OHIO LEGISLATIVE SERVICE COMMISSION

Bill Analysis

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H.B. 197

132nd General Assembly
(As Introduced)

Rep. Patton

BILL SUMMARY

- Permits an emergency medical technician (EMT) to provide nonemergency medical services to an individual pursuant to a care plan from the individual's primary care physician.
- Requires that the medical services be nonemergency services, be within the scope of the EMT's certification, and be administered under the direction of the medical director or cooperating physician advisory board.
- Requires a health insurance policy and Medicaid to cover medical services a covered individual receives from an EMT under a care plan.
- Compels a health plan issuer to provide the EMT with an explanation of benefits.
- Prohibits the EMT from billing a covered individual for anything other than the listed cost sharing requirements.
- Permits the EMT to bill the health plan issuer directly for the services rendered.
- Specifies that a violation of these provisions is a violation of the relevant licensing law.

CONTENT AND OPERATION

Provision of nonemergency medical services

Continuing law permits an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic (EMT) to provide medical services to an individual in a nonemergency situation if (1) the EMT is

authorized by law to perform the services and (2) the services are provided under the direction of the EMT's medical director or cooperating physician advisory board. No medical director or cooperating physician advisory board can authorize an EMT to perform any medical service that the EMT is not authorized by law to perform.[1]

The bill further permits an EMT to provide nonemergency medical services to an individual in accordance with the individual's care plan. The medical services must comply with the continuing law requirements described above and may include:

- Health assessments;
- Chronic disease monitoring and education;
- Medication compliance;
- Immunizations and vaccinations;
- Laboratory specimen collection;
- Hospital discharge follow-up care;
- Other minor medical procedures approved by the medical director or cooperating physician advisory board.[2]

Care plan requirements

The bill establishes requirements for care plans under which an EMT can provide these nonemergency medical services. The care plan must:

- Be established for an individual by the individual's primary care physician in consultation with the EMT's medical director or cooperating physician advisory board.
- Ensure that any medical service provided by the EMT is coordinated with other community health care practitioners and local health agencies. This requirement ensures that the provided medical service is not duplicated by different practitioners and agencies.[3]

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[1] R.C. 4765.361, not in the bill.

[2] R.C. 4765.362(B) and (D).

[3] R.C. 4765.362(B) and (C).

Additionally, if the individual is participating in a care coordination program, the care plan must be made in consultation with the health care practitioners providing the individual's care coordination services. "Care coordination" is the deliberate organization of patient care activities between two or more participants, including the patient, involved in a patient's care to facilitate the appropriate delivery of health care services.[4]

Health insurance coverage

Policies of health insurance

The bill requires a policy of health insurance (essentially a private health insurance policy, except for certain limited benefit or specialty plans) to cover nonemergency services administered by an EMT in accordance with a care plan pursuant to the bill. After such a medical service is administered, the health plan issuer must provide the EMT with a written explanation of benefits (EOB) specifying the applicable reimbursement for the service. The EOB must also include any deductible, copayment, or coinsurance amounts owed by the covered individual. The EMT cannot bill the covered individual for anything other than the applicable deductible, copayment, or coinsurance amounts for the medical service.[5]

Direct billing to health plan issuer

An EMT may bill the health plan issuer directly for the nonemergency medical service. Under those circumstances, the health plan issuer must reimburse the EMT the greatest of the following amounts:

- The amount of the bill from the EMT;
- The usual, customary, and reasonable rate for the service;
- The Medicare reimbursement rate for the service.[6]

Medicaid

Under the bill, the Medicaid program also must cover nonemergency medical services performed by an EMT in accordance with a care plan.[7] Reimbursement and billing for such services will be done in accordance with existing Medicaid procedure.

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[4] R.C. 4765.362(C).

[5] R.C. 4765.363(A), (B), and (C) and 4765.362(A).

[6] R.C. 4765.363(D).

Violations

The bill specifies that a violation of its (1) health insurance coverage or (2) direct billing provisions is a violation of the relevant licensing or certification law by the applicable licensing entity overseeing the EMT.[8]

Definition

Under the bill, "policy of health insurance" means:

- Any policy, contract, plan, or agreement of sickness and accident insurance; subscriber policies, contracts, certificates, agreements, or any other evidence of coverage issued by health plan issuers;
- Any certificate, contract, or policy issued by a fraternal benefit society;
- Any certificate issued pursuant to a group insurance policy; and
- Any evidence of coverage issued by a multiple employer welfare arrangement.[9]

HISTORY

ACTION	DATE
Introduced	05-02-17

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[7] R.C. 5164.11.

[8] R.C. 4765.363(E).

[9] R.C. 4765.362(A); and R.C. 3922.01, not in the bill.