

Issues

1. For the purposes of new Ohio Revised Code Chapter 3963, "provider" is defined to include a number of health care provider types including "provider organization[s]" and "physician-hospital organization[s]". Revised Code Section 3963.01(P) states that provider organizations and physician-hospital organizations are "providers" when "acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts". This section of the Revised Code further states that provider organizations and physician-hospital organizations are not "providers" when they "lease the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds". We interpret them to mean that "provider organizations" that act solely as a messenger for their participants – centrally negotiating contracts with third parties and offering those contracts to their participating providers – are "providers" for the purposes of Revised Code Chapter 3963. Those physician organizations and physician-hospital organizations that lease their networks or contract directly with third parties are not "providers" but are "contracting entities". Therefore, these physician organizations and physician-hospital organizations will be required to comply with the provisions of Revised Code Chapter 3963 that apply to "contracting entities".

2. The bill requires the use of the CAQH form for credentialing and recredentialing physicians after June 25, 2008. Does this mean the recredentialing after this date is only for those providers initially credentialed using the CAQH form?

3. Current federal law (42 USC Section 1395w-26(b)(3)) and regulations (42 CFR 422.402 and 42 CFR 422.108) preempt state laws, except those pertaining to solvency and licensing, with regard to Medicare Advantage Plans. The CMS Medicare Managed Care Manual provides that federal law and regulations "supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans." This statement is contained in Section 10 of the CMS Medicare Managed Care Manual. This manual can be found at <http://www.cms.hhs.gov/manuals/downloads/mc86c10.pdf>.

Therefore, it is our understanding that the provisions of HB 125 do not apply to Medicare Advantage plans. Please notify us immediately if ODI is aware of any other federal rule or regulations which would allow Ohio to apply these provisions to Medicare Advantage plans.

4. Section 3963.03 requires a contracting entity to include a summary disclosure form with each health care contract.

Is a summary disclosure form required for health care contracts that are in existence prior to June 25, 2008? If so, what triggers the distribution of the summary disclosure form for such contracts? The renewal of the contract only?

How often is a contracting entity expected to update the summary disclosure form once it has been distributed to a provider? Only when changes are made to a provider contract affecting the summary disclosure form?

5. Please advise if a provider terminates pursuant to an unwanted material amendment, what termination effective date would apply. The (60) day period appears to speak to the notice time period only. Is the statute silent on the termination effective date, is the termination effective immediately, at the end of some 60 day period, or the amendment effective date? Or do the termination provisions within the provider contract itself control? For example, if a provider issues a termination notice within the (60) day notice period as provided below, and has a (90) day notice provision for termination within his provider agreement, would he be obligated to fulfill the (90) day notice period under the provider agreement? This is an important question in particular as it relates to hospitals and member access concerns. Allowing a hospital to terminate from a network with only 60 days notice could create access issues for members. It does not allow a contracting entity time to prepare for an effective disruption plan.

6. RC 3963.04 - 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.
7. Section 3963.02(A)(1)(c)(ii) and (iii) states that PPOs, PPO networks, and entities engaged in the business of electronic claims transport contracting with the primary contracting entity (which may be a PPO or PPO network) must abide by all of the original contracting terms between the contracting entity and the provider. It looks like TPAs contracting with the contracting entity do not have to abide by the original terms of the contract (Section 3963.02(A)(1)(c)(i)). Is this correct or does Sec. 3963.02(A)(2)(b) subject TPAs to all of the terms and conditions of the original contract between the contracting entity and the provider?
8. What is the definition of "third party" in Section 3963.02? "Third party" is not defined in Section 3963.01. Is it being defined by 3702.51(A)(1)(a), (b), and (c)? If so a "third party" under HB 125 can only be a TPA, PPO, PPO network or an entity engaged in the business of electronic claims transport? For example is a PPO network prohibited from selling, renting, etc. directly to a payer?