Ohio's 'Healthcare Simplification Act' Imposes New Restrictions on Provider Contracting and Credentialing

Abstract of Ohio's Healthcare Simplification Act

Detailed Analysis of the Act

Ohio House Bill 125—the 'Healthcare Simplification Act'—was unanimously approved by the Senate on March 11, 2008, and signed into law by Ohio Governor Ted Strickland on March 25, 2008. This Act makes sweeping changes to Ohio law impacting nearly all healthcare providers (especially physicians), insurers, health insuring corporations, and other third party payors (possibly including ERISA plans in some cases), and certain third party administrators and other intermediaries. The Act regulates healthcare contracts entered into by the majority of providers with insurers on or after, and in some cases before, June 10, 2008.

The Act, which was endorsed by many healthcare providers and strongly championed by the Ohio State Medical Association, prohibits an insurer from selling or renting provider networks and from mandating certain predatory contract clauses, including 'all products', 'future products', 'most favored nation' (subject to a moratorium, except not applicable to existing hospital contracts), 'waiver of legal rights', and certain 'noncompetition' clauses. Additionally, the Act requires provider contracts to contain certain specific provisions—including reasonable 'for cause' termination, binding arbitration, and material and non-material amendment provisions—which afford providers a number of grounds upon which to terminate. Further, it requires insurers to deliver a Summary Disclosure Form to each participating provider that discloses to the provider early in the contracting process the insurer's fee structure, methodology for calculating provider compensation, and covered products and networks. It is still unclear whether these provisions will apply to self-funded ERISA plans.

The new law also contains a number of credentialing provisions that will eliminate economic credentialing, require new standardized credentialing forms, and mandate that credentialing be completed within a 90-day period.
Finally, the Act creates an Advisory Committee to examine the feasibility of ‘real time’ eligibility and claims adjudication and contains a number of other provisions relating to payor remittances, county nursing home licensing requirements, and obtaining informed consent for children of minor parents.

**Detailed Analysis of Ohio’s New ‘Healthcare Simplification Act’**

Ohio House Bill 125, the ‘Healthcare Simplification Act’ (the “Act”), was unanimously approved by the Senate on March 11, 2008, and signed into law by Ohio Governor Ted Strickland on March 25, 2008. The Act makes sweeping changes to Ohio law impacting nearly all providers of healthcare services, insurers, health insuring corporations, and other third party payors (possibly including ERISA plans in some cases), and certain third party administrators and other intermediaries. With certain exceptions noted below, the Act takes effect June 10, 2008.

Legislators contend the Act will strengthen the position of physicians and other providers of healthcare services in negotiations with health insurance companies and other third party payors by setting standards for transparency in medical contracting, credentialing and provider access to information. Unfortunately—or fortunately, depending upon one's perspective—the increased leverage will come at the detriment of healthcare payors operating in Ohio. As a result, both payors and providers need to be familiar with the Act.

**Provider Contracting**

The Act regulates contracts that are entered into, materially amended, or renewed between an entity that has a “primary business purpose” of contracting with healthcare providers for the delivery of healthcare services to an enrollee (“contracting entity”) on or after June 10, 2008. However, services provided by a pharmacist or nursing home are specifically excluded in many cases.

Under the Act, a contracting entity is prohibited from:

- Selling or renting provider networks, subject to certain exceptions.

- Requiring participating providers to provide services for all of the contracting entity's products. However, contracting entities may offer providers financial incentives to participate in all of the plans, or may refuse to contract unless all (existing) products are included.

- Requiring participating providers to provide services under any future product offered by the contracting entity. However, a refusal by a provider to accept such an offering may permit a contracting entity to terminate the provider's contract with 180 days prior notice.

- Requiring participating providers to waive or forego any right or benefit expressly conferred upon the provider by state or federal law.
Prohibiting a party from entering into a contract with any other contracting entity or provider.

If a contract permits termination 'for cause', it can not do so for any reason that is otherwise unlawful, or not specifically provided for by the Act. However, a contract may still include a 'without cause' termination provision.

Including a ‘most favored nation’ clause or executing any contract including, or amending any contract to include, such a clause (except with respect to a hospital contract) after March 25, 2011. The Act also creates a commission to study the impact of most favored nation clauses. ‘Most favored nation’ clauses typically require a provider to give an insurer the lowest rate it gave to any other insurer for the provision of the same service. Despite this delayed moratorium, an uncodified portion of the Act imposes an immediate moratorium by providing that beginning June 10, 2008, no contract (except hospital contracts) that includes a most favored nation clause shall be entered into, and no contract, at the insistence of a contracting entity, shall be amended (including clauses in existing hospital contracts) or renewed to include such a clause, for a period of 2 years (subject to a 1 year extension pending a final report by the Joint Commission).

Other requirements for healthcare contracts imposed by the Act include the following:

Contracts must expressly state the reasons that may be used for termination ‘for cause’ and such terms must be reasonable (once the contract is signed, the grounds for termination are deemed to be reasonable, perhaps subject to rebuttal).

Contracts must include a binding arbitration clause (mechanism to be agreed upon by the parties) for contract disputes related to certain statutory rights provided under newly enacted RC Chapter 3963.

Contracts must provide that any material amendment requires the amending party to send written notice not later than 90 days prior to the effective date of the amendment. If the provider objects and there is no resolution, either party may terminate the contract upon written notice.

Non-material amendments, however, can be made with 15 days prior written notice to the provider, or immediately, if harm to an enrollee is deemed imminent; material amendments can be made immediately if required by state or federal law (i.e., changes in the Medicare fee schedule or CPT codes) or contemplated by the terms of the contract.

While the Act does not alter existing requirements and restrictions for contacts between Ohio health insuring corporations and providers or healthcare facilities, it does prohibit those contracts from containing any
provision that violates these new provider contracting provisions.

Provider Access to Information

Prior to the execution of a provider contract, in addition to information required to be disclosed under existing law, the Act requires contracting entities to provide, or provide reasonable access to, basic information regarding its programs and procedures to providers, including:

- Compensation or payment terms, including (1) the manner of payment (fee for service, capitation, or risk), or if not applicable, the method used to calculate fees (RVUs, conversion factors, or percentage of billed charges) and anticipated timing of updates (including the identity of internal processing edits); (2) a written or electronic fee schedule, with updates, for relevant procedure codes in most cases; and (3) a method to calculate any effect on payment of multiple applicable procedure codes prior to providing service or billing.

- Covered products or networks.

- Contract term.

- Website address for the contracting entity or payor responsible for processing payment.

- Internal dispute resolution procedures regarding contract terms.

- Addenda, if any, to the contract.

This information must appear in a ‘Summary Disclosure Form’ that must be included with the contract. In addition, a contracting entity must provide specific information regarding utilization management, quality improvement, or similar programs within 14 days of request. Contracting entities may also require that providers agree to ‘reasonable’ confidentiality provisions regarding this information.

Remittances of Payment

Starting March 31, 2009, payor remittance notices must include the name of the payor issuing payment and the name of the contracting entity through which the payment rate and any discount are claimed (if different from the payor).

Repeated Violations

Repeated violations of RC Chapter 3963 by any person regulated by the Department of Insurance as an insurer or health insuring corporation that constitute a pattern or practice may be deemed to be an unfair or deceptive insurance practice.

Real-Time Eligibility and Claims Adjudication

The Act creates the ‘Advisory Committee on Eligibility and
Real Time Claim Adjudication to study and recommend mechanisms or standards to enable providers to send to, and receive from payors, sufficient information to allow providers to determine eligibility for services covered by the payor at the time of the enrollee's visit as well as real-time adjudication of provider claims for services.

**Credentialing**

The following credentialing provisions are effective September 8, 2008:

- The Act eliminates economic profiling as a factor in credentialing providers.

- The Act also requires the Ohio Department of Insurance to adopt and require contracting entities to use for physicians, the credentialing application form employed by the Council for Affordable Quality Healthcare ("CAQH") and a simple and straightforward standard credentialing form for all other providers, other than hospitals.

  - The Act reverses existing Ohio law by providing that a contracting entity may not require information in addition to that set forth on the applicable standard credentialing form.

  - The Ohio Medicaid program is required to accept any provider that completes a managed care plan's credentialing process.

  - Contracting entities must complete the credentialing process not later than 90 days after the contracting entity receives the credentialing form from the provider (except hospitals). In addition, providers must be allowed to submit a credentialing form prior their employment of a physician. A contracting entity that fails to complete the credentialing process within this 90 day period is liable for a civil penalty payable to the provider until the provider's application is approved or denied, or retroactive reimbursement for services rendered is granted or denied.

  - To the extent that the State Medical Board has verified through a primary source medical education, graduate medical education, and examination history of a physician (or the physician's status with the educational commission for foreign medical graduates), the Act provides that a contracting entity may accept the documentation (including information from the Board's website) and is not required to perform additional verification.

**Informed Consent and ‘Minor Parents’**

The Act clarifies that Ohio's informed consent laws permit a minor parent to provide informed consent for their minor child and permits a parent (whether an adult or minor) to grant (by
written authorization) authority to an adult to provide informed consent on behalf of that granting parent's child.

Looking Ahead

Providers contend the Act will mark the end of historic ‘take-it or leave-it’ predatory payor contract practices (such as ‘most favored nation’ clauses), which otherwise leave physicians with little to no bargaining power to negotiate fairer treatment. Supporters of the Act included the 20,000 member Ohio State Medical Association (‘OSMA’), which during the consideration of House Bill 125 issued a position paper expressing concern for the increasing amount of time physicians must spend dealing with administrative issues (such as credentialing, eligibility verification, and claims adjudication), as opposed to caring for patients. Opponents of the Act maintain that it poses a serious threat to consumer access due to administrative burdens and because contracting entities will no longer have the ability to require providers to participate in more than one product. The Senate amendments, reflected in the final version of the Act, were made in an attempt to address many of these issues.

However, a continuing concern among employers with self-funded ERISA health insurance plans is whether the Act will impact them. While the Act does not expressly apply to self-funded plans, the definition of the term ‘contracting entity’ could be broadly interpreted to include these types of employer plans. In considering House Bill 125, the Ohio House of Representatives heard testimony from attorneys (representing OSMA) that the bill would only regulate contracts between insurance companies and physicians (and other providers) and would not impact self-funded ERISA plans. Nevertheless, little was done to specifically clarify this issue in the final language of the Act and, therefore, employers should review their plan's terms and operations and consult with legal counsel to determine whether, and to what extent, the Act's provisions apply to them or are preempted by ERISA.

For more information, please contact Frank C. Miller, fmiller@bakerlaw.com or 614.462.5193 or Mark Hatcher, mhatcher@bakerlaw.com or 614.462.4765.

Baker & Hostetler LLP publications are intended to inform our clients and other friends of the Firm about current legal developments of general interest. They should not be construed as legal advice, and readers should not act upon the information contained in these publications without professional counsel. The hiring of a lawyer is an important decision that should not be based solely upon advertisements. Before you decide, ask us to send you written information about our qualifications and experience.

[Florida Rule 4-7.2(d)] © 2008 Baker & Hostetler LLP