

(2) "Member" as defined by section 1739.01 of the Revised Code; 1038 1039

(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code; 1040 1041

(4) "Beneficiary" as defined by section 3901.38 of the Revised Code. 1042 1043

(H) "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees. 1044 1045 1046 1047 1048

(I) "Health care services" means basic health care services, specialty health care services, and supplemental health care services. 1049 1050 1051

(J) "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following: 1052 1053 1054 1055 1056 1057

(1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract; 1058 1059 1060 1061

(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract; 1062 1063 1064 1065

(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract; 1066 1067 1068

(4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense; 1069 1070 1071

(5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to division (A)(1) of section 3963.04 of the Revised Code and the notice includes information sufficient for the provider to determine the effect of the change; 1072 1073 1074 1075 1076

(6) Changes to a health care contract described in division (B) of section 3963.04 of the Revised Code. 1077 1078

(K) "Participating provider" means a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract. 1079 1080 1081 1082

(L) "Payer" means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health care contract. 1083 1084 1085 1086

(M) "Primary enrollee" means a person who is responsible for making payments for participation in a health care plan or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health care plan. 1087 1088 1089 1090

(N) "Procedure codes" includes the American medical association's current procedural terminology code, the American dental association's current dental terminology, and the centers for medicare and medicaid services health care common procedure coding system. 1091 1092 1093 1094 1095

(O) "Product" means one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract: 1096 1097 1098 1099

(1) A health maintenance organization or other product provided by a health insuring corporation; 1100 1101

(2) A preferred provider organization; 1102

(3) Medicare; 1103

(4) Medicaid or the children's buy-in program established under section 5101.5211 to 5101.5216 of the Revised Code; 1104 1105

(5) Workers' compensation. 1106

(P) "Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, 1107 1108

advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds. 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121

(Q) "Specialty health care services" has the same meaning as in section 1751.01 of the Revised Code, except that it does not include any services listed in division (B) of section 1751.01 of the Revised Code that are provided by a pharmacist or a nursing home. 1122 1123 1124 1125 1126

(R) "Supplemental health care services" has the same meaning as in division (B) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home. 1127 1128 1129 1130

Sec. 3963.02. (A)(1) No contracting entity shall sell, rent, or give a third party the contracting entity's rights to a participating provider's services pursuant to the contracting entity's health care contract with the participating provider unless one of the following applies: 1131 1132 1133 1134 1135

(a) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract 1136 1137 1138 1139

with the contracting entity or its affiliate for the administration or processing of claims for payment for services provided pursuant to the health care contract with the participating provider. 1140 1141 1142 1143

(b) The third party accessing the participating provider's services under the health care contract either is an affiliate or subsidiary of the contracting entity or is providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity. 1144 1145 1146 1147 1148 1149

(c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following: 1150 1151 1152 1153 1154 1155 1156

(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer; 1157 1158

(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance with division (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement. 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169

(iii) An entity that is engaged in the business of providing 1170

electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement. 1171 1172 1173 1174 1175 1176

(2) The contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as provided in division (A)(1) of this section shall do both of the following: 1177 1178 1179 1180 1181

(a) Maintain a web page that contains a listing of third parties described in divisions (A)(1)(b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties; 1182 1183 1184 1185 1186 1187 1188 1189 1190

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider. 1191 1192 1193 1194 1195 1196 1197 1198

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider. 1199 1200 1201

(4) Except as provided in division (A)(1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract. 1202 1203 1204 1205

(B)(1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity. 1206 1207 1208 1209

(2) Division (B)(1) of this section shall not be construed to do any of the following: 1210 1211

(a) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under all of the contracting entity's products; 1212 1213 1214

(b) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under all of the contracting entity's products; 1215 1216 1217 1218 1219

(c) Require any contracting entity to contract with a participating provider to provide health care services for less than all of the contracting entity's products if the contracting entity does not wish to do so. 1220 1221 1222 1223

(3)(a) Notwithstanding division (B)(2) of this section, no contracting entity shall require, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes. 1224 1225 1226 1227 1228

(b) If a participating provider refuses to accept any future product offering that the contracting entity makes, the contracting entity may terminate the health care contract based on the participating provider's refusal upon written notice to the 1229 1230 1231 1232

participating provider no sooner than one hundred eighty days after the refusal. 1233 1234

(4) Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the financial incentive or other form of consideration that is specified in the health care contract pursuant to division (B)(2)(b) of this section is the financial incentive or other form of consideration that was offered by the contracting entity to induce the participating provider to enter into the contract. 1235 1236 1237 1238 1239 1240 1241

(C) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider waive or forego any right or benefit expressly conferred upon a participating provider by state or federal law. However, this division does not prohibit a contracting entity from restricting a participating provider's scope of practice for the services to be provided under the contract. 1242 1243 1244 1245 1246 1247 1248

(D) No health care contract shall do any of the following: 1249

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity; 1250 1251

(2) Prohibit any contracting entity from entering into a health care contract with any other provider; 1252 1253

(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information. 1254 1255 1256 1257 1258

(E)(1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described in division (A)(3) of section 3963.04 of the Revised Code. 1259 1260 1261 1262

(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. Subject to division (E)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice. 1263 1264 1265 1266 1267 1268 1269 1270 1271 1272 1273

(3) Nothing in divisions (E)(1) and (2) of this section shall be construed as prohibiting any health insuring corporation from terminating a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a health care contract pursuant to division (E)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. 1274 1275 1276 1277 1278 1279 1280 1281 1282 1283

(4) Subject to sections 3963.01 to 3963.11 of the Revised Code, nothing in this section prohibits the termination of a health care contract without cause if the health care contract otherwise provides for termination without cause. 1284 1285 1286 1287

(F)(1) Disputes among parties to a health care contract that only concern the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this section to the 1288 1289 1290 1291 1292 1293 1294

prevailing party. 1295

(2) The arbitrator shall make the arbitrator's decision in an arbitration proceeding having due regard for any applicable rules, bulletins, rulings, or decisions issued by the department of insurance or any court concerning the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code. 1296 1297 1298 1299 1300 1301

(3) A party shall not simultaneously maintain an arbitration proceeding as described in division (F)(1) of this section and pursue a complaint with the superintendent of insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the department of insurance, the superintendent may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The superintendent may request to receive a copy of the results of the arbitration. If the superintendent of insurance notifies an insurer or a health insuring corporation in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or health insuring corporation, the arbitration proceeding shall be stayed at the request of the insurer or health insuring corporation pending the outcome of the market conduct investigation by the superintendent. 1302 1303 1304 1305 1306 1307 1308 1309 1310 1311 1312 1313 1314 1315 1316 1317 1318

Sec. 3963.03. (A) Each health care contract shall include all of the following information: 1319 1320

(1)(a) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following, subject to division (A)(1)(b) of this section: 1321 1322 1323 1324

(i) The manner of payment, such as fee-for-service, 1325

capitation, or risk; 1326

(ii) The fee schedule of procedure codes reasonably expected to be billed by a participating provider's specialty for services provided pursuant to the health care contract and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a contracting entity shall provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that shall not be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted. 1327 1328 1329 1330 1331 1332 1333 1334 1335 1336 1337 1338 1339 1340 1341

(iii) The effect, if any, on payment or compensation if more than one procedure code applies to the service also shall be stated. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted. 1342 1343 1344 1345 1346 1347 1348 1349

(b) If the contracting entity is unable to include the information described in division (A)(1)(a)(ii) and (iii) of this section, the contracting entity shall include both of the following types of information instead: 1350 1351 1352 1353

(i) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage of billed charges. If applicable, the methodology disclosure shall include the name of any relative value unit system, its version, 1354 1355 1356 1357

edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract. 1358 1359 1360 1361

(ii) The identity of any internal processing edits , including the publisher, product name, version, and version update of any editing software. 1362 1363 1364

(c) If the contracting entity is not the payer and is unable to include the information described in division (A)(1)(a) or (b) of this section, then the contracting entity shall provide by telephone a readily available mechanism, such as a specific web site address, that allows the participating provider to obtain that information from the payer. 1365 1366 1367 1368 1369 1370

(2) Any product or network for which the participating provider is to provide services; 1371 1372

(3) The term of the health care contract; 1373

(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment; 1374 1375 1376

(5) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes. 1377 1378 1379 1380 1381 1382 1383 1384

(6) A list of addenda, if any, to the contract. 1385

(B)(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of 1386 1387

the information specified in division (A) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the information in the form refers. 1388 1389 1390 1391 1392 1393

(2) The summary disclosure form shall include all of the following statements: 1394 1395

(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties; 1396 1397 1398

(b) That reading the form is not a substitute for reading the entire health care contract; 1399 1400

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions; 1401 1402 1403

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract; 1404 1405 1406 1407

(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party. 1408 1409

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law. 1410 1411 1412 1413 1414 1415 1416

(4) The summary disclosure form described in divisions (B)(1) 1417

and (2) of this section shall be in substantially the following form: 1418 1419

"SUMMARY DISCLOSURE FORM 1420

(1) Compensation terms 1421

(a) Manner of payment 1422

[ ] Fee for service 1423

[ ] Capitation 1424

[ ] Risk 1425

[ ] Other .... See 1426

(b) Fee schedule available at 1427

(c) Fee calculation schedule available at 1428

(d) Identity of internal processing edits available at 1429 1430

(e) Information in (c) and (d) is not required if information in (b) is provided. 1431 1432

(2) List of products or networks covered by this contract 1433

[ ] 1434

[ ] 1435

[ ] 1436

[ ] 1437

[ ] 1438

(3) Term of this contract 1439

(4) Contracting entity or payer responsible for processing payment available at 1440 1441

(5) Internal mechanism for resolving disputes regarding contract terms available at 1442 1443

(6) Addenda to contract 1444

Title	Subject	
(a)		1446
(b)		1447
(c)		1448
(d)		1449

1445

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer. 1450 1451 1452 1453

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 1454

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties. 1455 1456 1457 1458 1459

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract. 1460 1461 1462 1463 1464 1465 1466

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party." 1467 1468

(C) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in division (A)(1) of this section. 1469 1470 1471 1472

(D) The contracting entity shall identify any utilization management, quality improvement, or a similar program that the 1473 1474

contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program applicable to a participating provider upon request by the participating provider within fourteen days after the date of the request. 1475 1476 1477 1478 1479 1480

(E) Nothing in this section shall be construed as preventing or affecting the application of section 1753.07 of the Revised Code that would otherwise apply to a contract with a participating provider. 1481 1482 1483 1484

(F) The requirements of division (C) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract. If either party violates the confidentiality agreement, a party to the confidentiality agreement may bring a civil action to enjoin the other party from continuing any act that is in violation of the confidentiality agreement, to recover damages, to terminate the contract, or to obtain any combination of relief. 1485 1486 1487 1488 1489 1490 1491 1492 1493

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Sec. 3963.04. (A)(1) If an amendment to a health care contract is not a material amendment, the contracting entity shall provide the participating provider notice of the amendment at least fifteen days prior to the effective date of the amendment. The contracting entity shall provide all other notices to the participating provider pursuant to the health care contract. 1495 1496 1497 1498 1499 1500

1501

(2) A material amendment to a health care contract shall occur only if the contracting entity provides to the participating provider the material amendment in writing and notice of the material amendment not later than ninety days prior to the 1502 1503 1504 1505

effective date of the material amendment. The notice shall be conspicuously entitled "Notice of Material Amendment to Contract." 1506 1507 1508

(3) If within fifteen days after receiving the material amendment and notice described in division (A)(2) of this section, the participating provider objects in writing to the material amendment, and there is no resolution of the objection, either party may terminate the health care contract upon written notice of termination provided to the other party not later than sixty days prior to the effective date of the material amendment. 1509 1510 1511 1512 1513 1514 1515 1516

(4) If the participating provider does not object to the material amendment in the manner described in division (A)(3) of this section, the material amendment shall be effective as specified in the notice described in division (A)(2) of this section. 1517 1518 1519 1520 1521

(B)(1) Division (A) of this section does not apply if the delay caused by compliance with that division could result in imminent harm to an enrollee, if the material amendment of a health care contract is required by state or federal law, rule, or regulation, or if the provider affirmatively accepts the material amendment in writing and agrees to an earlier effective date than otherwise required by division (A)(2) of this section. 1522 1523 1524 1525 1526 1527 1528

(2) This section does not apply under any of the following circumstances: 1529 1530

(a) The participating provider's payment or compensation is based on the current medicaid or medicare physician fee schedule, and the change in payment or compensation results solely from a change in that physician fee schedule. 1531 1532 1533 1534

(b) A routine change or update of the health care contract is made in response to any addition, deletion, or revision of any 1535 1536

service code, procedure code, or reporting code, or a pricing change is made by any third party source. 1537 1538

For purposes of division (B)(2)(b) of this section: 1539

(i) "Service code, procedure code, or reporting code" means the current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP). 1540 1541 1542 1543 1544

(ii) "Third party source" means the American medical association, American dental association, the centers for medicare and medicaid services, the national center for health statistics, the department of health and human services office of the inspector general, the Ohio department of insurance, or the Ohio department of job and family services. 1545 1546 1547 1548 1549 1550

(C) Notwithstanding divisions (A) and (B) of this section, a health care contract may be amended by operation of law as required by any applicable state or federal law, rule, or regulation. Nothing in this section shall be construed to require the renegotiation of a health care contract that is in existence before the effective date of this section, until the time that the contract is renewed or materially amended. 1551 1552 1553 1554 1555 1556 1557

Sec. 3963.05. (A) The department of insurance shall prescribe the credentialing application form used by the council for affordable quality healthcare (CAQH) in electronic or paper format for physicians. The department of insurance also shall prepare the standard credentialing form for all other providers and shall make the standard credentialing form as simple, straightforward, and easy to use as possible, having due regard for those credentialing forms that are widely in use in the state by contracting entities and that best serve these goals. 1558 1559 1560 1561 1562 1563 1564 1565 1566

(B) No contracting entity shall fail to use the applicable standard credentialing form described in division (A) of this section when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. 1567 1568 1569 1570 1571 1572

(C) No contracting entity shall require a provider to provide any information in addition to the information required by the applicable standard credentialing form described in division (A) of this section in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. 1573 1574 1575 1576 1577 1578 1579

(D) The credentialing process described in this section does not prohibit a contracting entity from limiting the scope of any participating provider's basic health care services, specialty health care services, or supplemental health care services. 1580 1581 1582 1583

(E) The requirement that the department of insurance prepare the standard credentialing form for all other providers does not include preparing the standard credentialing form for a hospital. 1584 1585 1586

Sec. 3963.06. (A) If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form shall notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, not later than twenty-one days after the contracting entity receives the form. 1587 1588 1589 1590 1591 1592 1593

(B) If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. 1594 1595 1596 1597

The contracting entity shall send the request described in this division electronically, by facsimile, or by certified mail, return receipt requested. 1598 1599 1600

(C)(1) Except as otherwise provided in division (C)(2) of this section, the credentialing process under this section starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, and the provider shall submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, return receipt requested. Subject to division (C)(3) of this section, a contracting entity shall complete the credentialing process not later than ninety days after the contracting entity receives that credentialing form from the provider. The contracting entity shall allow the provider to submit a credentialing application prior to the provider's employment. A contracting entity that does not complete the credentialing process within the ninety-day period specified in this division is liable for either a civil penalty payable to the provider in the amount of five hundred dollars per day, including weekend days, starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied or retroactive reimbursement to the provider according to the terms of the contract for any basic health care services, specialty health care services, or supplemental health care services the provider provided to enrollees starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied. When the credentialing process of the contracting entity exceeds the ninety-day period, the contracting entity shall select the liability to which the contracting entity is subject and shall inform the provider of the contracting entity's selection. 1601 1602 1603 1604 1605 1606 1607 1608 1609 1610 1611 1612 1613 1614 1615 1616 1617 1618 1619 1620 1621 1622 1623 1624 1625 1626 1627

1628

(2) The credentialing process for a medicaid managed care 1629

plan starts when the provider submits a credentialing form and the provider's national provider number issued by the centers for medicare and medicaid services. 1630 1631 1632

(3) The requirement that the credentialing process be completed within the ninety-day period specified in division (C)(1) of this section does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity under that division is a hospital. 1633 1634 1635 1636 1637

(D) Any communication between the provider and the contracting entity shall be electronically, by facsimile, or by certified mail, return receipt requested. 1638 1639 1640

(E) If the state medical board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the educational commission for foreign medical graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the state medical board's web site or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the educational commission for foreign medical graduates, if applicable, as a condition for initially credentialing or recredentialing the physician. 1641 1642 1643 1644 1645 1646 1647 1648 1649 1650 1651 1652 1653

Sec. 3963.07. (A) All remittance notices sent by a payer, whether written or electronic, shall include both of the following: 1654 1655 1656

(1) The name of the payer issuing the payment to the participating provider; 1657 1658

(2) The name of the contracting entity through which the 1659

payment rate and any discount are claimed, if the contracting entity is different from the payer. 1660 1661

(B) Division (A) of this section takes effect March 31, 2009. 1662

Sec. 3963.08. The superintendent of insurance shall adopt any rules necessary for the implementation of this chapter. 1663 1664

Sec. 3963.09. (A) A series of violations of this chapter by any person regulated by the department of insurance under Title XVII or Title XXXIX of the Revised Code that, taken together, constitute a pattern or practice of violating this chapter may be defined as an unfair and deceptive insurance practice under sections 3901.19 to 3901.26 of the Revised Code. 1665 1666 1667 1668 1669 1670

(B) The superintendent of insurance may conduct a market conduct examination of any person regulated by the department of insurance under Title XVII or Title XXXIX of the Revised Code to determine whether any violation of this chapter has occurred. When conducting that type of examination, the superintendent of insurance may assess the costs of the examination against the person examined. The superintendent may enter into a consent agreement to impose any administrative assessment or fine for conduct discovered that may be a violation of this chapter. All costs, assessments, and fines collected under this section shall be deposited to the credit of the department of insurance operating fund. 1671 1672 1673 1674 1675 1676 1677 1678 1679 1680 1681 1682

Sec. 3963.10. This chapter does not apply with respect to any of the following: 1683 1684

(A) A contract or provider agreement between a provider and the state or federal government, a state agency, or federal agency for health care services provided through a program for medicaid or medicare; 1685 1686 1687 1688

(B) A contract for payments made to providers for rendering health care services to claimants pursuant to claims made under Chapter 4121., 4123., 4127., or 4131. of the Revised Code; 1689 1690 1691

(C) An exclusive contract between a health insuring corporation and a single group of providers in a specific geographic area to provide or arrange for the provision of health care services. 1692 1693 1694 1695

Sec. 3963.11. (A) No contracting entity shall do any of the following: 1696 1697

(1) Offer to a provider other than a hospital a health care contract that includes a most favored nation clause; 1698 1699

(2) Enter into a health care contract with a provider other than a hospital that includes a most favored nation clause; 1700 1701

(3) Amend an existing health care contract previously entered into with a provider other than a hospital to include a most favored nation clause. 1702 1703 1704

(B) This section shall not go into effect until three years after the effective date of this section. 1705 1706

(C) As used in this section: 1707

(1) "Contracting entity," "health care contract," "health care services," "participating provider," and "provider" have the same meanings as in section 3963.01 of the Revised Code. 1708 1709 1710

(2) "Most favored nation clause" means a provision in a health care contract that does any of the following: 1711 1712

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract; 1713 1714 1715 1716

(b) Requires, or grants a contracting entity an option to 1717

require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price; 1718 1719 1720

(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price; 1721 1722 1723 1724 1725

(d) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities. 1726 1727 1728

Sec. 5111.17. (A) The department of job and family services may enter into contracts with managed care organizations, including health insuring corporations, under which the organizations are authorized to provide, or arrange for the provision of, health care services to medical assistance recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under section 5111.16 of the Revised Code. 1729 1730 1731 1732 1733 1734 1735 1736 1737

(B) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. 1738 1739 1740

(C) The department of job and family services shall allow managed care plans to use providers to render care upon completion of the managed care plan's credentialing process. 1741 1742 1743

Section 2. That existing sections 1751.13, 1753.01, 1753.07, 1753.09, 2317.54, 3701.741, 3702.51, and 5111.17 and sections 1753.03, 1753.04, 1753.05, and 1753.08 of the Revised Code are hereby repealed. 1744 1745 1746 1747

Section 3. Sections 3963.01 to 3963.11 of the Revised Code, as enacted by this act, shall apply only to contracts that are delivered, issued for delivery, or renewed or materially amended in this state on or after the effective date of this act. A health insuring corporation having fewer than fifteen thousand enrollees shall comply with the provisions of this section within twelve months after the effective date of this act. 1748 1749 1750 1751 1752 1753 1754

Section 4. Section 3963.06 of the Revised Code, as enacted by this act, takes effect ninety days after the effective date of this act. 1755 1756 1757

Section 5. (A) As used in this section and Section 6 of this act: 1758 1759

(1) "Most favored nation clause" means a provision in a health care contract that does any of the following: 1760 1761

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract; 1762 1763 1764 1765

(b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price; 1766 1767 1768 1769

(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price; 1770 1771 1772 1773 1774

(d) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with 1775 1776

other contracting entities. 1777

(2) "Contracting entity," "health care contract," "health care services," "participating provider," and "provider" have the same meanings as in section 3963.01 of the Revised Code, as enacted by this act. 1778 1779 1780 1781

(B) No health care contract that includes a most favored nation clause shall be entered into, and no health care contract at the instance of a contracting entity shall be amended or renewed to include a most favored nation clause, for a period of two years after the effective date of this act, subject to extension as provided in Section 6 of this act. This section does not apply to and does not prohibit the continued use of a most favored nation clause in a health care contract that is between a contracting entity and a hospital and that is in existence on the effective date of this act even if the health care contract is materially amended with respect to any provision of the health care contract other than the most favored nation clause during the two-year period specified in this section or during any extended period of time as provided in Section 6 of this act. 1782 1783 1784 1785 1786 1787 1788 1789 1790 1791 1792 1793 1794 1795

Section 6. (A) There is hereby created the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts consisting of seventeen members as follows: 1796 1797 1798

(1) The Superintendent of Insurance; 1799

(2) Two members of the House of Representatives, one representing the majority party and one representing the minority party; 1800 1801 1802

(3) Two members of the Senate, one representing the majority party and one representing the minority party; 1803 1804

(4) Three providers who are individuals; 1805

(5) Two representatives of hospitals; 1806

(6) Two representatives of contracting entities regulated by the Department of Insurance under Title XVII of the Revised Code; 1807 1808

(7) Two representatives of contracting entities regulated by the Department of Insurance under Title XXXIX of the Revised Code; 1809 1810

(8) One representative of an employer that pays for the health insurance coverage of its employees; 1811 1812

(9) A licensed attorney with an expertise in antitrust law who represents providers; 1813 1814

(10) A licensed attorney with an expertise in antitrust law who represents contracting entities that have used most favored nation clauses in their health care contracts and that are regulated by the Department of Insurance under either Title XVII or Title XXXIX of the Revised Code. 1815 1816 1817 1818 1819

(B) The members of the Commission shall be appointed as follows: 1820 1821

(1) The Speaker of the House of Representatives shall appoint the two members of the House specified in division (A)(2) of this section. 1822 1823 1824

(2) The President of the Senate shall appoint the two members of the Senate specified in division (A)(3) of this section. 1825 1826

(3) The Speaker of the House of Representatives and the President of the Senate jointly shall appoint the remaining members specified in divisions (A)(4) to (10) of this section. 1827 1828 1829

(C) Initial appointments to the Commission shall be made within thirty days after the effective date of this act. The appointments shall be for the term of the Commission as provided in division (F)(2) of this section. Vacancies shall be filled in the same manner provided for original appointments. 1830 1831 1832 1833 1834

(D)(1) The Superintendent of Insurance shall be the Chairperson of the Commission. Meetings of the Commission shall be 1835 1836

at the call of the Chairperson. All of the members of the Commission shall be voting members. Meetings of the Commission shall be held pursuant to section 121.22 of the Revised Code. 1837 1838 1839

(2) The Department of Insurance shall provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Commission. 1840 1841 1842 1843

(3) The Chairperson of the Commission shall keep the records of the Commission. Upon submission of the Commission's final report to the General Assembly under division (F) of this section, the Chairperson shall deliver all of the Commission's records to the General Assembly. 1844 1845 1846 1847 1848

(E)(1) The Commission shall study the following areas pertaining to health care contracts: 1849 1850

(a) The procompetitive and anticompetitive aspects of most favored nation clauses; 1851 1852

(b) The impact of most favored nation clauses on health care costs and on the availability of and accessibility to quality health care; 1853 1854 1855

(c) The costs associated with the enforcement of most favored nation clauses; 1856 1857

(d) Other state laws and rules pertaining to most favored nation clauses in their health care contracts; 1858 1859

(e) Matters determined by the Department of Insurance as relevant to the study of most favored nation clauses; 1860 1861

(f) Any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses. 1862 1863 1864

(2) The Commission may take testimony from experts or interested parties on the areas of its study as described in 1865 1866

division (E)(1) of this section. 1867

(F)(1) Not less than ninety days prior to the expiration of the two-year period specified in Section 5 of this act, the Commission shall report its preliminary findings to the General Assembly and a recommendation of whether to extend that two-year period for one additional year. If the General Assembly does not grant the extension, the Commission shall submit its final report to the General Assembly not later than three months after the expiration of the two-year period specified in Section 5 of this act. If the General Assembly grants the extension, the extension shall be for not more than one year after the expiration of the two-year period specified in Section 5 of this act, and the Commission shall submit its final report to the General Assembly not later than six months prior to the expiration of the one-year extension. 1868 1869 1870 1871 1872 1873 1874 1875 1876 1877 1878 1879 1880 1881

(2) The final report of the Commission shall include its findings and recommendations on whether state law should prohibit or restrict most favored nation clauses in health care contracts. The Commission shall cease to exist upon the submission of its final report to the General Assembly. 1882 1883 1884 1885 1886

Section 7. (A) There is hereby created the Advisory Committee on Eligibility and Real Time Claim Adjudication to study and recommend mechanisms or standards that will enable providers to send to and receive from payers sufficient information to enable a provider to determine at the time of the enrollee's visit the enrollee's eligibility for services covered by the payer as well as real time adjudication of provider claims for services. 1887 1888 1889 1890 1891 1892 1893

(B) The Superintendent of Insurance or the Superintendent's designee shall be a member of the Advisory Committee and shall appoint at least one representative from each of the following groups or entities: 1894 1895 1896 1897

(1) Persons eligible for health care benefits under a health benefit plan; 1898 1899

(2) Physicians; 1900

(3) Hospitals; 1901

(4) Health benefit plan issuers; 1902

(5) Other health care providers; 1903

(6) Health care administrators; 1904

(7) Payers of health care benefits, including employers; 1905

(8) Preferred provider networks; 1906

(9) Health care technology vendors; 1907

(10) The Office of Information Technology. 1908

(C) Initial appointments to the Advisory Committee shall be made within thirty days after the effective date of this act. The appointments shall be for the term of the Advisory Committee as provided in division (I) of this section. Vacancies shall be filled in the same manner provided for original appointments. Members of the Advisory Committee shall serve without compensation. 1909 1910 1911 1912 1913 1914 1915

(D)(1) The Superintendent of Insurance shall be the Chairperson of the Advisory Committee. Meetings of the Advisory Committee shall be at the call of the Chairperson. All of the members of the Advisory Committee shall be voting members. Meetings of the Advisory Committee shall be held pursuant to section 121.22 of the Revised Code. 1916 1917 1918 1919 1920 1921

(2) The Department of Insurance shall provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Advisory Committee. 1922 1923 1924 1925

(E)(1) The Advisory Committee shall advise the Superintendent 1926

of Insurance on both of the following: 1927

(a) The technical aspects of using the transaction standards mandated by the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., and the transaction standards and rules of the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange to require health benefit plan issuers and administrators to provide access to information technology that will enable physicians and other health care providers to generate a request for eligibility information at the point of service that is compliant with those transaction standards; 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937

(b) The data elements that health benefit plan issuers and administrators are required to make available, using, to the extent possible, the framework adopted by the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange. 1938 1939 1940 1941 1942

(2) The Advisory Committee shall consider including the following data elements in the information that must be made available in eligibility and real time adjudication transactions: 1943 1944 1945

(a) The name, date of birth, member identification number, and coverage status of the patient; 1946 1947

(b) The identification of the payer, insurer, issuer, and administrator, as applicable; 1948 1949

(c) The name and telephone number of the payer's contact person; 1950 1951

(d) The payer's address; 1952

(e) The name and address of the subscriber; 1953

(f) The patient's relationship to the subscriber; 1954

(g) The type of service; 1955

(h) The type of health benefit plan or product; 1956

(i) The effective date of the health care coverage; 1957

(j) For professional services: 1958

(i) The amount of any copayment; 1959

(ii) The amount of an individual deductible; 1960

(iii) The amount of a family deductible; 1961

(iv) Benefit limitations and maximums. 1962

(k) For facility services: 1963

(i) The amount of any copayment or coinsurance; 1964

(ii) The amount of an individual deductible; 1965

(iii) The amount of a family deductible; 1966

(iv) Benefit limitations and maximums. 1967

(l) Precertification or prior authorization requirements; 1968

(m) Policy maximum limits; 1969

(n) Patient liability for a proposed service; 1970

(o) The health benefit plan coverage amount for a proposed 1971
service. 1972

(F) The Advisory Committee shall make recommendations 1973
regarding all of the following: 1974

(1) The use of internet web site technologies, smart card 1975
technologies, magnetic strip technologies, biometric technologies, 1976
or other information technologies to facilitate the generation of 1977
a request for eligibility information that is compliant with the 1978
transaction standards and rules of the Council for Affordable 1979
Quality Healthcare Committee on Operating Rules for Information 1980
Exchange; 1981

(2) Time frames for the implementation of the recommendations 1982
in division (F)(1) of this section; 1983

(3) When a provider may rely upon the eligibility information transmitted by a payer regarding a service provided to an enrollee for purposes of allocating responsibility for payment for services rendered by the provider. The Advisory Committee shall further recommend how disputes over enrollee eligibility for services received shall be resolved taking into consideration the legal relationship between the provider, the enrollee, and the payer. 1984 1985 1986 1987 1988 1989 1990

(G) The recommendations made by the Advisory Committee shall not endorse or otherwise limit the choice of products or services available to health care payers, purchasers, or providers. 1991 1992 1993

(H) Not later than January 1, 2009, the Advisory Committee shall provide the General Assembly with a report of its findings and recommendations for legislative action to standardize eligibility and real time adjudication transactions between providers and payers. The transaction standards adopted by the General Assembly shall, at a minimum, comply with the standards mandated by the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as further defined in Title 45, part 162 of the Code of Federal Regulations to the extent that the "Health Insurance Portability and Accountability Act of 1996" applies to the transaction. 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004

(I) The Advisory Committee shall cease to exist upon the submission of its report and recommendations to the General Assembly. 2005 2006 2007