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136th General Assembly  
Regular Session  
2025-2026

Sub. H. B. No. 795

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To amend sections 109.85, 117.10, 2903.216, 1  
2913.40, 2923.31, 4113.52, 5164.32, 5164.33, 2  
5164.34, 5164.342, 5164.36, 5164.57, and 5167.18 3  
and to enact sections 103.413, 3901.93, 4  
5162.138, 5162.139, 5162.1311, 5162.17, 5162.19, 5  
5163.05, 5164.12, 5164.13, 5164.292, 5164.302, 6  
5164.303, 5164.304, 5164.305, 5164.331, 7  
5164.332, 5164.40, 5164.401, 5164.402, 5164.403, 8  
5164.404, 5164.405, 5164.406, 5164.41, 5164.42, 9  
5164.421, 5164.43, and 5167.23 of the Revised 10  
Code regarding program integrity for certain 11  
components of the Medicaid program, regarding 12  
the authority of the Attorney General and 13  
Auditor of State, and to name this act the Ohio 14  
Medicaid Program Integrity and Fraud Prevention 15  
Act. 16

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

**Section 1.** That sections 109.85, 117.10, 2903.216, 17  
2913.40, 2923.31, 4113.52, 5164.32, 5164.33, 5164.34, 5164.342, 18  
5164.36, 5164.57, and 5167.18 be amended and sections 103.413, 19



3901.93, 5162.138, 5162.139, 5162.1311, 5162.17, 5162.19, 20  
5163.05, 5164.12, 5164.13, 5164.292, 5164.302, 5164.303, 21  
5164.304, 5164.305, 5164.331, 5164.332, 5164.40, 5164.401, 22  
5164.402, 5164.403, 5164.404, 5164.405, 5164.406, 5164.41, 23  
5164.42, 5164.421, 5164.43, and 5167.23 of the Revised Code be 24  
enacted to read as follows: 25

Sec. 103.413. Annually, the standing committees of the 26  
house of representatives and the senate that primarily consider 27  
legislation governing the medicaid program shall meet jointly 28  
and conduct a review of one-quarter of the medicaid waiver 29  
components as defined in section 5166.01 of the Revised Code 30  
operating within the medicaid program. The review shall focus on 31  
the waiver's purpose and evaluate the waiver's success at 32  
achieving the desired purpose. The standing committees shall 33  
review all medicaid waiver components within the medicaid 34  
program before conducting a subsequent review of any medicaid 35  
waiver component. 36

Sec. 109.85. (A) Upon the written request of the governor, 37  
the general assembly, the auditor of state, the medicaid 38  
director, the director of health, or the director of budget and 39  
management, or upon the attorney general's becoming aware of 40  
criminal or improper activity related to Chapter 3721. of the 41  
Revised Code and the medicaid program, the attorney general 42  
shall investigate any criminal or civil violation of law related 43  
to Chapter 3721. of the Revised Code or the medicaid program. In 44  
any investigation conducted pursuant to this section the 45  
attorney general may administer oaths, subpoena witnesses, 46  
adduce evidence, and subpoena the production of any book, 47  
document, record, or other relevant matter. 48

~~(B)~~ (B) (1) If the attorney general under division (A) of 49

this section subpoenas the production of any relevant matter 50  
that is located outside this state, the attorney general may 51  
designate a representative, including an official of the state 52  
in which that relevant matter is located, to inspect the 53  
relevant matter on the attorney general's behalf. The attorney 54  
general may carry out similar requests received from officials 55  
of other states. 56

(2) Any person who is subpoenaed to produce relevant 57  
matter pursuant to division (A) of this section shall make that 58  
relevant matter available at a convenient location within this 59  
state or the state of the representative designated under 60  
division (B) (1) of this section. 61

(C) Any person who is subpoenaed as a witness or to 62  
produce relevant matter pursuant to division (A) of this section 63  
may file in the court of common pleas of Franklin county, the 64  
county in this state in which the person resides, or the county 65  
in this state in which the person's principal place of business 66  
is located a petition to extend for good cause shown the date on 67  
which the subpoena is to be returned or to modify or quash for 68  
good cause shown that subpoena. The person may file the petition 69  
at any time prior to the date specified for the return of the 70  
subpoena or within twenty days after the service of the 71  
subpoena, whichever is earlier. 72

(D) Any person who is subpoenaed as a witness or to 73  
produce relevant matter pursuant to division (A) of this section 74  
shall comply with the terms of the subpoena unless the court 75  
orders otherwise prior to the date specified for the return of 76  
the subpoena or, if applicable, that date as extended. If a 77  
person fails without lawful excuse to obey a subpoena, the 78  
attorney general may apply to the same court of common pleas as 79

designated in division (C) of this section for an order that 80  
does one or more of the following: 81

(1) Compels the requested discovery; 82

(2) Adjudges the person in contempt of court; 83

(3) Grants other relief that may be required until the 84  
person obeys the subpoena. 85

(E) If the court finds that a person's failure to comply 86  
with a subpoena issued under this section was in bad faith or 87  
for the purpose of delay, it may order the person to pay to the 88  
attorney general the reasonable expenses incurred in obtaining 89  
the order, including attorney's fees, and may invoke the 90  
sanctions provided by Rule 37 of the Rules of Civil Procedure. 91

(F) When it appears to the attorney general, as a result 92  
of an investigation under division (A) of this section, that 93  
there is cause to prosecute for the commission of a crime or to 94  
pursue a civil remedy, the attorney general may refer the 95  
evidence to the prosecuting attorney having jurisdiction of the 96  
matter, or to a regular grand jury drawn and impaneled pursuant 97  
to sections 2939.01 to 2939.24 of the Revised Code, or to a 98  
special grand jury drawn and impaneled pursuant to section 99  
2939.17 of the Revised Code, or the attorney general may 100  
initiate and prosecute any necessary criminal or civil actions 101  
in any court or tribunal of competent jurisdiction in this 102  
state. When proceeding under this section, the attorney general, 103  
and any assistant or special counsel designated by the attorney 104  
general for that purpose, have all rights, privileges, and 105  
powers of prosecuting attorneys. The attorney general shall have 106  
exclusive supervision and control of all investigations and 107  
prosecutions initiated by the attorney general under this 108

section. The forfeiture provisions of Chapter 2981. of the 109  
Revised Code apply in relation to any such criminal action 110  
initiated and prosecuted by the attorney general. 111

~~(C)~~(G) Nothing in this section shall prevent a county 112  
prosecuting attorney from investigating and prosecuting criminal 113  
activity related to Chapter 3721. of the Revised Code and the 114  
medicaid program. The forfeiture provisions of Chapter 2981. of 115  
the Revised Code apply in relation to any prosecution of 116  
criminal activity related to the medicaid program undertaken by 117  
the prosecuting attorney. 118

**Sec. 117.10.** (A) The auditor of state shall audit all 119  
public offices as provided in this chapter. The auditor of state 120  
also may audit the specific funds or accounts of private 121  
institutions, associations, boards, and corporations into which 122  
has been placed or deposited public money from a public office 123  
and may require of them annual reports in such form as the 124  
auditor of state prescribes. The auditor of state may audit some 125  
or all of the other funds or accounts of a private institution, 126  
association, board, or corporation that has received public 127  
money from a public office only if one or more of the following 128  
applies: 129

(1) The audit is specifically required or authorized by 130  
the Revised Code; 131

(2) The private institution, association, board, or 132  
corporation requests that the auditor of state audit some or all 133  
of its other funds or accounts; 134

(3) All of the revenue of the private institution, 135  
association, board, or corporation is composed of public money; 136

(4) The private institution, association, board, or 137

corporation failed to separately and independently account for 138  
the public money in its possession, in violation of section 139  
117.431 of the Revised Code; 140

(5) The auditor of state has a reasonable belief that the 141  
private institution, association, board, or corporation 142  
illegally expended, converted, misappropriated, or otherwise 143  
cannot account for the public money it received from a public 144  
office and that it is necessary to audit its other funds or 145  
accounts to make that determination. 146

(B) If the auditor of state performs or contracts for the 147  
performance of an audit, including a special audit, of the 148  
public employees retirement system, school employees retirement 149  
system, state teachers retirement system, state highway patrol 150  
retirement system, or Ohio police and fire pension fund, the 151  
auditor of state shall make a timely report of the results of 152  
the audit to the Ohio retirement study council. 153

(C) The auditor of state may audit the accounts of any 154  
medicaid provider, as defined in section 5164.01 of the Revised 155  
Code. 156

(D) If a public office has been audited by an agency of 157  
the United States government, the auditor of state may, if 158  
satisfied that the federal audit has been conducted according to 159  
principles and procedures not contrary to those of the auditor 160  
of state, use and adopt the federal audit and report in lieu of 161  
an audit by the auditor of state's own office. 162

(E) Within thirty days after the creation or dissolution 163  
or the winding up of the affairs of any public office, that 164  
public office shall notify the auditor of state in writing that 165  
this action has occurred. 166

(F) The auditor of state may issue subpoenas compelling 167  
the production of books, records, accounts, documents, 168  
electronically-stored information, testimony, or other 169  
information relevant to any audit, examination, special audit, 170  
investigation, or review within the authority of the auditor of 171  
state under this chapter. Upon request of the auditor of state, 172  
the attorney general shall bring an action in a court of 173  
competent jurisdiction to enforce compliance with any subpoena 174  
issued pursuant to this section. 175

(G) Nothing in this section precludes the auditor of state 176  
from issuing to a private institution, association, board, or 177  
corporation a subpoena and compulsory process for the attendance 178  
of witnesses or the production of records under section 117.18 179  
of the Revised Code if the subpoena and compulsory process is in 180  
furtherance of an audit the auditor of state is authorized by 181  
law to perform. 182

**Sec. 2903.216.** (A) As used in this section: 183

(1) "Business entity" means any form of corporation, 184  
partnership, association, cooperative, joint venture, business 185  
trust, or sole proprietorship that conducts business in this 186  
state. 187

(2) "Business of private investigation" and "private 188  
investigator" have the same meanings as in section 4749.01 of 189  
the Revised Code. 190

(3) "Disabled adult" and "elderly person" have the same 191  
meanings as in section 2913.01 of the Revised Code. 192

(4) "Electronic monitoring" and "electronic monitoring 193  
device" have the same meanings as in section 2929.01 of the 194  
Revised Code. 195

(5) "Law enforcement agency" means any organization or unit comprised of law enforcement officers, and also includes any federal or military law enforcement agency.

(6) "Person" means an individual, but does not include a business entity.

(7) "Ohio protection order" means a protection order filed or issued or a consent agreement approved pursuant to section 2919.26 or 3113.31 of the Revised Code, a protection order filed or issued pursuant to section 2151.34, 2903.213, or 2903.214 of the Revised Code, or a no contact order issued as any of the following:

(a) As part of a person's sentence under a community control sanction imposed under section 2929.16, 2929.17, 2929.26, or 2929.27 of the Revised Code;

(b) As a term or condition of a person's release under section 2929.20 of the Revised Code;

(c) As a post-release control sanction imposed as a condition of a person's post-release control under section 2967.28 of the Revised Code;

(d) As a term of supervision for a person transferred to transitional control under section 2967.26 of the Revised Code;

(e) As a term or condition of the intervention plan of a person granted intervention in lieu of conviction under section 2951.041 of the Revised Code.

(8) "Protection order issued by a court of another state" has the same meaning as in section 2919.27 of the Revised Code.

(9) "Tracking application" means any software program that permits a person to remotely determine or track the position or

movement of another person or another person's property.	224
(10) "Tracking device" means an electronic or mechanical	225
device that permits a person to remotely determine or track the	226
position or movement of another person or another person's	227
property, including an electronic monitoring device.	228
(B) Except as otherwise provided in division (D) of this	229
section, no person shall knowingly do either of the following:	230
(1) Install a tracking device or tracking application on	231
another person's property without the other person's consent or	232
cause a tracking device or tracking application to track the	233
position or movement of another person or another person's	234
property without the other person's consent;	235
(2) If the person installed a tracking device or tracking	236
application on another's property with the other person's	237
consent and the other person subsequently revokes that consent,	238
fail to remove or ensure the removal of the device or	239
application after the other person revokes the consent.	240
(C) (1) For purposes of this section, if a person has given	241
consent for another to install a tracking device or tracking	242
application on the consenting person's property, it is presumed	243
that the consenting person has revoked that consent if any of	244
the following applies:	245
(a) The consenting person and the person to whom consent	246
was given are lawfully married and one of them files a complaint	247
for divorce or a petition for dissolution of marriage from the	248
other. Not later than seventy-two hours after being served with	249
a complaint for divorce or a petition for dissolution of	250
marriage, the person to whom consent was given shall lawfully	251
uninstall or discontinue use of the tracking device or tracking	252

application. If the person to whom consent was given cannot 253  
lawfully uninstall or discontinue use of the tracking device or 254  
tracking application, the person to whom consent was given shall 255  
notify the court in which the complaint for divorce or the 256  
petition for dissolution of marriage was filed in writing. 257

(b) The consenting person or the person to whom consent 258  
was given files an Ohio protection order against the other 259  
person or an Ohio protection order is issued against the other 260  
person, and the person to be protected under the order is the 261  
consenting person. Not later than seventy-two hours after being 262  
served with the Ohio protection order, the person to whom 263  
consent was given shall lawfully uninstall or discontinue use of 264  
the tracking device or tracking application. If the person to 265  
whom consent was given cannot lawfully uninstall or discontinue 266  
use of the tracking device or tracking application, the person 267  
to whom consent was given shall notify the court that issued the 268  
Ohio protection order in writing that the person to whom consent 269  
was given has installed or is using a tracking device or 270  
tracking application on the previously consenting person's 271  
person or the person's property and cannot uninstall or 272  
discontinue its use without violating the Ohio protection order. 273

(2) Revocation of consent under this division is effective 274  
upon the service of the petition or motion or an Ohio protection 275  
order. 276

(D) This section does not apply to any of the following: 277

(1) A law enforcement officer, or any law enforcement 278  
agency, that installs a tracking device or tracking application 279  
on another person's property or causes a tracking device or 280  
tracking application to track the position or movement of 281  
another person or another person's property as part of a 282

criminal investigation, or a probation officer, parole officer, 283  
or employee of the department of rehabilitation and correction, 284  
a halfway house, or a community-based correctional facility when 285  
engaged in the lawful performance of the officer's or employee's 286  
official duties; 287

(2) A parent or legal guardian of a minor child who 288  
installs or uses a tracking device or tracking application to 289  
track the minor child if any of the following applies: 290

(a) The parents or legal guardians of the child are 291  
lawfully married to each other and are not separated or 292  
otherwise living apart, and either of those parents or legal 293  
guardians consents to the installation of the tracking device or 294  
tracking application; 295

(b) The parent or legal guardian of the child is the sole 296  
surviving parent or legal guardian of the child; 297

(c) The parent or legal guardian of the child has sole 298  
custody of the child; 299

(d) The parents or legal guardians of the child are 300  
divorced, separated, or otherwise living apart and neither 301  
parent has sole custody of the child, and both consent to the 302  
installation of the tracking device or tracking application; 303

(e) The parents or legal guardians of the child are 304  
divorced, separated, or otherwise living apart, neither parent 305  
has sole custody of the child, and either only one parent 306  
consents to the installation of the tracking device or tracking 307  
application or one parent revokes consent, if the consenting 308  
parent only uses the tracking device or tracking application 309  
during that parent's parenting or custodial time and disables or 310  
removes the tracking device or application during the 311

nonconsenting parent's parenting or custodial time. 312

(3) A caregiver of an elderly person or disabled adult, if 313  
the elderly person's or disabled adult's treating physician 314  
certifies that the installation of a tracking device or tracking 315  
application onto the elderly person's or disabled adult's 316  
property is necessary to ensure the safety of the elderly person 317  
or disabled adult; 318

(4) A person acting in good faith on behalf of a business 319  
entity for a legitimate business purpose, provided that this 320  
division does not apply to a private investigator engaged in the 321  
business of private investigation on behalf of another person; 322

(5) (a) A private investigator or other person licensed 323  
under section 4749.03 of the Revised Code, who is acting in the 324  
normal course of the investigator's business of private 325  
investigation on behalf of another person and who has the 326  
consent of the owner of the property upon which the tracking 327  
device or tracking application is installed, for the purpose of 328  
obtaining information with reference to any of the following: 329

(i) Criminal offenses committed, threatened, or suspected 330  
against the United States, a territory of the United States, a 331  
state, or any person or legal entity; 332

(ii) Locating an individual known to be a fugitive from 333  
justice; 334

(iii) Locating lost or stolen property or other assets 335  
that have been awarded by the court; 336

(iv) Investigating claims related to workers' 337  
compensation. 338

(b) This division does not apply if the person on whose 339

behalf the private investigator is working is the subject of an 340  
Ohio protection order or a protection order issued by a court of 341  
another state or if the private investigator knows or reasonably 342  
should know that the person on whose behalf the private 343  
investigator is working seeks the investigator's services to aid 344  
in the commission of a crime. 345

(6) An owner or lessee of a motor vehicle who installs, or 346  
directs the installation of, a tracking device or tracking 347  
application on the vehicle during the period of ownership or 348  
lease, if any of the following applies: 349

(a) The tracking device or tracking application is removed 350  
before the vehicle's title is transferred or the vehicle's lease 351  
expires; 352

(b) The new owner of the vehicle, in the case of a sale, 353  
or the lessor of the vehicle, in the case of an expired lease, 354  
consents in writing to the non-removal of the tracking device or 355  
tracking application; 356

(c) The owner of the vehicle at the time of the 357  
installation of the tracking device or tracking application was 358  
the original manufacturer of the vehicle. 359

(7) A person who installs a tracking device or application 360  
on property in which the person has an ownership or contractual 361  
interest, unless the person is the subject of a protective order 362  
and the property is likely to be used by the person who obtained 363  
the protective order; 364

(8) A person or business entity that installs a tracking 365  
device or tracking application on any fixed wing aircraft or 366  
rotorcraft operated or managed by the person or business entity 367  
pursuant to 14 C.F.R. part 91 or part 135 to track the position 368

or movement of the fixed wing aircraft or rotorcraft; 369

(9) A surety bail bond agent, or any employee or 370  
contractor of a surety bail bond agent, that installs a tracking 371  
device or tracking application on another person's property or 372  
causes a tracking device or tracking application to track the 373  
position or movement of another person or another person's 374  
property as part of the surety bail bond agent's, employee's, or 375  
contractor's official responsibilities or duties; 376

(10) The use of location verification technology by the 377  
department of medicaid, a medicaid provider, a provider's 378  
employee or contractor, or an electronic visit verification 379  
vendor when the technology is used solely to comply with 380  
electronic visit verification requirements under state or 381  
federal law including all of the following, provided that 382  
verification technology is not used for continuous tracking 383  
outside of the delivery of medicaid-covered services: 384

(a) Verification of the beginning or ending of a medicaid- 385  
covered service; 386

(b) Validating a claim for medicaid payment; 387

(c) Support for integrity of the medicaid program 388  
including audit, investigation, payment, or recovery activities. 389

(E) For purposes of division (D) (1) of this section, a 390  
probation officer, parole officer, or employee of the department 391  
of rehabilitation and correction, a halfway house, or a 392  
community-based correctional facility is engaged in the lawful 393  
performance of the officer's or employee's duties if both of the 394  
following apply: 395

(1) The court or the department of rehabilitation and 396  
correction imposes electronic monitoring on a person. 397

(2) The officer or employee installs or uses an electronic 398  
monitoring device on that person in accordance with the court's 399  
or department's imposition of electronic monitoring of that 400  
person. 401

(F) Whoever violates this section is guilty of illegal use 402  
of a tracking device or application. 403

(1) Except as otherwise provided in division (F)(2) of 404  
this section, illegal use of a tracking device or application is 405  
a misdemeanor of the first degree. 406

(2) Illegal use of a tracking device or application is a 407  
felony of the fourth degree if any of the following applies: 408

(a) The offender previously has been convicted of or 409  
pleaded guilty to a violation of this section or section 410  
2903.211 of the Revised Code. 411

(b) At the time of the commission of the offense, the 412  
offender was the subject of a protection order issued under 413  
section 2903.213 or 2903.214 of the Revised Code, regardless of 414  
whether the person to be protected under the order is the victim 415  
of the offense or another person. 416

(c) Prior to committing the offense, the offender had been 417  
determined to represent a substantial risk of physical harm to 418  
others as manifested by evidence of then-recent homicidal or 419  
other violent behavior, evidence of then-recent threats that 420  
placed another in reasonable fear of violent behavior and 421  
serious physical harm, or other evidence of then-present 422  
dangerousness. 423

(d) The offender has a history of violence toward the 424  
victim or a history of other violent acts towards the victim. 425

<b>Sec. 2913.40.</b> (A) As used in this section:	426
(1) "Statement or representation" means any oral, written, electronic, electronic impulse, or magnetic communication that is used to identify an item of goods or a service for which reimbursement may be made under the medicaid program or that states income and expense and is or may be used to determine a rate of reimbursement under the medicaid program.	427 428 429 430 431 432
(2) "Provider" means any person who has signed a provider agreement with the department of medicaid to provide goods or services pursuant to the medicaid program or any person who has signed an agreement with a party to such a provider agreement under which the person agrees to provide goods or services that are reimbursable under the medicaid program.	433 434 435 436 437 438
(3) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.	439 440
(4) "Recipient" means any individual who receives goods or services from a provider under the medicaid program.	441 442
(5) "Records" means any medical, professional, financial, or business records relating to the treatment or care of any recipient, to goods or services provided to any recipient, or to rates paid for goods or services provided to any recipient and any records that are required by the rules of the medicaid director to be kept for the medicaid program.	443 444 445 446 447 448
<u>(6) "Presumption that a prison term shall be imposed" means a presumption, as described in division (D) of section 2929.13 of the Revised Code, that a prison term is a necessary sanction for a felony in order to comply with the purposes and principles of sentencing under section 2929.11 of the Revised Code.</u>	449 450 451 452 453 454

(B) No person shall knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from the medicaid program.

(C) No person, with purpose to commit fraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Contrary to the terms of the person's provider agreement, charge, solicit, accept, or receive for goods or services that the person provides under the medicaid program any property, money, or other consideration in addition to the amount of reimbursement under the medicaid program and the person's provider agreement for the goods or services and any cost-sharing expenses authorized by section 5162.20 of the Revised Code or rules adopted by the medicaid director regarding the medicaid program.

(2) Solicit, offer, or receive any remuneration, other than any cost-sharing expenses authorized by section 5162.20 of the Revised Code or rules adopted by the medicaid director regarding the medicaid program, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the medicaid program.

(D) No person, having submitted a claim for or provided goods or services under the medicaid program, shall do either of the following for a period of at least six years after a reimbursement pursuant to that claim, or a reimbursement for those goods or services, is received under the medicaid program:

(1) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of

all goods or services for which the claim was submitted, or for 484  
which reimbursement was received, by the person; 485

(2) Knowingly alter, falsify, destroy, conceal, or remove 486  
any records that are necessary to disclose fully all income and 487  
expenditures upon which rates of reimbursements were based for 488  
the person. 489

(E) Whoever violates this section is guilty of medicaid 490  
fraud. Except as otherwise provided in this division, medicaid 491  
fraud is a ~~misdemeanor of the first~~ felony of the fifth degree 492  
and, notwithstanding section 2929.18 of the Revised Code, the 493  
court shall impose as the fine for the offense a fine of one 494  
thousand dollars. ~~If~~ 495

(1) If the value of property, services, or funds obtained 496  
in violation of this section is one thousand dollars or more and 497  
is less than seven thousand five hundred dollars, medicaid fraud 498  
is a felony of the ~~fifth~~ fourth degree and, notwithstanding 499  
section 2929.18 of the Revised Code, the court shall impose as 500  
the fine for the offense a fine of five thousand dollars. ~~If~~ 501

(2) If the value of property, services, or funds obtained 502  
in violation of this section is seven thousand five hundred 503  
dollars or more and is less than ~~one hundred fifty~~ seventy-five 504  
thousand dollars, medicaid fraud is a felony of the ~~fourth~~ third 505  
degree and, notwithstanding section 2929.18 of the Revised Code, 506  
the court shall impose as the fine for the offense a fine of 507  
twenty-five thousand dollars. ~~If~~ 508

(3) If the value of the property, services, or funds 509  
obtained in violation of this section is ~~one hundred fifty~~ 510  
~~seventy-five~~ thousand dollars or more and is less than one 511  
hundred fifty thousand dollars, medicaid fraud is a felony of 512

the third degree and there is a presumption for a prison term. 513  
Notwithstanding section 2929.18 of the Revised Code, the court 514  
shall impose as the fine for the offense a fine of seventy-five 515  
thousand dollars. 516

(4) If the value of the property, services, or funds 517  
obtained in violation of this section is one hundred fifty 518  
thousand dollars or more and is less than seven hundred fifty 519  
thousand dollars, medicaid fraud is a felony of the second 520  
degree and there is a presumption of a prison term. 521  
Notwithstanding section 2929.18 of the Revised Code, the court 522  
shall impose as the fine for the offense a fine of one hundred 523  
fifty thousand dollars. 524

(5) If the value of the property or services stolen is 525  
seven hundred fifty thousand dollars or more, medicaid fraud is 526  
a felony of the first degree and there is a presumption of a 527  
prison term. Notwithstanding section 2929.18 of the Revised 528  
Code, the court shall impose as the fine for the offense a fine 529  
of one hundred fifty thousand dollars. 530

(F) Upon application of the governmental agency, office, 531  
or other entity that conducted the investigation and prosecution 532  
in a case under this section, the court shall order any person 533  
who is convicted of a violation of this section for receiving 534  
any reimbursement for furnishing goods or services under the 535  
medicaid program to which the person is not entitled to pay to 536  
the applicant its cost of investigating and prosecuting the 537  
case. The costs of investigation and prosecution that a 538  
defendant is ordered to pay pursuant to this division shall be 539  
in addition to any other penalties for the receipt of that 540  
reimbursement that are provided in this section, section 5164.35 541  
of the Revised Code, or any other provision of law. 542

(G) The provisions of this section are not intended to be 543  
exclusive remedies and do not preclude the use of any other 544  
criminal or civil remedy for any act that is in violation of 545  
this section. 546

**Sec. 2923.31.** As used in sections 2923.31 to 2923.36 of 547  
the Revised Code: 548

(A) "Beneficial interest" means any of the following: 549

(1) The interest of a person as a beneficiary under a 550  
trust in which the trustee holds title to personal or real 551  
property; 552

(2) The interest of a person as a beneficiary under any 553  
other trust arrangement under which any other person holds title 554  
to personal or real property for the benefit of such person; 555

(3) The interest of a person under any other form of 556  
express fiduciary arrangement under which any other person holds 557  
title to personal or real property for the benefit of such 558  
person. 559

"Beneficial interest" does not include the interest of a 560  
stockholder in a corporation or the interest of a partner in 561  
either a general or limited partnership. 562

(B) "Costs of investigation and prosecution" and "costs of 563  
investigation and litigation" mean all of the costs incurred by 564  
the state or a county or municipal corporation under sections 565  
2923.31 to 2923.36 of the Revised Code in the prosecution and 566  
investigation of any criminal action or in the litigation and 567  
investigation of any civil action, and includes, but is not 568  
limited to, the costs of resources and personnel. 569

(C) "Enterprise" includes any individual, sole 570

proprietorship, partnership, limited partnership, corporation, 571  
trust, union, government agency, or other legal entity, or any 572  
organization, association, or group of persons associated in 573  
fact although not a legal entity. "Enterprise" includes illicit 574  
as well as licit enterprises. 575

(D) "Innocent person" includes any bona fide purchaser of 576  
property that is allegedly involved in a violation of section 577  
2923.32 of the Revised Code, including any person who 578  
establishes a valid claim to or interest in the property in 579  
accordance with division (E) of section 2981.04 of the Revised 580  
Code, and any victim of an alleged violation of that section or 581  
of any underlying offense involved in an alleged violation of 582  
that section. 583

(E) "Pattern of corrupt activity" means two or more 584  
incidents of corrupt activity, whether or not there has been a 585  
prior conviction, that are related to the affairs of the same 586  
enterprise, are not isolated, and are not so closely related to 587  
each other and connected in time and place that they constitute 588  
a single event. 589

At least one of the incidents forming the pattern shall 590  
occur on or after January 1, 1986. Unless any incident was an 591  
aggravated murder or murder, the last of the incidents forming 592  
the pattern shall occur within six years after the commission of 593  
any prior incident forming the pattern, excluding any period of 594  
imprisonment served by any person engaging in the corrupt 595  
activity. 596

For the purposes of the criminal penalties that may be 597  
imposed pursuant to section 2923.32 of the Revised Code, at 598  
least one of the incidents forming the pattern shall constitute 599  
a felony under the laws of this state in existence at the time 600

it was committed or, if committed in violation of the laws of 601  
the United States or of any other state, shall constitute a 602  
felony under the law of the United States or the other state and 603  
would be a criminal offense under the law of this state if 604  
committed in this state. 605

(F) "Pecuniary value" means money, a negotiable 606  
instrument, a commercial interest, or anything of value, as 607  
defined in section 1.03 of the Revised Code, or any other 608  
property or service that has a value in excess of one hundred 609  
dollars. 610

(G) "Person" means any person, as defined in section 1.59 611  
of the Revised Code, and any governmental officer, employee, or 612  
entity. 613

(H) "Personal property" means any personal property, any 614  
interest in personal property, or any right, including, but not 615  
limited to, bank accounts, debts, corporate stocks, patents, or 616  
copyrights. Personal property and any beneficial interest in 617  
personal property are deemed to be located where the trustee of 618  
the property, the personal property, or the instrument 619  
evidencing the right is located. 620

(I) "Corrupt activity" means engaging in, attempting to 621  
engage in, conspiring to engage in, or soliciting, coercing, or 622  
intimidating another person to engage in any of the following: 623

(1) Conduct defined as "racketeering activity" under the 624  
"Organized Crime Control Act of 1970," 84 Stat. 941, 18 U.S.C. 625  
1961(1)(B), (1)(C), (1)(D), and (1)(E), as amended; 626

(2) Conduct constituting any of the following: 627

(a) A violation of section 1315.55, 1322.07, 2903.01, 628  
2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2905.01, 2905.02, 629

2905.11, 2905.22, 2905.32 as specified in division (I)(2)(g) of 630  
this section, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 631  
2909.22, 2909.23, 2909.24, 2909.26, 2909.27, 2909.28, 2909.29, 632  
2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2911.31, 2913.05, 633  
2913.06, 2913.30, 2921.02, 2921.03, 2921.04, 2921.11, 2921.12, 634  
2921.32, 2921.41, 2921.42, 2921.43, 2923.12, or 2923.17; 635  
division (F)(1)(a), (b), or (c) of section 1315.53; division (A) 636  
(1) or (2) of section 1707.042; division (B), (C)(4), (D), (E), 637  
or (F) of section 1707.44; division (A)(1) or (2) of section 638  
2923.20; division (E) or (G) of section 3772.99; division (J)(1) 639  
of section 4712.02; section 4719.02, 4719.05, or 4719.06; 640  
division (C), (D), or (E) of section 4719.07; section 4719.08; 641  
or division (A) of section 4719.09 of the Revised Code. 642

(b) Any violation of section 3769.11, 3769.15, 3769.16, or 643  
3769.19 of the Revised Code as it existed prior to July 1, 1996, 644  
any violation of section 2915.02 of the Revised Code that occurs 645  
on or after July 1, 1996, and that, had it occurred prior to 646  
that date, would have been a violation of section 3769.11 of the 647  
Revised Code as it existed prior to that date, or any violation 648  
of section 2915.05 of the Revised Code that occurs on or after 649  
July 1, 1996, and that, had it occurred prior to that date, 650  
would have been a violation of section 3769.15, 3769.16, or 651  
3769.19 of the Revised Code as it existed prior to that date. 652

(c) Any violation of section 2907.21, 2907.22, 2907.31, 653  
2913.02, 2913.11, 2913.21, 2913.31, 2913.32, 2913.34, 2913.40, 654  
2913.42, 2913.47, 2913.51, 2915.03, 2925.03, 2925.04, 2925.05, 655  
or 2925.37 of the Revised Code, any violation of section 2925.11 656  
of the Revised Code that is a felony of the first, second, 657  
third, or fourth degree and that occurs on or after July 1, 658  
1996, any violation of section 2915.02 of the Revised Code that 659  
occurred prior to July 1, 1996, any violation of section 2915.02 660

of the Revised Code that occurs on or after July 1, 1996, and 661  
that, had it occurred prior to that date, would not have been a 662  
violation of section 3769.11 of the Revised Code as it existed 663  
prior to that date, any violation of section 2915.06 of the 664  
Revised Code as it existed prior to July 1, 1996, or any 665  
violation of division (B) of section 2915.05 of the Revised Code 666  
as it exists on and after July 1, 1996, when the proceeds of the 667  
violation, the payments made in the violation, the amount of a 668  
claim for payment or for any other benefit that is false or 669  
deceptive and that is involved in the violation, or the value of 670  
the contraband or other property illegally possessed, sold, or 671  
purchased in the violation exceeds one thousand dollars, or any 672  
combination of violations described in division (I) (2) (c) of 673  
this section when the total proceeds of the combination of 674  
violations, payments made in the combination of violations, 675  
amount of the claims for payment or for other benefits that is 676  
false or deceptive and that is involved in the combination of 677  
violations, or value of the contraband or other property 678  
illegally possessed, sold, or purchased in the combination of 679  
violations exceeds one thousand dollars; 680

(d) Any violation of section 5743.112 of the Revised Code 681  
when the amount of unpaid tax exceeds one hundred dollars; 682

(e) Any violation or combination of violations of section 683  
2907.32 of the Revised Code involving any material or 684  
performance containing a display of bestiality or of sexual 685  
conduct, as defined in section 2907.01 of the Revised Code, that 686  
is explicit and depicted with clearly visible penetration of the 687  
genitals or clearly visible penetration by the penis of any 688  
orifice when the total proceeds of the violation or combination 689  
of violations, the payments made in the violation or combination 690  
of violations, or the value of the contraband or other property 691

illegally possessed, sold, or purchased in the violation or 692  
combination of violations exceeds one thousand dollars; 693

(f) Any combination of violations described in division 694  
(I) (2) (c) of this section and violations of section 2907.32 of 695  
the Revised Code involving any material or performance 696  
containing a display of bestiality or of sexual conduct, as 697  
defined in section 2907.01 of the Revised Code, that is explicit 698  
and depicted with clearly visible penetration of the genitals or 699  
clearly visible penetration by the penis of any orifice when the 700  
total proceeds of the combination of violations, payments made 701  
in the combination of violations, amount of the claims for 702  
payment or for other benefits that is false or deceptive and 703  
that is involved in the combination of violations, or value of 704  
the contraband or other property illegally possessed, sold, or 705  
purchased in the combination of violations exceeds one thousand 706  
dollars; 707

(g) Any violation of section 2905.32 of the Revised Code 708  
to the extent the violation is not based solely on the same 709  
conduct that constitutes corrupt activity pursuant to division 710  
(I) (2) (c) of this section due to the conduct being in violation 711  
of section 2907.21 of the Revised Code. 712

(3) Conduct constituting a violation of any law of any 713  
state other than this state that is substantially similar to the 714  
conduct described in division (I) (2) of this section, provided 715  
the defendant was convicted of the conduct in a criminal 716  
proceeding in the other state; 717

(4) Animal or ecological terrorism; 718

(5) (a) Conduct constituting any of the following: 719

(i) Organized retail theft; 720

(ii) Conduct that constitutes one or more violations of 721  
any law of any state other than this state, that is 722  
substantially similar to organized retail theft, and that if 723  
committed in this state would be organized retail theft, if the 724  
defendant was convicted of or pleaded guilty to the conduct in a 725  
criminal proceeding in the other state. 726

(b) By enacting division (I) (5) (a) of this section, it is 727  
the intent of the general assembly to add organized retail theft 728  
and the conduct described in division (I) (5) (a) (ii) of this 729  
section as conduct constituting corrupt activity. The enactment 730  
of division (I) (5) (a) of this section and the addition by 731  
division (I) (5) (a) of this section of organized retail theft and 732  
the conduct described in division (I) (5) (a) (ii) of this section 733  
as conduct constituting corrupt activity does not limit or 734  
preclude, and shall not be construed as limiting or precluding, 735  
any prosecution for a violation of section 2923.32 of the 736  
Revised Code that is based on one or more violations of section 737  
2913.02 or 2913.51 of the Revised Code, one or more similar 738  
offenses under the laws of this state or any other state, or any 739  
combination of any of those violations or similar offenses, even 740  
though the conduct constituting the basis for those violations 741  
or offenses could be construed as also constituting organized 742  
retail theft or conduct of the type described in division (I) (5) 743  
(a) (ii) of this section. 744

(J) "Real property" means any real property or any 745  
interest in real property, including, but not limited to, any 746  
lease of, or mortgage upon, real property. Real property and any 747  
beneficial interest in it is deemed to be located where the real 748  
property is located. 749

(K) "Trustee" means any of the following: 750

(1) Any person acting as trustee under a trust in which 751  
the trustee holds title to personal or real property; 752

(2) Any person who holds title to personal or real 753  
property for which any other person has a beneficial interest; 754

(3) Any successor trustee. 755

"Trustee" does not include an assignee or trustee for an 756  
insolvent debtor or an executor, administrator, administrator 757  
with the will annexed, testamentary trustee, guardian, or 758  
committee, appointed by, under the control of, or accountable to 759  
a court. 760

(L) "Unlawful debt" means any money or other thing of 761  
value constituting principal or interest of a debt that is 762  
legally unenforceable in this state in whole or in part because 763  
the debt was incurred or contracted in violation of any federal 764  
or state law relating to the business of gambling activity or 765  
relating to the business of lending money at an usurious rate 766  
unless the creditor proves, by a preponderance of the evidence, 767  
that the usurious rate was not intentionally set and that it 768  
resulted from a good faith error by the creditor, 769  
notwithstanding the maintenance of procedures that were adopted 770  
by the creditor to avoid an error of that nature. 771

(M) "Animal activity" means any activity that involves the 772  
use of animals or animal parts, including, but not limited to, 773  
hunting, fishing, trapping, traveling, camping, the production, 774  
preparation, or processing of food or food products, clothing or 775  
garment manufacturing, medical research, other research, 776  
entertainment, recreation, agriculture, biotechnology, or 777  
service activity that involves the use of animals or animal 778  
parts. 779

(N) "Animal facility" means a vehicle, building, 780  
structure, nature preserve, or other premises in which an animal 781  
is lawfully kept, handled, housed, exhibited, bred, or offered 782  
for sale, including, but not limited to, a zoo, rodeo, circus, 783  
amusement park, hunting preserve, or premises in which a horse 784  
or dog event is held. 785

(O) "Animal or ecological terrorism" means the commission 786  
of any felony that involves causing or creating a substantial 787  
risk of physical harm to any property of another, the use of a 788  
deadly weapon or dangerous ordnance, or purposely, knowingly, or 789  
recklessly causing serious physical harm to property and that 790  
involves an intent to obstruct, impede, or deter any person from 791  
participating in a lawful animal activity, from mining, 792  
forestry, harvesting, gathering, or processing natural 793  
resources, or from being lawfully present in or on an animal 794  
facility or research facility. 795

(P) "Research facility" means a place, laboratory, 796  
institution, medical care facility, government facility, or 797  
public or private educational institution in which a scientific 798  
test, experiment, or investigation involving the use of animals 799  
or other living organisms is lawfully carried out, conducted, or 800  
attempted. 801

(Q) "Organized retail theft" means the theft of retail 802  
property with a retail value of one thousand dollars or more 803  
from one or more retail establishments with the intent to sell, 804  
deliver, or transfer that property to a retail property fence. 805

(R) "Retail property" means any tangible personal property 806  
displayed, held, stored, or offered for sale in or by a retail 807  
establishment. 808

(S) "Retail property fence" means a person who possesses, 809  
procures, receives, or conceals retail property that was 810  
represented to the person as being stolen or that the person 811  
knows or believes to be stolen. 812

(T) "Retail value" means the full retail value of the 813  
retail property. In determining whether the retail value of 814  
retail property equals or exceeds one thousand dollars, the 815  
value of all retail property stolen from the retail 816  
establishment or retail establishments by the same person or 817  
persons within any one-hundred-eighty-day period shall be 818  
aggregated. 819

**Sec. 3901.93.** (A) As used in this section: 820

(1) "Department" has the same meaning as in section 121.01 821  
of the Revised Code. 822

(2) "Health plan issuer" has the same meaning as in 823  
section 3922.01 of the Revised Code. 824

(3) "Medicaid managed care organization" has the same 825  
meaning as in section 5167.01 of the Revised Code. 826

(4) "Payer" includes a health plan issuer, a medicaid 827  
managed care organization, the medicaid program, and the 828  
medicare program. 829

(B) (1) Not later than one year after the effective date of 830  
this section, the superintendent of insurance shall establish 831  
and administer an all-payer claims database. 832

(2) To the extent permitted by federal law and except as 833  
otherwise provided in this division, each payer shall submit its 834  
claims to the superintendent for inclusion in the database. Such 835  
claims shall be submitted in the format and according to the 836

schedule prescribed by the superintendent in rule. 837

In the case of a payer that is a health plan issuer, the 838  
requirement to submit claims begins January 1, 2028. 839

(3) The superintendent shall include in the database each 840  
claim the superintendent receives. 841

(4) The superintendent shall make claims information 842  
included in the database available to any person or government 843  
entity. The superintendent may require a person to obtain a 844  
subscription with the department of insurance to access 845  
information included in the database in accordance with section 846  
149.43 of the Revised Code. 847

(C) The superintendent shall adopt rules to implement this 848  
section, including rules establishing standards and procedures 849  
for the following: 850

(1) Submitting claims for inclusion in the database, 851  
including the prescribed format and schedule; 852

(2) Maintaining the privacy and security of personal and 853  
health information contained in claims; 854

(3) Making available to persons or government entities 855  
claims information from the database; 856

(4) Imposing penalties when claims are not submitted. 857

The superintendent may adopt any other rules the 858  
superintendent considers necessary to implement this section. 859  
All rules shall be adopted in accordance with Chapter 119. of 860  
the Revised Code. 861

(D) Notwithstanding any provision of section 121.95 of the 862  
Revised Code to the contrary, a regulatory restriction contained 863

in a rule adopted under division (C) of this section is not 864  
subject to sections 121.95 to 121.953 of the Revised Code. 865

**Sec. 4113.52.** (A) (1) (a) All state officials and employees 866  
employed by or appointed to a state agency as defined in 867  
division (D) of section 121.41 of the Revised Code shall report 868  
alleged fraud, theft in office, or the misuse or 869  
misappropriation of public money by a state official or employee 870  
~~to the inspector general. All other state employees and elected~~ 871  
~~officials shall report fraud, theft in office, or the misuse or~~ 872  
~~misappropriation of public money to the auditor of state's~~ 873  
fraud-reporting system under section 117.103 of the Revised 874  
Code. An official or employee of the auditor of state may report 875  
alleged fraud, theft in office, or the misuse or 876  
misappropriation of public money to the inspector general. 877  
Nothing in this division prohibits the auditor of state or the 878  
inspector general from referring a report to the other office 879  
when appropriate. 880

(b) A person is required to make a report under division 881  
(A) (1) (c) of this section if the person meets any of the 882  
following: 883

(i) The person is elected to local public office. 884

(ii) The person is appointed to or within a local public 885  
office. 886

(iii) The person has a fiduciary duty to a local public 887  
office. 888

(iv) The person holds a supervisory position within a 889  
local public office. 890

(v) The person is employed in the department or office 891  
responsible for processing any revenue or expenses of the local 892

public office. 893

(c) If a person identified in division (A) (1) (b) of this 894  
section, during the person's term of office or in the course of 895  
the person's employment, becomes aware of fraud, theft in 896  
office, or the misuse or misappropriation of public money, the 897  
person shall timely notify the auditor of state via the auditor 898  
of state's fraud-reporting system under section 117.103 of the 899  
Revised Code or via other means. 900

(d) A person who serves as legal counsel, or who is 901  
employed as legal counsel, for a local public office or a state 902  
official or employee employed by or appointed to a state agency 903  
is not required to make a report under division (A) (1) (a) or (c) 904  
of this section concerning any communication received from a 905  
client in an attorney-client relationship. 906

(e) Divisions (A) (1) (a), (b), and (c) of this section do 907  
not apply to a prosecuting attorney, director of law, village 908  
solicitor, or similar chief legal officer of a municipal 909  
corporation, or to any employee of the prosecuting attorney, 910  
director of law, village solicitor, or similar chief legal 911  
officer of a municipal corporation. 912

(f) If a person becomes aware in the course of the 913  
person's employment of a violation of any state or federal 914  
statute or any ordinance or regulation of a political 915  
subdivision that the person's employer has authority to correct, 916  
and the person reasonably believes that the violation is a 917  
criminal offense that is likely to cause an imminent risk of 918  
physical harm to persons or a hazard to public health or safety, 919  
a felony, or an improper solicitation for a contribution, the 920  
person orally shall notify the person's supervisor or other 921  
responsible officer of the person's employer of the violation 922

and subsequently shall file with that supervisor or officer a 923  
written report that provides sufficient detail to identify and 924  
describe the violation. If the employer does not correct the 925  
violation or make a reasonable and good faith effort to correct 926  
the violation within twenty-four hours after the oral 927  
notification or the receipt of the report, whichever is earlier, 928  
the person may file a written report that provides sufficient 929  
detail to identify and describe the violation with the 930  
prosecuting authority of the county or municipal corporation 931  
where the violation occurred, with a peace officer, with the 932  
inspector general if the violation is within the inspector 933  
general's jurisdiction, with the auditor of state's fraud- 934  
reporting system under section 117.103 of the Revised Code if 935  
applicable, or with any other appropriate public official or 936  
agency that has regulatory authority over the employer and the 937  
industry, trade, or business in which the employer is engaged. 938

(g) If a person makes a report under division (A) (1) (f) of 939  
this section, the employer, within twenty-four hours after the 940  
oral notification was made or the report was received or by the 941  
close of business on the next regular business day following the 942  
day on which the oral notification was made or the report was 943  
received, whichever is later, shall notify the person, in 944  
writing, of any effort of the employer to correct the alleged 945  
violation or hazard or of the absence of the alleged violation 946  
or hazard. 947

(2) If a person becomes aware in the course of the 948  
person's employment of a violation of Chapter 3704., 3734., 949  
6109., or 6111. of the Revised Code that is a criminal offense, 950  
the person directly may notify, either orally or in writing, any 951  
appropriate public official or agency that has regulatory 952  
authority over the employer and the industry, trade, or business 953

in which the employer is engaged. 954

(3) If a person becomes aware in the course of the 955  
person's employment of a violation by a fellow employee of any 956  
state or federal statute, any ordinance or regulation of a 957  
political subdivision, or any work rule or company policy of the 958  
person's employer and the person reasonably believes that the 959  
violation is a criminal offense that is likely to cause an 960  
imminent risk of physical harm to persons or a hazard to public 961  
health or safety, a felony, or an improper solicitation for a 962  
contribution, the person orally shall notify the person's 963  
supervisor or other responsible officer of the person's employer 964  
of the violation and subsequently shall file with that 965  
supervisor or officer a written report that provides sufficient 966  
detail to identify and describe the violation. 967

(4) The reporting requirements under division (A) of this 968  
section are not intended to infringe, and should not be 969  
interpreted as infringing on, the constitutional right against 970  
self-incrimination. 971

(B) Except as otherwise provided in division (C) of this 972  
section, no employer shall take any disciplinary or retaliatory 973  
action against ~~an~~ a person for making any report authorized by 974  
division (A) (1) or (2) of this section, or as a result of the 975  
person's having made any inquiry or taken any other action to 976  
ensure the accuracy of any information reported under either 977  
such division. No employer shall take any disciplinary or 978  
retaliatory action against a person for making any report 979  
authorized by division (A) (3) of this section if the person made 980  
a reasonable and good faith effort to determine the accuracy of 981  
any information so reported, or as a result of the person's 982  
having made any inquiry or taken any other action to ensure the 983

accuracy of any information reported under that division. For 984  
purposes of this division, disciplinary or retaliatory action by 985  
the employer includes, without limitation, doing any of the 986  
following: 987

- (1) Removing or suspending the person from employment; 988
- (2) Withholding from the person salary increases or 989  
employee benefits to which the person is otherwise entitled; 990
- (3) Transferring or reassigning the person; 991
- (4) Denying the person a promotion that otherwise would 992  
have been received; 993
- (5) Reducing the person in pay or position. 994

(C) A person shall make a reasonable and good faith effort 995  
to determine the accuracy of any information reported under 996  
division (A) (1) or (2) of this section. If the person who makes 997  
a report under either division fails to make such an effort, the 998  
person may be subject to disciplinary action by the person's 999  
employer, including suspension or removal, for reporting 1000  
information without a reasonable basis to do so under division 1001  
(A) (1) or (2) of this section. 1002

(D) If an employer takes any disciplinary or retaliatory 1003  
action against ~~an~~a person as a result of the person's having 1004  
filed a report under division (A) of this section, the person 1005  
may bring a civil action for appropriate injunctive relief or 1006  
for the remedies set forth in division (E) of this section, or 1007  
both, within one hundred eighty days after the date the 1008  
disciplinary or retaliatory action was taken, in a court of 1009  
common pleas in accordance with the Rules of Civil Procedure. A 1010  
civil action under this division is not available to a person as 1011  
a remedy for any disciplinary or retaliatory action taken by an 1012

appointing authority against the person as a result of the 1013  
person's having filed a report under division (A) of section 1014  
124.341 of the Revised Code. 1015

(E) The court, in rendering a judgment for the person in 1016  
an action brought pursuant to division (D) of this section, may 1017  
order, as it determines appropriate, reinstatement of the person 1018  
to the same position that the person held at the time of the 1019  
disciplinary or retaliatory action and at the same site of 1020  
employment or to a comparable position at that site, the payment 1021  
of back wages, full reinstatement of fringe benefits and 1022  
seniority rights, or any combination of these remedies. The 1023  
court also may award the prevailing party all or a portion of 1024  
the costs of litigation and, if the person who brought the 1025  
action prevails in the action, may award the prevailing person 1026  
reasonable attorney's fees, witness fees, and fees for experts 1027  
who testify at trial, in an amount the court determines 1028  
appropriate. If the court determines that an employer 1029  
deliberately has violated division (B) of this section, the 1030  
court, in making an award of back pay, may include interest at 1031  
the rate specified in section 1343.03 of the Revised Code. 1032

(F) Any report filed with the inspector general under this 1033  
section shall be filed as a complaint in accordance with section 1034  
121.46 of the Revised Code. 1035

(G) As used in this section: 1036

(1) "Contribution" has the same meaning as in section 1037  
3517.01 of the Revised Code. 1038

(2) "Improper solicitation for a contribution" means a 1039  
solicitation for a contribution that satisfies all of the 1040  
following: 1041

(a) The solicitation violates division (B), (C), or (D) of 1042  
section 3517.092 of the Revised Code; 1043

(b) The solicitation is made in person by a public 1044  
official or by an employee who has a supervisory role within the 1045  
public office; 1046

(c) The public official or employee knowingly made the 1047  
solicitation, and the solicitation violates division (B), (C), 1048  
or (D) of section 3517.092 of the Revised Code; 1049

(d) The employee reporting the solicitation is an employee 1050  
of the same public office as the public official or the employee 1051  
with the supervisory role who is making the solicitation. 1052

(3) "Misappropriation of public money" means knowingly 1053  
using public money or public property for an unauthorized, 1054  
improper, or unlawful purpose to serve a private or personal 1055  
benefit or interest. 1056

(4) "Misuse of public money" means knowingly using public 1057  
money or public property in a manner not authorized by law. 1058

(5) "Public office" has the same meaning as in section 1059  
117.01 of the Revised Code. 1060

(H) Nothing in this section shall be construed to limit 1061  
the authority of an auditor to make inquiries or interview state 1062  
or local government employees or officials or otherwise perform 1063  
audit procedures related to fraud during the course of an audit 1064  
or attestation engagement. 1065

Sec. 5162.138. The department of medicaid shall annually 1066  
prepare and submit a report to the chairpersons and ranking 1067  
members of the committees of the house of representatives and 1068  
senate with jurisdiction over medicaid detailing the 1069

department's efforts to ensure integrity within the medicaid 1070  
program. 1071

**Sec. 5162.139.** (A) As used in this section, "electronic 1072  
visit verification" or "EVV" has the same meaning as in section 1073  
1903(1) of the "Social Security Act," 42 U.S.C. 1903(1). 1074

(B) Not later than the first day of March annually, the 1075  
medicaid director shall submit a report to the governor, the 1076  
speaker of the house of representatives, the president of the 1077  
senate, and the auditor of state regarding electronic visit 1078  
verification utilization and compliance for the immediately 1079  
preceding calendar year. The report shall, at a minimum, include 1080  
all of the following: 1081

(1) Provider utilization rates; 1082

(2) Provider compliance rates; 1083

(3) The number and percentage of claims or service visits 1084  
with complete EVV data; 1085

(4) The number and percentage of claims or service visits 1086  
with missing, incomplete, manually entered, modified, late, or 1087  
unmatched EVV data; 1088

(5) The number of claims denied or paid due to EVV 1089  
compliance status; 1090

(6) Compliance trends by provider type and geographic 1091  
region; 1092

(7) Enforcement or corrective actions taken by the 1093  
department; 1094

(8) Any recommendations to improve EVV utilization, 1095  
compliance, payment integrity, and fraud prevention. 1096

(C) The department of medicaid shall make the report 1097  
publicly available on the department's internet web site not 1098  
later than thirty days after submitting the report in accordance 1099  
with division (B) of this section, except that the department 1100  
shall redact any information that is confidential under state or 1101  
federal law or would otherwise compromise an ongoing audit, 1102  
investigation, or enforcement action. 1103

(D) Nothing in this section shall be construed to limit 1104  
the authority of the auditor of state under Chapter 117. of the 1105  
Revised Code. 1106

**Sec. 5162.1311.** The department of medicaid shall prepare 1107  
and submit an annual report to the general assembly in 1108  
accordance with section 101.68 of the Revised Code that details 1109  
any billing code that represents an increase or decrease of 1110  
greater than fifty per cent in the utilization rate or total 1111  
expenditures for a particular service from the previous state 1112  
fiscal year. As part of the report, the department shall also 1113  
provide data concerning any identified billing code or 1114  
utilization rate or expenditure data for an identified service 1115  
from the five years preceding the report. 1116

**Sec. 5162.17.** (A) As used in this section: 1117

(1) "Electronic visit verification" or "EVV" has the same 1118  
meaning as in section 1903(1) of the "Social Security Act," 42 1119  
U.S.C. 1396b(1). 1120

(2) "Provider" means a medicaid provider required by state 1121  
or federal law to utilize an electronic visit verification 1122  
system as a condition of payment for services provided under the 1123  
medicaid program. 1124

(B) The department of medicaid shall maintain a statewide 1125

electronic visit verification performance dashboard. The 1126  
dashboard shall include all of the following information, 1127  
updated not less than quarterly: 1128

(1) Statewide utilization rates of electronic visit 1129  
verification; 1130

(2) Rates of successful matching between EVV records and 1131  
submitted claims for medicaid payment; 1132

(3) Provider compliance trends; 1133

(4) The percentage of claims that are supported by 1134  
verified EVV documentation; 1135

(5) Aggregate statistics regarding manually adjusted EVV 1136  
entries; 1137

(6) Any other metrics the department determines 1138  
appropriate for monitoring compliance, fraud prevention, and 1139  
program integrity. 1140

(C) The department shall make aggregate statewide data 1141  
available to the public on the department's internet web site. 1142

(D) The department shall use information collected and 1143  
maintained under this section to identify providers that may 1144  
require technical assistance, additional training, corrective 1145  
action, or program integrity review. The department may provide 1146  
provider-specific compliance information through a secure 1147  
provider portal or dashboard. 1148

(E) The medicaid director may adopt rules under section 1149  
5162.02 of the Revised Code to implement this section. 1150

**Sec. 5162.19.** (A) As used in this section, "alternative 1151  
primary insurance coverage source" means an insurance coverage 1152

source that is not coverage under the medicaid program, 1153  
including coverage under the medicare program or coverage under 1154  
a health benefit plan as defined in section 3922.01 of the 1155  
Revised Code. 1156

(B) Prior to the issuance of any payment on a claim for 1157  
services provided under either the fee-for-service component of 1158  
the medicaid program or the care management system established 1159  
under Chapter 5167. of the Revised Code, the department of 1160  
medicaid shall require that all claims be electronically 1161  
evaluated to determine whether an alternative primary insurance 1162  
coverage source exists that is responsible for payment of the 1163  
claim. 1164

(C) An evaluation conducted under division (B) of this 1165  
section shall use automated algorithmic analysis and insurance 1166  
discovery engines capable of identifying alternative primary 1167  
insurance coverage sources associated with the medicaid 1168  
recipient prior to any payment being issued. 1169

(D) Neither the department nor a medicaid managed care 1170  
organization shall issue payment for a claim that has not been 1171  
subjected to an evaluation under this section. 1172

(E) If an alternative primary insurance coverage source is 1173  
identified, the claim shall be redirected to the identified 1174  
alternative primary insurance coverage source prior to any 1175  
medicaid payment for the claim, consistent with all medicaid 1176  
payer-of-last-resort requirements under state and federal law. 1177

(F) The department shall adopt rules in accordance with 1178  
Chapter 119. of the Revised Code as necessary to implement the 1179  
requirements of this section, including standards for approved 1180  
insurance discovery engines, claims processing timelines, and 1181

reporting requirements. 1182

Sec. 5163.05. No individual is eligible to participate in 1183  
the medicaid program in this state unless that individual is 1184  
eligible to participate in the medicaid program under section 1185  
1903(v) (5) of the "Social Security Act," 42 U.S.C. 1396b(v) (5). 1186

Sec. 5164.12. The department of medicaid shall impose a 1187  
prior authorization requirement on all therapeutic behavioral 1188  
services that are provided under the medicaid program. 1189

Sec. 5164.13. (A) As used in this section: 1190

(1) "Independent provider" has the same meaning as in 1191  
section 5164.341 of the Revised Code. 1192

(2) "Personal care services" means any service reimbursed 1193  
under the medicaid program that assists a recipient who is not 1194  
an inpatient in a hospital or a resident of a nursing facility 1195  
or ICF/IID with activities of daily living, instrumental 1196  
activities of daily living, supervision, homemaker tasks, 1197  
attendant care, personal support services, or substantially 1198  
similar in-home support services that are not medical services. 1199

(3) "Prior authorization" means advance written approval 1200  
issued by the department of medicaid, a medicaid managed care 1201  
organization, or other entity contracted to perform utilization 1202  
review functions before medicaid payment may be made. 1203

(4) "Waiver agency" has the same meaning as in section 1204  
5164.342 of the Revised Code. 1205

(B) Subject to division (I) of this section, the 1206  
department of medicaid shall require prior authorization for 1207  
personal care services provided under the medicaid program in 1208  
accordance with the requirements of this section. 1209

(C) (1) To initiate a request for prior authorization under this section, an independent provider shall submit a signed and dated request to the department. An employee of a waiver agency shall submit a signed and dated request to the waiver agency, and the waiver agency shall submit the request to the department. 1210  
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(2) Included in a request, the independent provider waiver agency employee shall submit supporting documentation that provides evidence that the requested services are medically necessary in accordance with the standards established under division (E) of this section. 1216  
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(D) (1) Within ten business days of receiving a request under division (C) of this section, the department shall notify the independent provider or waiver agency if additional information is needed to make a determination. The independent provider or waiver agency shall submit the additional information to the department within five business days of receiving notification from the department. 1221  
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(2) The department shall review the request and make a determination within ten business days of receiving all necessary information. 1228  
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(E) When reviewing a request submitted under division (C) of this section, the department shall determine whether the services for which prior authorization is requested are medically necessary. The department shall determine services to be medically necessary if the services satisfy the following: 1231  
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(1) The services are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes. 1236  
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(2) The services are of an appropriate type, amount, duration, scope, and intensity. 1239  
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(3) The services are the most efficient, effective, and lowest cost alternative that, when combined with other services, ensure the health and welfare of the individual receiving the services. 1241  
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(4) The services protect the individual from substantial harm expected to occur if the requested services are not authorized. 1245  
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(F) After conducting a review of a request received under this section, the department shall do one of the following: 1248  
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(1) Approve the request if the department finds that the services for which prior authorization is requested meet the criteria established under division (E) of this section; 1250  
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(2) Deny the request; 1253

(3) Approve the request in part if some of the criteria set forth in division (E) of this section are satisfied. 1254  
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(G) When the department makes a determination regarding a request for prior authorization, the department shall provide written notification to the independent provider or waiver agency either setting forth the reason for denial or indicating that prior authorization has been approved. The department shall update the prior authorization status to reflect its determination. 1256  
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(H) If a request for prior authorization is denied, an individual, independent provider, or waiver agency may appeal the denial in accordance with procedures established by the medicaid director under rules adopted under division (J) of this 1263  
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section. 1267

(I) This section does not apply to personal care services 1268  
provided under a medicaid waiver component administered by the 1269  
department of developmental disabilities. 1270

(J) The medicaid director shall adopt rules in accordance 1271  
with Chapter 119. of the Revised Code as necessary to implement 1272  
this section. 1273

**Sec. 5164.292.** (A) The department of medicaid shall 1274  
require the providers and facilities described in this section 1275  
to provide the department or the department's credentialing 1276  
designee with the information described in divisions (B) and (C) 1277  
of this section every twenty-four months, or sooner if required 1278  
under division (D) of this section, as a condition of continued 1279  
participation in the medicaid program. 1280

(B) (1) Each of the following providers shall provide the 1281  
department or the department's credentialing designee with the 1282  
information described in division (B) (2) of this section as 1283  
required by this section: 1284

(a) Physicians licensed under Chapter 4731. of the Revised 1285  
Code to practice medicine and surgery, osteopathic medicine and 1286  
surgery, or podiatric medicine and surgery; 1287

(b) Psychologists licensed under Chapter 4732. of the 1288  
Revised Code; 1289

(c) Physician assistants licensed under Chapter 4730. of 1290  
the Revised Code; 1291

(d) Dentists licensed under Chapter 4715. of the Revised 1292  
Code; 1293

(e) Optometrists licensed under Chapter 4725. of the 1294

<u>Revised Code;</u>	1295
<u>(f) Pharmacists licensed under Chapter 4729. of the</u>	1296
<u>Revised Code;</u>	1297
<u>(g) Chiropractors licensed under Chapter 4734. of the</u>	1298
<u>Revised Code;</u>	1299
<u>(h) Acupuncturists licensed under Chapter 4762. of the</u>	1300
<u>Revised Code;</u>	1301
<u>(i) Clinical nurse specialists, certified nurse-midwives,</u>	1302
<u>or certified nurse practitioners licensed under Chapter 4723. of</u>	1303
<u>the Revised Code;</u>	1304
<u>(j) Licensed independent social workers, licensed</u>	1305
<u>independent marriage and family therapists, or licensed</u>	1306
<u>professional clinical counselors licensed under Chapter 4757. of</u>	1307
<u>the Revised Code;</u>	1308
<u>(k) Licensed independent chemical dependency counselors</u>	1309
<u>licensed under Chapter 4758. of the Revised Code;</u>	1310
<u>(l) Certified Ohio behavior analysts licensed under</u>	1311
<u>Chapter 4783. of the Revised Code;</u>	1312
<u>(m) Audiologists and speech-language pathologists licensed</u>	1313
<u>under Chapter 4753. of the Revised Code;</u>	1314
<u>(n) Occupational therapists and physical therapists</u>	1315
<u>licensed under Chapter 4755. of the Revised Code;</u>	1316
<u>(o) Dietitians licensed under Chapter 4759. of the Revised</u>	1317
<u>Code.</u>	1318
<u>(2) Providers described in division (B)(1) of this section</u>	1319
<u>shall provide the department or department's credentialing</u>	1320
<u>designee with all of the following about the provider in</u>	1321

<u>accordance with this section:</u>	1322
<u>(a) Access to the standard provider credentialing</u>	1323
<u>application form used by the council for affordable quality</u>	1324
<u>healthcare in accordance with section 3963.05 of the Revised</u>	1325
<u>Code within one hundred eighty days prior to credentialing date;</u>	1326
<u>(b) Active provider licensing information;</u>	1327
<u>(c) Board certification, if applicable;</u>	1328
<u>(d) Educational background;</u>	1329
<u>(e) Clinical privileges, if applicable;</u>	1330
<u>(f) Medical malpractice insurance;</u>	1331
<u>(g) Drug enforcement administration certification, if</u>	1332
<u>applicable;</u>	1333
<u>(h) National practitioner data bank information regarding</u>	1334
<u>malpractice and clinical privilege actions;</u>	1335
<u>(i) Sanctions or limitations on licensure;</u>	1336
<u>(j) Eligibility for participation in medicare and</u>	1337
<u>medicaid, if applicable.</u>	1338
<u>(C) (1) Each of the following facilities shall provide the</u>	1339
<u>department or the department's credentialing designee with the</u>	1340
<u>information described in division (C) (2) of this section as</u>	1341
<u>required by this section:</u>	1342
<u>(a) Nursing facilities as defined in Chapter 5165. of the</u>	1343
<u>Revised Code;</u>	1344
<u>(b) Hospitals as defined in Chapter 3727. of the Revised</u>	1345
<u>Code;</u>	1346
<u>(c) Hospice care programs licensed under Chapter 3712. of</u>	1347

<u>the Revised Code;</u>	1348
<u>(d) Home health agencies licensed by the department of health under Chapter 3740. of the Revised Code;</u>	1349 1350
<u>(e) Ambulatory surgical facilities as defined in section 3702.30 of the Revised Code;</u>	1351 1352
<u>(f) Community mental health services providers and community addiction services providers as defined in Chapter 5119. of the Revised Code;</u>	1353 1354 1355
<u>(g) Freestanding dialysis centers and freestanding radiation therapy centers licensed by the department of health under Chapter 3702. of the Revised Code;</u>	1356 1357 1358
<u>(h) Residential facilities as defined in Chapter 5119. of the Revised Code.</u>	1359 1360
<u>(2) Facilities described in division (C) (1) of this section shall provide the department or department's credentialing designee with all of the following about the facility in accordance with this section:</u>	1361 1362 1363 1364
<u>(a) The standardized credentialing form part B maintained by the department of insurance;</u>	1365 1366
<u>(b) Active provider licensing information;</u>	1367
<u>(c) Certification through an accrediting body or a site visit completed by a state designated agency;</u>	1368 1369
<u>(d) Eligibility for participation in medicare and medicaid, if applicable;</u>	1370 1371
<u>(e) Verification of good standing with applicable state and federal bodies;</u>	1372 1373
<u>(f) Active malpractice insurance.</u>	1374

(D) The department of medicaid shall require a provider or facility to provide the information described in this section to the department or the department's credentialing designee sooner than every twenty-four months if required under federal law or if the medicaid director determines that a shorter time frame is necessary. 1375  
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(E) Nothing in this section prohibits the department from requesting additional clarifying information at any time during the credentialing or recredentialing process from a provider or facility. 1381  
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**Sec. 5164.302.** (A) Before entering into a provider agreement with a medicaid provider that seeks initial enrollment as a provider of home and community-based services under the medicaid program, the department of medicaid shall conduct an in-person review of the individual or site inspection of the entity seeking enrollment as a provider. The department shall thereafter conduct a subsequent in-person review or site inspection every three years. 1385  
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(B) The department shall deny, refuse to revalidate, suspend, or terminate a provider agreement if the department determines that an individual or entity seeking enrollment as a provider of home and community-based services under the medicaid program is principally located at the same address as more than six other active home and community-based services medicaid providers or is principally located at the same address as another home and community-based services medicaid provider when the address contains less than one thousand square feet of space. 1393  
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(C) The department of medicaid shall make a referral to the auditor of state whenever it is determined that a single 1403  
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address is the principal place of business for more than six 1405  
home and community-based services medicaid providers. 1406

**Sec. 5164.303.** (A) The department of medicaid shall 1407  
coordinate with the attorney general to create a disclaimer form 1408  
that provides an affirmative and explicit explanation of the 1409  
penalties specified in section 2913.40 of the Revised Code for 1410  
medicaid fraud. 1411

(B) The department shall provide a copy of the disclaimer 1412  
form to each person or government entity seeking to participate 1413  
in the medicaid program as a provider. The department shall not 1414  
enter into a provider agreement with a person or government 1415  
entity until the person or government entity has signed and 1416  
returned the disclaimer form to the department, acknowledging 1417  
that the person or government entity has received and reviewed 1418  
the form. 1419

**Sec. 5164.304.** The department of medicaid shall establish 1420  
a standardized onboarding process for all providers with a valid 1421  
provider agreement with the department. The onboarding process 1422  
shall provide instruction regarding and an explanation of all 1423  
relevant state and federal laws governing the medicaid program, 1424  
including the relevant requirements for home care and personal 1425  
care service providers established by the department of 1426  
medicaid, the department of developmental disabilities, and the 1427  
department of aging. 1428

**Sec. 5164.305.** (A) As a condition of entering into a 1429  
provider agreement with the department of medicaid or 1430  
revalidating an existing provider agreement, each person or 1431  
government entity seeking to enroll in the medicaid program as a 1432  
provider or to revalidate an existing provider agreement shall 1433  
disclose to the department the identity of each person with at 1434

least a five per cent direct or indirect ownership interest in 1435  
the person or entity. 1436

(B) The department shall verify all ownership disclosures 1437  
under division (A) of this section against the exclusion list 1438  
maintained by the United States department of health and human 1439  
services office of inspector general, prior medicaid sanctions 1440  
imposed by another state, and any prior convictions for fraud 1441  
that a person may have. 1442

(C) The department shall enter into all agreements 1443  
necessary to share information and data obtained under this 1444  
section with medicaid managed care organizations to enable 1445  
parallel verification by medicaid managed care organizations. An 1446  
agreement entered into between the department and a medicaid 1447  
managed care organization under this section shall ensure 1448  
confidentiality and privacy of the information and data in 1449  
accordance with state and federal law. 1450

(D) In implementing this section, the department may 1451  
implement best practices from other states' medicaid programs. 1452

**Sec. 5164.32.** (A) Each medicaid provider agreement shall 1453  
expire not later than five~~three~~ years from its effective date\_ 1454  
or sooner if determined necessary by the medicaid director. If a 1455  
provider agreement entered into before the effective date of 1456  
this amendment does not have a time limit, the department of 1457  
medicaid shall convert the agreement to a provider agreement 1458  
with a time limit. 1459

(B) The medicaid director shall adopt rules under section 1460  
5164.02 of the Revised Code as necessary to implement this 1461  
section. The rules shall be consistent with subpart E of 42 1462  
C.F.R. Part 455 and include a process for revalidating medicaid 1463

providers' continued enrollments as providers. All of the 1464  
following apply to the revalidation process: 1465

(1) The department shall refuse to revalidate a provider's 1466  
provider agreement when the provider fails to file a complete 1467  
application for revalidation within the time and in the manner 1468  
required under the revalidation process. 1469

(2) If a provider files a complete application for 1470  
revalidation within the time and in the manner required under 1471  
the revalidation process, but the provider agreement expires 1472  
before the department acts on the application or before the 1473  
effective date of the department's decision on the application, 1474  
the provider, subject to division (B)(3) of this section, may 1475  
continue operating under the terms of the expired provider 1476  
agreement until the effective date of the department's decision. 1477

(3) If a provider continues operating under the terms of 1478  
an expired provider agreement pursuant to division (B)(2) of 1479  
this section and the department denies the provider's 1480  
application for revalidation, medicaid payments shall not be 1481  
made for services or items the provider provides during the 1482  
period beginning on the date the provider agreement expired and 1483  
ending on the effective date of a subsequent provider agreement, 1484  
if any, the department enters into with the provider. 1485

**Sec. 5164.33.** ~~(A)~~(A) (1) The medicaid director may do the 1486  
following for any reason permitted or required by federal law 1487  
and when the director determines that the action is in the best 1488  
interests of medicaid recipients or the state: 1489

~~(1)~~(a) Deny, refuse to revalidate, suspend, or terminate a 1490  
provider agreement; 1491

~~(2)~~(b) Exclude an individual, provider of services or 1492

goods, or other entity from participation in the medicaid 1493  
program; 1494

(c) Place a provider or entity at a high risk of fraud on 1495  
heightened scrutiny when suspension, termination, or exclusion 1496  
of the provider will result in access to care issues for 1497  
medicaid recipients. Heightened scrutiny shall include close 1498  
monitoring of billing and claims, increased compliance through 1499  
corrective action plans, and the potential for termination or 1500  
exclusion if violations occur. 1501

(d) Deny an application for a provider agreement or refuse 1502  
to revalidate a provider agreement, including applications or 1503  
revalidations where the applicant is an owner of, or individual 1504  
that resides with an owner of, a current or former medicaid 1505  
provider whose provider agreement was terminated or suspended by 1506  
the department. 1507

(2) The medicaid director shall suspend a provider 1508  
agreement of any provider who has not submitted a claim for 1509  
payment to the department for a period of one year. 1510

(3) Whenever a temporary moratorium on the enrollment of 1511  
new providers or provider types is issued pursuant to 42 C.F.R. 1512  
424.570, the medicaid director shall issue a similar moratorium 1513  
and deny all pending applications for provider agreements, 1514  
including applications that were pending prior to the issuance 1515  
of the temporary moratorium and were still awaiting approval 1516  
when the moratorium was issued. In issuing a moratorium under 1517  
this section, the director shall comply with the requirements 1518  
specified in 42 C.F.R. 455.470. 1519

(B) No individual, provider, or entity excluded from 1520  
participation in the medicaid program under this section shall 1521

do any of the following:	1522
(1) Own, or provide services to, any other medicaid provider or risk contractor;	1523 1524
(2) Arrange for, render, or order services for medicaid recipients during the period of exclusion;	1525 1526
(3) During the period of exclusion, receive direct payments under the medicaid program or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any other medicaid provider or risk contractor.	1527 1528 1529 1530 1531
(C) An individual, provider, or entity excluded from participation in the medicaid program under this section may request a reconsideration of the exclusion. The director shall adopt rules under section 5164.02 of the Revised Code governing the process for requesting a reconsideration.	1532 1533 1534 1535 1536
(D) Nothing in this section limits the applicability of section 5164.38 of the Revised Code to a medicaid provider.	1537 1538
<u>(E) To the extent permitted under state or federal law, the department of medicaid shall share information concerning the director's decision to deny, refuse to revalidate, suspend, or terminate a provider agreement under this section with any other state board or commission responsible for regulating a component of the health care industry.</u>	1539 1540 1541 1542 1543 1544
<u>(F) The medicaid director may adopt rules under section 5164.02 of the Revised Code as necessary to implement this section.</u>	1545 1546 1547
<u>Sec. 5164.331. The department of medicaid shall conduct an investigation if the department determines that an individual or</u>	1548 1549

entity seeking initial enrollment as a provider shares the same 1550  
address or telephone number as a current provider. If an 1551  
investigation conducted by the department determines it 1552  
necessary, the department shall take the actions described in 1553  
section 5164.302 of the Revised Code with regard to the 1554  
individual or entity seeking initial enrollment as a provider. 1555

**Sec. 5164.332.** (A) The department of medicaid shall impose 1556  
a temporary suspension of medicaid payments and conduct an 1557  
investigation if the department determines there is a suspicious 1558  
increase in the number of claims for payment submitted by a 1559  
provider in the first sixty days of the provider entering into a 1560  
provider agreement with the department. 1561

(B) The department shall flag and investigate any time the 1562  
department determines that the number of claims for payment 1563  
submitted by a provider in a month increases by more than one 1564  
hundred per cent without a corresponding increase in the number 1565  
of medicaid enrollees receiving services from the provider. 1566

**Sec. 5164.34.** (A) As used in this section: 1567

(1) "Criminal records check" has the same meaning as in 1568  
section 109.572 of the Revised Code. 1569

(2) "Disqualifying offense" means any of the offenses 1570  
listed or described in divisions (A) (3) (a) to (e) of section 1571  
109.572 of the Revised Code. 1572

(3) "Owner" means a person who has an ownership interest 1573  
in a medicaid provider in an amount designated in rules 1574  
authorized by this section. 1575

(4) "Person subject to the criminal records check 1576  
requirement" means the following: 1577

(a) A medicaid provider who is notified under division (E)	1578
(1) of this section that the provider is subject to a criminal	1579
records check;	1580
(b) An owner or prospective owner, officer or prospective	1581
officer, or board member or prospective board member of a	1582
medicaid provider if, pursuant to division (E)(1)(a) of this	1583
section, the owner or prospective owner, officer or prospective	1584
officer, or board member or prospective board member is	1585
specified in information given to the provider under division	1586
(E)(1) of this section;	1587
(c) An employee or prospective employee of a medicaid	1588
provider if both of the following apply:	1589
(i) The employee or prospective employee is specified,	1590
pursuant to division (E)(1)(b) of this section, in information	1591
given to the provider under division (E)(1) of this section.	1592
(ii) The provider is not prohibited by division (D)(3)(b)	1593
of this section from employing the employee or prospective	1594
employee.	1595
(5) "Responsible entity" means the following:	1596
(a) With respect to a criminal records check required	1597
under this section for a medicaid provider, the department of	1598
medicaid or the department's designee;	1599
(b) With respect to a criminal records check required	1600
under this section for an owner or prospective owner, officer or	1601
prospective officer, board member or prospective board member,	1602
or employee or prospective employee of a medicaid provider, the	1603
provider.	1604
(B) This section does not apply to any of the following:	1605

(1) An individual who is subject to a criminal records check under section 3712.09, 3721.121, 5123.081, or 5123.169 of the Revised Code;

(2) An individual who is subject to a database review or criminal records check under section 173.38, 173.381, 3740.11, or 5164.342 of the Revised Code;

(3) An individual who is an applicant or independent provider, both as defined in section 5164.341 of the Revised Code.

(C) The department of medicaid may do any of the following:

(1) Require that any medicaid provider submit to a criminal records check as a condition of obtaining or maintaining a provider agreement;

(2) Require that any medicaid provider require an owner or prospective owner, officer or prospective officer, or board member or prospective board member of the provider submit to a criminal records check as a condition of being an owner, officer, or board member of the provider;

(3) Require that any medicaid provider do the following:

(a) If so required by rules authorized by this section, determine pursuant to a database review conducted under division (F) (1) (a) of this section whether any employee or prospective employee of the provider is included in a database;

(b) Unless the provider is prohibited by division (D) (3) (b) of this section from employing the employee or prospective employee, require the employee or prospective employee to submit to a criminal records check as a condition of being an employee

of the provider. 1634

(D) (1) The department or the department's designee shall 1635  
deny or terminate a medicaid provider's provider agreement if 1636  
the provider is a person subject to the criminal records check 1637  
requirement and either of the following applies: 1638

(a) The provider fails to obtain the criminal records 1639  
check after being given the information specified in division 1640  
(G) (1) of this section. 1641

(b) Except as provided in rules authorized by this 1642  
section, the provider is found by the criminal records check to 1643  
have been convicted of or have pleaded guilty to a disqualifying 1644  
offense, regardless of the date of the conviction or the date of 1645  
entry of the guilty plea. 1646

(2) No medicaid provider shall permit a person to be an 1647  
owner, officer, or board member of the provider if the person is 1648  
a person subject to the criminal records check requirement and 1649  
either of the following applies: 1650

(a) The person fails to obtain the criminal records check 1651  
after being given the information specified in division (G) (1) 1652  
of this section. 1653

(b) Except as provided in rules authorized by this 1654  
section, the person is found by the criminal records check to 1655  
have been convicted of or have pleaded guilty to a disqualifying 1656  
offense, regardless of the date of the conviction or the date of 1657  
entry of the guilty plea. 1658

(3) Except as provided in division (I) of this section, no 1659  
medicaid provider shall employ a person if any of the following 1660  
apply: 1661

(a) The person has been excluded from being a medicaid provider, a medicare provider, or provider for any other federal health care program.

(b) If the person is subject to a database review conducted under division (F) (1) (a) of this section, the person is found by the database review to be included in a database and the rules authorized by this section regarding the database review prohibit the provider from employing a person included in the database.

(c) If the person is a person subject to the criminal records check requirement, either of the following applies:

(i) The person fails to obtain the criminal records check after being given the information specified in division (G) (1) of this section.

(ii) Except as provided in rules authorized by this section, the person is found by the criminal records check to have been convicted of or have pleaded guilty to a disqualifying offense, regardless of the date of the conviction or the date of entry of the guilty plea.

(E) (1) The department or the department's designee shall inform each medicaid provider whether the provider is subject to a criminal records check. For providers with valid provider agreements, the information shall be given at times designated in rules authorized by this section. For providers applying to be medicaid providers, the information shall be given at the time of initial application. When the information is given, the department or the department's designee shall specify the following:

(a) Which of the provider's owners or prospective owners,

officers or prospective officers, or board members or 1691  
prospective board members are subject to a criminal records 1692  
check; 1693

(b) Which of the provider's employees or prospective 1694  
employees are subject to division (C)(3) of this section. 1695

(2) At times designated in rules authorized by this 1696  
section, a medicaid provider that is a person subject to the 1697  
criminal records check requirement shall do the following: 1698

(a) Inform each person specified under division (E)(1)(a) 1699  
of this section that the person is required to submit to a 1700  
criminal records check as a condition of being an owner, 1701  
officer, or board member of the provider; 1702

(b) Inform each person specified under division (E)(1)(b) 1703  
of this section that the person is subject to division (C)(3) of 1704  
this section. 1705

(F)(1) If a medicaid provider is a person subject to the 1706  
criminal records check requirement, the department or the 1707  
department's designee shall require the conduct of a criminal 1708  
records check by the superintendent of the bureau of criminal 1709  
identification and investigation. A medicaid provider shall 1710  
require the conduct of a criminal records check by the 1711  
superintendent with respect to each of the persons specified 1712  
under division (E)(1)(a) of this section. With respect to each 1713  
employee and prospective employee specified under division (E) 1714  
(1)(b) of this section, a medicaid provider shall do the 1715  
following: 1716

(a) If rules authorized by this section require the 1717  
provider to conduct a database review to determine whether the 1718  
employee or prospective employee is included in a database, 1719

conduct the database review in accordance with the rules; 1720

(b) Unless the provider is prohibited by division (D) (3) 1721

(b) of this section from employing the employee or prospective 1722

employee, require the conduct of a criminal records check of the 1723

employee or prospective employee by the superintendent. 1724

(2) If a person subject to the criminal records check 1725

requirement does not present proof of having been a resident of 1726

this state for the five-year period immediately prior to the 1727

date the criminal records check is requested or provide evidence 1728

that within that five-year period the superintendent has 1729

requested information about the person from the federal bureau 1730

of investigation in a criminal records check, the responsible 1731

entity shall require the person to request that the 1732

superintendent obtain information from the federal bureau of 1733

investigation as part of the criminal records check of the 1734

person. Even if the person presents proof of having been a 1735

resident of this state for the five-year period, the responsible 1736

entity may require that the person request that the 1737

superintendent obtain information from the federal bureau of 1738

investigation and include it in the criminal records check of 1739

the person. 1740

(G) Criminal records checks required by this section shall 1741

be obtained as follows: 1742

(1) The responsible entity shall provide each person 1743

subject to the criminal records check requirement information 1744

about accessing and completing the form prescribed pursuant to 1745

division (C) (1) of section 109.572 of the Revised Code and the 1746

standard impression sheet prescribed pursuant to division (C) (2) 1747

of that section. 1748

(2) The person subject to the criminal records check 1749  
requirement shall submit the required form and one complete set 1750  
of the person's fingerprint impressions directly to the 1751  
superintendent for purposes of conducting the criminal records 1752  
check using the applicable methods prescribed by division (C) of 1753  
section 109.572 of the Revised Code. The person shall pay all 1754  
fees associated with obtaining the criminal records check. 1755

(3) The superintendent shall conduct the criminal records 1756  
check in accordance with section 109.572 of the Revised Code. 1757  
The person subject to the criminal records check requirement 1758  
shall instruct the superintendent to submit the report of the 1759  
criminal records check directly to the responsible entity. If 1760  
the department or the department's designee is not the 1761  
responsible entity, the department or designee may require the 1762  
responsible entity to submit the report to the department or 1763  
designee. 1764

~~(H)(1) A medicaid provider may employ conditionally a 1765  
person for whom a criminal records check is required by this 1766  
section prior to obtaining the results of the criminal records 1767  
check if both of the following apply: 1768~~

~~(a) The provider is not prohibited by division (D) (3) (b) 1769  
of this section from employing the person. 1770~~

~~(b) The person submits a request for the criminal records 1771  
check not later than five business days after the person begins 1772  
conditional employment. 1773~~

~~(2) Except as provided in division (I) of this section, a 1774  
medicaid provider that employs a person conditionally under 1775  
division (H) (1) of this section shall terminate the person's 1776  
employment if either of the following apply: 1777~~

~~(a) The results of the criminal records check request are not obtained within the period ending sixty days after the date the request is made.~~ 1778  
1779  
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~~(b) Regardless of when the results of the criminal records check are obtained, the results indicate that the person has been convicted of or has pleaded guilty to a disqualifying offense, unless circumstances specified in rules authorized by this section exist that permit the provider to employ the person and the provider chooses to employ the person.~~ 1781  
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~~(I) As used in this division, "behavioral health services" means alcohol and drug addiction services, mental health services, or both.~~ 1787  
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A medicaid provider of behavioral health services may choose to employ a person who the provider would be prohibited by division (D) (3) of this section from employing ~~or would be required by division (H) (2) of this section to terminate the person's employment~~ if both of the following apply: 1790  
1791  
1792  
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(1) The person holds a valid health professional license issued under the Revised Code granting the person authority to provide behavioral health services, holds a valid peer recovery supporter certificate issued pursuant to rules adopted by the department of mental behavioral health and addiction services, or is in the process of obtaining such a license or certificate. 1795  
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(2) The provider does not submit any medicaid claims for any services the person provides. 1801  
1802

~~(J)~~ (I) The report of a criminal records check conducted pursuant to this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following: 1803  
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- (1) The person who is the subject of the criminal records check or the person's representative; 1807  
1808
- (2) The medicaid director and the staff of the department who are involved in the administration of the medicaid program; 1809  
1810
- (3) The department's designee; 1811
- (4) The medicaid provider who required the person who is the subject of the criminal records check to submit to the criminal records check; 1812  
1813  
1814
- (5) An individual receiving or deciding whether to receive, from the subject of the criminal records check, home and community-based services available under the medicaid state plan; 1815  
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- (6) A court, hearing officer, or other necessary individual involved in a case or administrative hearing dealing with any of the following: 1819  
1820  
1821
- (a) The denial, suspension, or termination of a provider agreement; 1822  
1823
- (b) A person's denial of employment, termination of employment, or employment or unemployment benefits; 1824  
1825
- (c) A civil or criminal action regarding the medicaid program. 1826  
1827
- With respect to an administrative hearing dealing with the denial, suspension, or termination of a provider agreement, the report of a criminal records check may be introduced as evidence at the hearing and if admitted, becomes part of the hearing record. Any such report shall be admitted only under seal and shall maintain its status as not a public record. 1828  
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~~(K)~~(J) The medicaid director may adopt rules under section 1834  
5164.02 of the Revised Code to implement this section. If the 1835  
director adopts such rules, the rules shall designate the times 1836  
at which a criminal records check must be conducted under this 1837  
section. The rules may do any of the following: 1838

(1) Designate the categories of persons who are subject to 1839  
a criminal records check under this section; 1840

(2) Specify circumstances under which the department or 1841  
the department's designee may continue a provider agreement or 1842  
issue a provider agreement when the medicaid provider is found 1843  
by a criminal records check to have been convicted of or pleaded 1844  
guilty to a disqualifying offense; 1845

(3) Specify circumstances under which a medicaid provider 1846  
may permit a person to be an employee, owner, officer, or board 1847  
member of the provider when the person is found by a criminal 1848  
records check conducted pursuant to this section to have been 1849  
convicted of or have pleaded guilty to a disqualifying offense; 1850

(4) Specify all of the following: 1851

(a) The circumstances under which a database review must 1852  
be conducted under division (F)(1)(a) of this section to 1853  
determine whether an employee or prospective employee of a 1854  
medicaid provider is included in a database; 1855

(b) The procedures for conducting the database review; 1856

(c) The databases that are to be checked; 1857

(d) The circumstances under which, except as provided in 1858  
division ~~(I)~~(H) of this section, a medicaid provider is 1859  
prohibited from employing a person who is found by the database 1860  
review to be included in a database. 1861

**Sec. 5164.342.** (A) As used in this section: 1862

"Applicant" means a person who is under final 1863  
consideration for employment with a waiver agency in a full- 1864  
time, part-time, or temporary position that involves providing 1865  
home and community-based services. 1866

"Community-based long-term care provider" means a provider 1867  
as defined in section 173.39 of the Revised Code. 1868

"Community-based long-term care subcontractor" means a 1869  
subcontractor as defined in section 173.38 of the Revised Code. 1870

"Criminal records check" has the same meaning as in 1871  
section 109.572 of the Revised Code. 1872

"Disqualifying offense" means any of the offenses listed 1873  
or described in divisions (A) (3) (a) to (e) of section 109.572 of 1874  
the Revised Code. 1875

"Employee" means a person employed by a waiver agency in a 1876  
full-time, part-time, or temporary position that involves 1877  
providing home and community-based services. 1878

"Waiver agency" means a person or government entity that 1879  
provides home and community-based services under a home and 1880  
community-based services medicaid waiver component administered 1881  
by the department of medicaid, other than such a person or 1882  
government entity that is certified under the medicare program. 1883  
"Waiver agency" does not mean an independent provider as defined 1884  
in section 5164.341 of the Revised Code. 1885

(B) This section does not apply to any individual who is 1886  
subject to a database review or criminal records check under 1887  
section 3740.11 of the Revised Code. If a waiver agency also is 1888  
a community-based long-term care provider or community-based 1889

long-term care subcontractor, the waiver agency may provide for 1890  
any of its applicants and employees who are not subject to 1891  
database reviews and criminal records checks under section 1892  
173.38 of the Revised Code to undergo database reviews and 1893  
criminal records checks in accordance with that section rather 1894  
than this section. 1895

(C) No waiver agency shall employ an applicant or continue 1896  
to employ an employee in a position that involves providing home 1897  
and community-based services if any of the following apply: 1898

(1) A review of the databases listed in division (E) of 1899  
this section reveals any of the following: 1900

(a) That the applicant or employee is included in one or 1901  
more of the databases listed in divisions (E) (1) to (5) of this 1902  
section; 1903

(b) That there is in the state nurse aide registry 1904  
established under section 3721.32 of the Revised Code a 1905  
statement detailing findings by the director of health that the 1906  
applicant or employee abused, neglected, or exploited a long- 1907  
term care facility or residential care facility resident or 1908  
misappropriated property of such a resident; 1909

(c) That the applicant or employee is included in one or 1910  
more of the databases, if any, specified in rules authorized by 1911  
this section and the rules prohibit the waiver agency from 1912  
employing an applicant or continuing to employ an employee 1913  
included in such a database in a position that involves 1914  
providing home and community-based services. 1915

(2) After the applicant or employee is given the 1916  
information and notification required by divisions (F) (2) (a) and 1917  
(b) of this section, the applicant or employee fails to do 1918

either of the following: 1919

(a) Access, complete, or forward to the superintendent of 1920  
the bureau of criminal identification and investigation the form 1921  
prescribed to division (C) (1) of section 109.572 of the Revised 1922  
Code or the standard impression sheet prescribed pursuant to 1923  
division (C) (2) of that section; 1924

(b) Instruct the superintendent to submit the completed 1925  
report of the criminal records check required by this section 1926  
directly to the chief administrator of the waiver agency. 1927

(3) Except as provided in rules authorized by this 1928  
section, the applicant or employee is found by a criminal 1929  
records check required by this section to have been convicted of 1930  
or have pleaded guilty to a disqualifying offense, regardless of 1931  
the date of the conviction or date of entry of the guilty plea. 1932

(D) At the time of each applicant's initial application 1933  
for employment in a position that involves providing home and 1934  
community-based services, the chief administrator of a waiver 1935  
agency shall inform the applicant of both of the following: 1936

(1) That a review of the databases listed in division (E) 1937  
of this section will be conducted to determine whether the 1938  
waiver agency is prohibited by division (C) (1) of this section 1939  
from employing the applicant in the position; 1940

(2) That, unless the database review reveals that the 1941  
applicant may not be employed in the position, a criminal 1942  
records check of the applicant will be conducted and the 1943  
applicant is required to provide a set of the applicant's 1944  
fingerprint impressions as part of the criminal records check. 1945

(E) As a condition of employing any applicant in a 1946  
position that involves providing home and community-based 1947

services, the chief administrator of a waiver agency shall 1948  
conduct a database review of the applicant in accordance with 1949  
rules authorized by this section. If rules authorized by this 1950  
section so require, the chief administrator of a waiver agency 1951  
shall conduct a database review of an employee in accordance 1952  
with the rules as a condition of continuing to employ the 1953  
employee in a position that involves providing home and 1954  
community-based services. A database review shall determine 1955  
whether the applicant or employee is included in any of the 1956  
following: 1957

(1) The excluded parties list system that is maintained by 1958  
the United States general services administration pursuant to 1959  
subpart 9.4 of the federal acquisition regulation and available 1960  
at the federal web site known as the system for award 1961  
management; 1962

(2) The list of excluded individuals and entities 1963  
maintained by the office of inspector general in the United 1964  
States department of health and human services pursuant to the 1965  
"Social Security Act," sections 1128 and 1156, 42 U.S.C. 1320a-7 1966  
and 1320c-5; 1967

(3) The registry of developmental disabilities employees 1968  
established under section 5123.52 of the Revised Code; 1969

(4) The internet-based sex offender and child-victim 1970  
offender database established under division (A) (11) of section 1971  
2950.13 of the Revised Code; 1972

(5) The internet-based database of inmates established 1973  
under section 5120.66 of the Revised Code; 1974

(6) The state nurse aide registry established under 1975  
section 3721.32 of the Revised Code; 1976

(7) Any other database, if any, specified in rules 1977  
authorized by this section. 1978

(F) (1) As a condition of employing any applicant in a 1979  
position that involves providing home and community-based 1980  
services, the chief administrator of a waiver agency shall 1981  
require the applicant to request that the superintendent of the 1982  
bureau of criminal identification and investigation conduct a 1983  
criminal records check of the applicant. If rules authorized by 1984  
this section so require, the chief administrator of a waiver 1985  
agency shall require an employee to request that the 1986  
superintendent conduct a criminal records check of the employee 1987  
at times specified in the rules as a condition of continuing to 1988  
employ the employee in a position that involves providing home 1989  
and community-based services. However, a criminal records check 1990  
is not required for an applicant or employee if the waiver 1991  
agency is prohibited by division (C) (1) of this section from 1992  
employing the applicant or continuing to employ the employee in 1993  
a position that involves providing home and community-based 1994  
services. If an applicant or employee for whom a criminal 1995  
records check request is required by this section does not 1996  
present proof of having been a resident of this state for the 1997  
five-year period immediately prior to the date the criminal 1998  
records check is requested or provide evidence that within that 1999  
five-year period the superintendent has requested information 2000  
about the applicant or employee from the federal bureau of 2001  
investigation in a criminal records check, the chief 2002  
administrator shall require the applicant or employee to request 2003  
that the superintendent obtain information from the federal 2004  
bureau of investigation as part of the criminal records check. 2005  
Even if an applicant or employee for whom a criminal records 2006  
check request is required by this section presents proof of 2007

having been a resident of this state for the five-year period, 2008  
the chief administrator may require the applicant or employee to 2009  
request that the superintendent include information from the 2010  
federal bureau of investigation in the criminal records check. 2011

(2) The chief administrator shall provide the following to 2012  
each applicant and employee for whom a criminal records check is 2013  
required by this section: 2014

(a) Information about accessing, completing, and 2015  
forwarding to the superintendent of the bureau of criminal 2016  
identification and investigation the form prescribed pursuant to 2017  
division (C) (1) of section 109.572 of the Revised Code and the 2018  
standard impression sheet prescribed pursuant to division (C) (2) 2019  
of that section; 2020

(b) Written notification that the applicant or employee is 2021  
to instruct the superintendent to submit the completed report of 2022  
the criminal records check directly to the chief administrator. 2023

(3) A waiver agency shall pay to the bureau of criminal 2024  
identification and investigation the fee prescribed pursuant to 2025  
division (C) (3) of section 109.572 of the Revised Code for any 2026  
criminal records check required by this section. However, a 2027  
waiver agency may require an applicant to pay to the bureau the 2028  
fee for a criminal records check of the applicant. If the waiver 2029  
agency pays the fee for an applicant, it may charge the 2030  
applicant a fee not exceeding the amount the waiver agency pays 2031  
to the bureau under this section if the waiver agency notifies 2032  
the applicant at the time of initial application for employment 2033  
of the amount of the fee and that, unless the fee is paid, the 2034  
applicant will not be considered for employment. 2035

~~(G) (1) A waiver agency may employ conditionally an~~ 2036

~~applicant for whom a criminal records check is required by this~~ 2037  
~~section prior to obtaining the results of the criminal records~~ 2038  
~~check if both of the following apply:~~ 2039

~~(a) The waiver agency is not prohibited by division (C) (1)~~ 2040  
~~of this section from employing the applicant in a position that~~ 2041  
~~involves providing home and community-based services.~~ 2042

~~(b) The chief administrator of the waiver agency requires~~ 2043  
~~the applicant to request a criminal records check regarding the~~ 2044  
~~applicant in accordance with division (F) (1) of this section not~~ 2045  
~~later than five business days after the applicant begins~~ 2046  
~~conditional employment.~~ 2047

~~(2) A waiver agency that employs an applicant~~ 2048  
~~conditionally under division (C) (1) of this section shall~~ 2049  
~~terminate the applicant's employment if the results of the~~ 2050  
~~criminal records check, other than the results of any request~~ 2051  
~~for information from the federal bureau of investigation, are~~ 2052  
~~not obtained within the period ending sixty days after the date~~ 2053  
~~the request for the criminal records check is made. Regardless~~ 2054  
~~of when the results of the criminal records check are obtained,~~ 2055  
~~if the results indicate that the applicant has been convicted of~~ 2056  
~~or has pleaded guilty to a disqualifying offense, the waiver~~ 2057  
~~agency shall terminate the applicant's employment unless~~ 2058  
~~circumstances specified in rules authorized by this section~~ 2059  
~~exist that permit the waiver agency to employ the applicant and~~ 2060  
~~the waiver agency chooses to employ the applicant.~~ 2061

~~(H) The report of any criminal records check conducted~~ 2062  
~~pursuant to a request made under this section is not a public~~ 2063  
~~record for the purposes of section 149.43 of the Revised Code~~ 2064  
~~and shall not be made available to any person other than the~~ 2065  
~~following:~~ 2066

(1) The applicant or employee who is the subject of the criminal records check or the representative of the applicant or employee;

(2) The chief administrator of the waiver agency that requires the applicant or employee to request the criminal records check or the administrator's representative;

(3) The medicaid director and the staff of the department who are involved in the administration of the medicaid program;

(4) The director of aging or the director's designee if the waiver agency also is a community-based long-term care provider or community-based long-term care subcontractor;

(5) An individual receiving or deciding whether to receive home and community-based services from the subject of the criminal records check;

(6) A court, hearing officer, or other necessary individual involved in a case or administrative hearing dealing with any of the following:

(a) A denial of employment of the applicant or employee;

(b) Employment or unemployment benefits of the applicant or employee;

(c) A civil or criminal action regarding the medicaid program;

(d) A denial, suspension, or termination of a provider agreement.

With respect to an administrative hearing dealing with a denial, suspension, or termination of a provider agreement, the report of a criminal records check may be introduced as evidence

at the hearing and if admitted, becomes part of the hearing 2094  
record. Any such report shall be admitted only under seal and 2095  
shall maintain its status as not a public record. 2096

~~(I)~~(H) The medicaid director shall adopt rules under 2097  
section 5164.02 of the Revised Code to implement this section. 2098

(1) The rules may do the following: 2099

(a) Require employees to undergo database reviews and 2100  
criminal records checks under this section; 2101

(b) If the rules require employees to undergo database 2102  
reviews and criminal records checks under this section, exempt 2103  
one or more classes of employees from the requirements; 2104

(c) For the purpose of division (E) (7) of this section, 2105  
specify other databases that are to be checked as part of a 2106  
database review conducted under this section. 2107

(2) The rules shall specify all of the following: 2108

(a) The procedures for conducting a database review under 2109  
this section; 2110

(b) If the rules require employees to undergo database 2111  
reviews and criminal records checks under this section, the 2112  
times at which the database reviews and criminal records checks 2113  
are to be conducted; 2114

(c) If the rules specify other databases to be checked as 2115  
part of a database review, the circumstances under which a 2116  
waiver agency is prohibited from employing an applicant or 2117  
continuing to employ an employee who is found by the database 2118  
review to be included in one or more of those databases; 2119

(d) The circumstances under which a waiver agency may 2120

employ an applicant or employee who is found by a criminal 2121  
records check required by this section to have been convicted of 2122  
or have pleaded guilty to a disqualifying offense. 2123

~~(J)~~(I) The amendments made by H.B. 487 of the 129th 2124  
general assembly to this section do not preclude the department 2125  
of medicaid from taking action against a person for failure to 2126  
comply with former division (H) of this section as that division 2127  
existed on the day preceding January 1, 2013. 2128

**Sec. 5164.36.** (A) As used in this section: 2129

(1) "Credible allegation of fraud" has the same meaning as 2130  
in 42 C.F.R. 455.2, except that for purposes of this section any 2131  
reference in that regulation to the "state" or the "state 2132  
medicaid agency" means the department of medicaid. A "credible 2133  
allegation of fraud" includes falsified or fake check-ins, 2134  
forged paperwork, double billing for medicaid services, identity 2135  
misuse, impossible travel patterns, claims that overlap with a 2136  
hospital stay that are not provided in accordance with an 2137  
authorized individual service plan, and coordinated billing 2138  
rings. 2139

(2) "Disqualifying indictment" means an indictment of a 2140  
medicaid provider or its officer, authorized agent, associate, 2141  
manager, employee, or, if the provider is a noninstitutional 2142  
provider, its owner, if either of the following applies: 2143

(a) The indictment charges the person with committing an 2144  
act to which both of the following apply: 2145

(i) The act would be a felony or misdemeanor under the 2146  
laws of this state or the jurisdiction within which the act 2147  
occurred. 2148

(ii) The act relates to or results from furnishing or 2149

billing for medicaid services under the medicaid program or 2150  
relates to or results from performing management or 2151  
administrative services relating to furnishing medicaid services 2152  
under the medicaid program. 2153

(b) The indictment charges the person with committing an 2154  
act that would constitute a disqualifying offense. 2155

(3) "Disqualifying offense" means any of the offenses 2156  
listed or described in divisions (A) (3) (a) to (e) of section 2157  
109.572 of the Revised Code. 2158

(4) "Noninstitutional medicaid provider" means any person 2159  
or entity with a provider agreement other than a hospital, 2160  
nursing facility, or ICF/IID. 2161

(5) "Owner" means any person having at least five per cent 2162  
ownership in a noninstitutional medicaid provider. 2163

(B) (1) Except as provided in division (C) of this section 2164  
and in rules authorized by this section, the department of 2165  
medicaid shall suspend the provider agreement held by a medicaid 2166  
provider on determining either of the following: 2167

(a) There is a credible allegation of fraud against any of 2168  
the following for which an investigation is pending under the 2169  
medicaid program: 2170

(i) The medicaid provider; 2171

(ii) The medicaid provider's owner, officer, authorized 2172  
agent, associate, manager, or employee. 2173

(b) A disqualifying indictment has been issued against any 2174  
of the following: 2175

(i) The medicaid provider; 2176

(ii) The medicaid provider's officer, authorized agent, 2177  
associate, manager, or employee; 2178

(iii) If the medicaid provider is a noninstitutional 2179  
provider, its owner. 2180

(2) Subject to division (C) of this section, the 2181  
department shall also suspend all medicaid payments to a 2182  
medicaid provider for services rendered, regardless of the date 2183  
that the services are rendered, when the department suspends the 2184  
provider's provider agreement under this section. 2185

(3) Except as otherwise provided in 42 C.F.R. 455.23, when 2186  
the attorney general or auditor of state submits a credible 2187  
allegation of fraud with evidence to the department, the 2188  
department shall take the following actions: 2189

(a) Suspend medicaid payments to the provider in whole, in 2190  
part, or as applied to targeted payments; 2191

(b) Require pre-payment review of the provider's claims. 2192

(4) The suspension of a provider agreement or medicaid 2193  
payments shall continue in effect until the latest of the 2194  
following occurs: 2195

(a) If the suspension is the result of a credible 2196  
allegation of fraud, the department or a prosecuting authority 2197  
determines that there is insufficient evidence of fraud by the 2198  
medicaid provider; 2199

(b) Regardless of whether the suspension is the result of 2200  
a credible allegation of fraud or a disqualifying indictment, 2201  
the proceedings in any related criminal case are completed 2202  
through dismissal of the indictment or through sentencing after 2203  
conviction or entry of a guilty plea or through finding of not 2204

guilty or, if the department commences a process to terminate 2205  
the suspended provider agreement, the termination process is 2206  
concluded; 2207

(c) The medicaid provider pays in full all fines and debts 2208  
due and owing to the department or makes arrangements 2209  
satisfactory to the department to fulfill those obligations; 2210

(d) A civil action related to a credible allegation of 2211  
fraud or disqualifying indictment is not pending against the 2212  
medicaid provider; 2213

(e) If payments are suspended under division (B) (3) of 2214  
this section, until the completion of the administrative review 2215  
described in division (D) (2) of this section. 2216

~~(4) (a)~~ (5) (a) When a provider agreement is suspended under 2217  
this section, none of the following shall take, during the 2218  
period of the suspension, any of the actions specified in 2219  
division ~~(B) (4) (b)~~ (B) (5) (b) of this section: 2220

(i) The medicaid provider; 2221

(ii) If the suspension is the result of an action taken by 2222  
an officer, authorized agent, associate, manager, or employee of 2223  
the medicaid provider, that person; 2224

(iii) If the medicaid provider is a noninstitutional 2225  
provider and the suspension is the result of an action taken by 2226  
the owner of the provider, the owner. 2227

(b) The following are the actions that persons specified 2228  
in division ~~(B) (4) (a)~~ (B) (5) (a) of this section cannot take 2229  
during the suspension of a provider agreement: 2230

(i) Own any other medicaid provider or risk contractor; 2231

(ii) Arrange, render, or order services on behalf of any other medicaid provider or risk contractor; 2232  
2233

(iii) Arrange or order services for medicaid recipients or render services to medicaid recipients; 2234  
2235

(iv) Receive direct payments under the medicaid program or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any other medicaid provider or risk contractor. 2236  
2237  
2238  
2239

(C) The department shall not suspend a provider agreement or medicaid payments under division (B) of this section if either of the following is the case: 2240  
2241  
2242

(1) The medicaid provider or, if the provider is a noninstitutional provider, the owner can demonstrate through the submission of written evidence that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the credible allegation of fraud or disqualifying indictment. 2243  
2244  
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(2) The medicaid provider or, if the provider is a noninstitutional provider, the owner can demonstrate that good cause exists not to suspend the provider agreement or payments. 2249  
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2251

With respect to the evidence described in division (C) (1) of this section, the department shall grant, prior to suspension, the provider or owner an opportunity to submit the written evidence to the department. 2252  
2253  
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2255

With respect to a demonstration of good cause described in division (C) (2) of this section, the department shall specify in rules adopted under section 5164.02 of the Revised Code what constitutes good cause and the information, documents, or other evidence that must be submitted to the department as part of the 2256  
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demonstration. 2261

~~(D)~~(D) (1) After suspending a provider agreement under 2262  
division ~~(B)~~(B) (1) of this section, the department shall send 2263  
notice of the suspension to the affected medicaid provider or, 2264  
if the provider is a noninstitutional provider, the owner in 2265  
accordance with the following time frames: 2266

~~(1)~~(a) Not later than five days after the suspension, 2267  
unless a law enforcement agency makes a written request to 2268  
temporarily delay the notice; 2269

~~(2)~~(b) If a law enforcement agency makes a written request 2270  
to temporarily delay the notice, not later than thirty days 2271  
after the suspension occurs subject to the conditions specified 2272  
in division (E) of this section. 2273

(2) If medicaid payments are suspended in accordance with 2274  
division (B) (3) of this section, the medicaid provider or, if 2275  
the provider is a noninstitutional provider, the owner shall be 2276  
entitled to a hearing and independent administrative review of 2277  
the suspension. 2278

(E) A written request for a temporary delay described in 2279  
division ~~(D)~~~~(2)~~(D) (1) (b) of this section may be renewed in 2280  
writing by a law enforcement agency not more than two times 2281  
except that under no circumstances shall the notice be issued 2282  
more than ninety days after the suspension occurs. 2283

(F) The notice required by division (D) of this section 2284  
shall do all of the following: 2285

(1) State that payments are being suspended in accordance 2286  
with this section and 42 C.F.R. 455.23; 2287

(2) Set forth the general allegations related to the 2288

nature of the conduct leading to the suspension, except that it 2289  
is not necessary to disclose any specific information concerning 2290  
an ongoing investigation; 2291

(3) State that the suspension continues to be in effect 2292  
until the latest of the circumstances specified in division ~~(B)~~ 2293  
~~(3)~~(B) (4) of this section occur; 2294

(4) Specify, if applicable, the type or types of medicaid 2295  
claims or business units of the medicaid provider that are 2296  
affected by the suspension; 2297

(5) Inform the medicaid provider or owner of the 2298  
opportunity to submit to the department, not later than thirty 2299  
days after receiving the notice, a request for reconsideration 2300  
of the suspension in accordance with division (G) of this 2301  
section. 2302

(G) (1) Pursuant to the procedure specified in division (G) 2303  
(2) of this section, a medicaid provider subject to a suspension 2304  
under this section or, if the provider is a noninstitutional 2305  
provider, the owner may request a reconsideration of the 2306  
suspension. The request shall be made not later than thirty days 2307  
after receipt of a notice required by division ~~(D)~~(D) (1) of this 2308  
section. The reconsideration is not subject to an adjudication 2309  
hearing pursuant to Chapter 119. of the Revised Code. 2310

(2) In requesting a reconsideration, the medicaid provider 2311  
or owner shall submit written information and documents to the 2312  
department. The information and documents may pertain to either 2313  
of the following issues: 2314

(a) Whether the determination to suspend the provider 2315  
agreement was based on a mistake of fact, other than the 2316  
validity of an indictment in a related criminal case. 2317

(b) If there has been an indictment in a related criminal case, whether the indictment is a disqualifying indictment.

(H) The department shall review the information and documents submitted in a request made under division (G) of this section for reconsideration of a suspension. After the review, the suspension may be affirmed, reversed, or modified, in whole or in part. The department shall notify the affected provider or owner of the results of the review.

(I) Rules adopted under section 5164.02 of the Revised Code may specify circumstances under which the department would not suspend a provider agreement pursuant to this section. The department shall adopt rules establishing expedited appeal procedures for purposes of an administrative review conducted under division (D) (2) of this section.

**Sec. 5164.40.** As used in sections 5164.40 to 5164.406 of the Revised Code:

(A) "Breadcrumb location data" means data that provides a geographical position during a designated time period allowing the movements of a user to be tracked.

(B) "Electronic verification system" means an electronic system capable of recording and verifying data elements related to the delivery of health care services covered by the medicaid program.

(C) "GPS-based verification" has the same meaning as in section 5164.42 of the Revised Code.

(D) "Nonemergency medical transportation" means transportation for which immediate response is not needed for the provision of medical treatment and is provided to a medicaid recipient in accordance with 42 C.F.R. 431.53. "Nonemergency

medical transportation" does not include transportation 2347  
conducted by an emergency medical service organization or 2348  
nonemergency medical service organization as defined in section 2349  
4766.01 of the Revised Code that is licensed by the state board 2350  
of emergency medical, fire, and transportation services. 2351

**Sec. 5164.401.** (A) The department of medicaid shall 2352  
develop, procure, certify, or approve a process or system to 2353  
obtain global positioning system coordinates to verify 2354  
nonemergency medical transportation services provided under the 2355  
medicaid program to medicaid recipients. In developing, 2356  
procuring, certifying, or approving a system under this section, 2357  
the department may do any of the following: 2358

(1) Establish an internal electronic verification system; 2359

(2) Contract with one or more vendors to establish an 2360  
electronic verification system; 2361

(3) Integrate with existing electronic verification 2362  
systems utilized by the department. 2363

(B) A system or systems developed, procured, certified, or 2364  
approved in accordance with this section shall do all of the 2365  
following: 2366

(1) Utilize a ride dispatch system that is similar to 2367  
other private transportation services; 2368

(2) Utilize GPS-based verification to track a provider's 2369  
arrival at a pickup location, initiation of a transport, arrival 2370  
at a drop-off location, and completion of a transport; 2371

(3) Record timestamps, route data, and total distance 2372  
traveled during a transport; 2373

(4) Be capable of transmitting data directly to the 2374

department as a condition of payment. 2375

(C) (1) An electronic verification system developed, 2376  
procured, certified, or approved in accordance with this section 2377  
shall be used to ensure payment integrity within the medicaid 2378  
program, compliance with state and federal requirements, and 2379  
serve as a fraud prevention measure within the medicaid program. 2380  
No data transmitted or stored by an electronic verification 2381  
system shall be used to conduct unrelated surveillance of 2382  
medicaid providers or for enforcement purposes unrelated to the 2383  
medicaid program. 2384

(2) All data transmitted or stored by an electronic 2385  
verification system shall be encrypted, be subject to role-based 2386  
access controls and audit logs, and comply with all requirements 2387  
under state and federal law regarding the protection of patient 2388  
information. 2389

(D) The department shall integrate any electronic 2390  
verification system developed, procured, certified, or approved 2391  
under this section with the department's existing claims and 2392  
encounters database and systems. If necessary, the department 2393  
shall coordinate with medicaid managed care organizations and 2394  
seek any necessary federal approval to facilitate coordination 2395  
with electronic verification systems in the medicare program. 2396

(E) (1) Not later than six months after the effective date 2397  
of this section, the department shall develop technical 2398  
standards and a plan for implementing the requirement of this 2399  
section and sections 5164.402 to 5164.406 of the Revised Code. 2400  
The department shall submit a copy of the plan to the general 2401  
assembly in accordance with section 101.68 of the Revised Code. 2402

(2) Not later than twelve months after the effective date 2403

of this section, the department shall establish a pilot program 2404  
under which certain medicaid providers must utilize the 2405  
electronic verification systems established under this section. 2406

(3) Beginning not later than eighteen months after the 2407  
effective date of this section, the department shall require all 2408  
nonemergency medical transportation service providers to utilize 2409  
an electronic verification system established under division (B) 2410  
of this section. 2411

(F) In establishing and requiring utilization of 2412  
electronic visit verification systems under this section, the 2413  
department shall ensure that medicaid recipients are not denied 2414  
medically necessary services solely on the basis of a provider's 2415  
failure to utilize a required system. The department shall 2416  
further ensure that any transition periods that are the result 2417  
of implementing the requirements of this section do not impact 2418  
the continuity of care for medicaid recipients. The department 2419  
shall provide training and technical support to providers to 2420  
ensure compliance with this section. 2421

**Sec. 5164.402.** (A) Upon full implementation of the 2422  
electronic verification systems developed, procured, certified, 2423  
or approved in accordance with section 5164.401 of the Revised 2424  
Code, no nonemergency medical transportation service provider 2425  
shall be eligible to receive medicaid payment for transportation 2426  
services provided to a medicaid recipient unless the provider 2427  
submits all necessary data through an electronic verification 2428  
system. The department of medicaid shall pay a claim for 2429  
transportation services submitted through an electronic 2430  
verification system if all of the following conditions are 2431  
satisfied: 2432

(1) All required GPS-based verification and timestamp data 2433

are present. 2434

(2) The breadcrumb location data utilized by an electronic verification system is consistent with the billed services. 2435  
2436

(3) No unresolved discrepancies about the claim exist. 2437

(B) The department shall establish a process by which a nonemergency medical transportation service provider may seek an exemption from utilizing an electronic verification system. The department may permit an exemption for any of the following reasons: 2438  
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(1) Equipment failure or network unavailability, including rural connectivity issues; 2443  
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(2) Emergencies; 2445

(3) Concerns for the safety of the medicaid recipient. 2446

(C) Before granting an exemption under division (B) of this section, the department shall require a nonemergency medical transportation service provider to submit written documentation detailing why an exemption should be granted. The department shall routinely monitor the number of exemptions requested by a provider. 2447  
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**Sec. 5164.403.** (A) Not later than five years after the effective date of this section, the department of medicaid shall develop and implement a system by which global positioning system coordinates data received from a nonemergency medical transportation service provider may be cross-referenced with claims for medicaid payment submitted to the department by other medicaid providers. The system established in accordance with this section shall be capable of verifying all of the following: 2453  
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(1) The medicaid recipient who received the nonemergency 2461

medical transportation services was transported for the purpose 2462  
of receiving a medicaid service. 2463

(2) The medicaid recipient who received the nonemergency 2464  
medical transportation services was transported to a medicaid 2465  
provider with an active and valid provider agreement at the time 2466  
of transport. 2467

(3) The records are received by the department within an 2468  
allowable timeframe established under division (B) of this 2469  
section and reflect an encounter, claim, or billing activity for 2470  
a service described in division (A) (1) or (2) of this section. 2471

(B) The department shall establish an allowable timeframe 2472  
under which claims for medicaid payment for transportation 2473  
claims may be cross-referenced and matched against claims for 2474  
other medicaid services. The allowable timeframe shall account 2475  
for documented exceptions that create delays including provider 2476  
cancellations, appointment rescheduling, emergency diversions, 2477  
delayed billing, and administrative errors. 2478

**Sec. 5164.404.** (A) The department of medicaid shall 2479  
develop and implement automated fraud-detection tools to assist 2480  
with identifying fraud through the use of the electronic 2481  
verification systems developed, procured, certified, or approved 2482  
under section 5164.401 of the Revised Code. Any fraud-detection 2483  
tools shall be capable of flagging irregular patterns of 2484  
activity by medicaid providers that are required to utilize the 2485  
electronic verification systems, including all of the following: 2486

(1) The seeking and approval of repeated exceptions under 2487  
section 5164.402 of the Revised Code; 2488

(2) Anomalous or irregular patterns by nonemergency 2489  
medical transportation service providers; 2490

<u>(3) Discrepancies between location data and submitted</u>	2491
<u>claims.</u>	2492
<u>(B) The department shall conduct periodic audits and</u>	2493
<u>investigations concerning data collected through use of the</u>	2494
<u>electronic verification systems under section 5164.401 of the</u>	2495
<u>Revised Code and fraud-detection tools implemented under this</u>	2496
<u>section. The department may suspend a medicaid provider's</u>	2497
<u>provider agreement for failing to comply with an audit or</u>	2498
<u>investigation conducted under this section.</u>	2499
<u>(C) If an audit or investigation conducted in accordance</u>	2500
<u>with this section results in a credible allegation of fraud as</u>	2501
<u>defined in section 5164.36 of the Revised Code, the department</u>	2502
<u>shall handle the credible allegation in accordance with that</u>	2503
<u>section and refer the credible allegation to the attorney</u>	2504
<u>general for investigation.</u>	2505
<b><u>Sec. 5164.405.</u></b> <u>Annually, the department of medicaid shall</u>	2506
<u>submit a report to the general assembly detailing electronic</u>	2507
<u>verification systems developed, procured, certified, or approved</u>	2508
<u>under section 5164.401 of the Revised Code. The report shall be</u>	2509
<u>submitted to the general assembly in accordance with section</u>	2510
<u>101.68 of the Revised Code and detail all of the following:</u>	2511
<u>(A) The verified number of service claims submitted</u>	2512
<u>through electronic verification systems;</u>	2513
<u>(B) The number of claims denied or recouped;</u>	2514
<u>(C) The number of cases of fraud referred to the medicaid</u>	2515
<u>fraud control unit as a result of electronic verification</u>	2516
<u>systems;</u>	2517
<u>(D) The number of provider sanctions issued as a result of</u>	2518
<u>electronic verification system data;</u>	2519

<u>(E) The total amount of cost savings to the medicaid</u>	2520
<u>program achieved as a result of electronic verification systems;</u>	2521
<u>(F) Any impacts to medicaid recipient access to medicaid</u>	2522
<u>services that result from the use of electronic verification</u>	2523
<u>systems;</u>	2524
<u>(G) Any additional information or data the department</u>	2525
<u>considers relevant concerning electronic verification systems.</u>	2526
<u><b>Sec. 5164.406.</b> The department of medicaid shall adopt</u>	2527
<u>rules in accordance with Chapter 119. of the Revised Code to</u>	2528
<u>implement sections 5164.40 to 5164.406 of the Revised Code. The</u>	2529
<u>rules shall address all of the following:</u>	2530
<u>(A) Technical standards for electronic verification</u>	2531
<u>systems developed, procured, certified, or approved under</u>	2532
<u>section 5164.401 of the Revised Code including GPS intervals,</u>	2533
<u>breadcrumb location data parameters, and criteria for</u>	2534
<u>certification of electronic verification systems;</u>	2535
<u>(B) Procedures by which a provider may seek an exemption</u>	2536
<u>from electronic verification requirements under section 5164.402</u>	2537
<u>of the Revised Code;</u>	2538
<u>(C) Protocols by which the department will conduct audits</u>	2539
<u>and enforcement of electronic verification requirements under</u>	2540
<u>section 5164.404 of the Revised Code;</u>	2541
<u>(D) Other standards and procedures as necessary to</u>	2542
<u>implement sections 5164.40 to 5164.406 of the Revised Code.</u>	2543
<u><b>Sec. 5164.41.</b> (A) As used in this section, "home and</u>	2544
<u>community-based services medicaid waiver component" has the same</u>	2545
<u>meaning as in section 5166.01 of the Revised Code.</u>	2546
<u>(B) The department of medicaid shall establish oversight</u>	2547

<u>mechanisms concerning services provided by a family caregiver</u>	2548
<u>under a home and community-based services medicaid waiver</u>	2549
<u>component. Oversight may include any of the following:</u>	2550
<u>(1) Quarterly audits;</u>	2551
<u>(2) Enhanced check-in review;</u>	2552
<u>(3) Annual recertification as a medicaid provider;</u>	2553
<u>(4) Independent case manager verification;</u>	2554
<u>(5) Caps on hours of compensated care absent documented</u>	2555
<u>medical necessity;</u>	2556
<u>(6) Forensic review triggers;</u>	2557
<u>(7) Background check monitoring pursuant to section</u>	2558
<u>5164.341 of the Revised Code through the retained applicant</u>	2559
<u>fingerprint database established under section 109.5721 of the</u>	2560
<u>Revised Code.</u>	2561
<u>(C) The department may require a family caregiver who the</u>	2562
<u>department considers to be high risk or who has repeatedly</u>	2563
<u>violated the department's requirements concerning family</u>	2564
<u>caregivers to provide services through a waiver agency as</u>	2565
<u>defined in section 5164.342 of the Revised Code, rather than as</u>	2566
<u>an independent provider.</u>	2567
<b><u>Sec. 5164.42.</u></b> (A) <u>As used in this section and section</u>	2568
<u>5164.421 of the Revised Code:</u>	2569
<u>(1) "Electronic visit verification" has the same meaning</u>	2570
<u>as in section 1903(1) of the "Social Security Act," 42 U.S.C.</u>	2571
<u>1396b(1).</u>	2572
<u>(2) "GPS-based verification" means real-time satellite</u>	2573
<u>location data that can be used to confirm the physical presence</u>	2574

<u>of a person or device in a specified location.</u>	2575
<u>(3) (a) "In-home care services" include all of the</u>	2576
<u>following:</u>	2577
<u>(i) Personal care services as defined in 42 C.F.R.</u>	2578
<u>440.167;</u>	2579
<u>(ii) Home health services covered by the medicaid program</u>	2580
<u>as part of the home health services benefit pursuant to 42</u>	2581
<u>C.F.R. 440.70;</u>	2582
<u>(iii) Services provided under a medicaid home and</u>	2583
<u>community-based services medicaid waiver component as defined in</u>	2584
<u>section 5166.01 of the Revised Code;</u>	2585
<u>(iv) Any other medicaid services that are provided to a</u>	2586
<u>medicaid recipient in either a residential or community setting.</u>	2587
<u>(b) "In-home care services" does not include residential</u>	2588
<u>services billed on a daily rate, habilitation services,</u>	2589
<u>transportation services under a developmental disabilities level</u>	2590
<u>of care home and community-based services medicaid waiver</u>	2591
<u>component, services provided in an ICF/IID, or services provided</u>	2592
<u>under the assisted living program as defined in section 173.51</u>	2593
<u>of the Revised Code.</u>	2594
<u>(B) (1) The department of medicaid shall require each claim</u>	2595
<u>for a service that is subject to electronic visit verification</u>	2596
<u>requirements under state or federal law, including claims</u>	2597
<u>submitted by in-home care service providers, to be supported by</u>	2598
<u>a validated electronic visit verification record as a condition</u>	2599
<u>of payment.</u>	2600
<u>(2) The department shall establish standards and</u>	2601
<u>procedures for matching claims for medicaid payment to</u>	2602

electronic visit verification records. The standards and 2603  
procedures shall identify the data elements necessary to 2604  
validate that the service billed was delivered to a medicaid 2605  
recipient, including the type of service performed, the 2606  
individual receiving the service, the date of service, the 2607  
location of service delivery, the individual providing the 2608  
service, and the time the service began and ended. 2609

(3) The standards described in division (B) (2) of this 2610  
section shall do all of the following: 2611

(a) Require in-home care service providers to clock in and 2612  
clock out when physically present at the location where services 2613  
are being provided; 2614

(b) Utilize GPS-based verification to track when a 2615  
provider clocks in and clocks out; 2616

(c) Record timestamps and the total duration of delivered 2617  
services; 2618

(d) Be capable of transmitting data directly to the 2619  
department for integration with other claims submissions. 2620

(4) In addition to the standards described in divisions 2621  
(B) (2) and (3) of this section, all services provided under the 2622  
self-direction service model shall require a provider to clock 2623  
in and clock out when physically present at the location where 2624  
services are being provided. 2625

(C) (1) The department may deny, suspend, defer, or recoup 2626  
payment for a claim that is not supported by a validated 2627  
electronic visit verification record. 2628

(2) Prior to taking an action described in division (C) (1) 2629  
of this section, the department shall provide affected providers 2630

with notice, training, technical assistance, and compliance 2631  
education regarding claim validation requirements established 2632  
under this section. 2633

(D) The department may establish performance benchmarks or 2634  
minimum compliance thresholds related to electronic visit 2635  
verification utilization, matching accuracy, manual entry rates, 2636  
modified visit rates, late visit entry rates, and unmatched 2637  
claim rates. 2638

(E) The medicaid director shall adopt rules under section 2639  
5164.02 of the Revised Code to implement this section. The rules 2640  
shall establish all of the following: 2641

(1) Claim validation procedures; 2642

(2) Standards for verified electronic visit verification 2643  
records; 2644

(3) Good-cause exemptions; 2645

(4) Corrective action processes; 2646

(5) Procedures for technical assistance and provider 2647  
remediation; 2648

(6) Phased implementation schedules by provider type or 2649  
service category; 2650

(7) Standards for denying, suspending, deferring, or 2651  
recouping payment for claims not supported by validated 2652  
electronic visit verification records. 2653

(F) Nothing in this section prohibits the department, the 2654  
auditor of state, the attorney general, or any other authorized 2655  
state or federal entity from conducting a post-payment review, 2656  
audit, investigation, enforcement action, or recovery action 2657

related to a claim subject to electronic visit verification 2658  
requirements. 2659

**Sec. 5164.421.** (A) In addition to the electronic visit 2660  
verification system described in section 5165.42 of the Revised 2661  
Code, the department of medicaid shall establish requirements 2662  
under which high risk in-home care service providers are 2663  
required to verify data regarding the services provided to a 2664  
medicaid recipient. 2665

(B) The department shall establish criteria under which an 2666  
in-home care service provider is considered to be a high-risk 2667  
provider. The criteria shall at a minimum include all of the 2668  
following: 2669

(1) Repeated mismatches in check-in data; 2670

(2) Data that indicates impossible travel times; 2671

(3) Claims data that overlaps with a medicaid recipient's 2672  
stay in a hospital for services that were not provided in 2673  
accordance with an authorized individual service plan; 2674

(4) Unusual outliers in billing data; 2675

(5) Other data indicators that demonstrate a high risk of 2676  
fraud. 2677

(C) Each in-home care service provider classified by the 2678  
department as a high risk provider shall satisfy the 2679  
requirements established under this section, including that the 2680  
high-risk provider utilize fingerprint scanning, facial 2681  
recognition, vocal recognition, a secure personal identification 2682  
number, or other approved verification method as a condition of 2683  
receiving payment for services provided under the medicaid 2684  
program. 2685

(D) The department shall not sell or otherwise distribute 2686  
any data transmitted or stored as part of a provider's use of 2687  
electronic visit verification under this section. No such data 2688  
shall be used for any purpose other than to verify medicaid 2689  
payment claims submitted by a provider and reduce fraud within 2690  
the medicaid program. 2691

**Sec. 5164.43.** (A) As used in this section: 2692

(1) "Employee" means any person who performs a service for 2693  
wages or other remuneration for an employer. 2694

(2) "Employer" means any person who has one or more 2695  
employees and includes an agent of an employer, the state or any 2696  
agency or instrumentality of the state, and any political 2697  
subdivision or any agency or instrumentality thereof. 2698

(B) No employer shall discharge, demote, reassign, or take 2699  
any punitive action against an employee because the employee, 2700  
based on a reasonable belief, submitted a good faith report that 2701  
an instance of fraud occurred in the medicaid program. 2702

(C) An employee alleging an employer has violated division 2703  
(B) of this section may commence an action in any court of 2704  
competent jurisdiction for reinstatement with back pay, if the 2705  
action is based on discharge, or for equitable relief, together 2706  
with reasonable attorney's fees. 2707

**Sec. 5164.57.** (A) (1) Except as provided in division (A) (2) 2708  
and division (E) of this section, the department of medicaid may 2709  
recover a medicaid payment or portion of a payment made to a 2710  
medicaid provider to which the provider is not entitled if the 2711  
department notifies the provider of the overpayment during the 2712  
five-year period immediately following the end of the state 2713  
fiscal year in which the overpayment was made. 2714

(2) In the case of a hospital medicaid provider, if the department determines as a result of a medicare or medicaid cost report settlement that the provider received an amount under the medicaid program to which the provider is not entitled, the department may recover the overpayment if the department notifies the provider of the overpayment during the later of the following:

(a) The five-year period immediately following the end of the state fiscal year in which the overpayment was made;

(b) The one-year period immediately following the date the department receives from the United States centers for medicare and medicaid services a completed, audited, medicare cost report for the provider that applies to the state fiscal year in which the overpayment was made.

(B) Among the overpayments that may be recovered under this section are the following:

(1) Payment for a medicaid service, or a day of service, not rendered;

(2) Payment for a day of service at a full per diem rate that should have been paid at a percentage of the full per diem rate;

(3) Payment for a medicaid service, or day of service, that was paid by, or partially paid by, a third party, as defined in section 5160.35 of the Revised Code, and the third party's payment or partial payment was not offset against the amount paid by the medicaid program to reduce or eliminate the amount that was paid by the medicaid program;

(4) Payment when a medicaid recipient's responsibility for payment was understated and resulted in an overpayment to the

provider. 2744

(C) The department may recover an overpayment under this 2745  
section prior to or after any of the following: 2746

(1) Adjudication of a final fiscal audit that section 2747  
5164.38 of the Revised Code requires to be conducted in 2748  
accordance with Chapter 119. of the Revised Code; 2749

(2) Adjudication of a finding under any other provision of 2750  
state statutes governing the medicaid program or the rules 2751  
adopted under those statutes; 2752

(3) Expiration of the time to issue a final fiscal audit 2753  
that section 5164.38 of the Revised Code requires to be 2754  
conducted in accordance with Chapter 119. of the Revised Code; 2755

(4) Expiration of the time to issue a finding under any 2756  
other provision of state statutes governing the medicaid program 2757  
or the rules adopted under those statutes. 2758

(D) (1) Subject to division (D) (2) of this section, the 2759  
recovery of an overpayment under this section does not preclude 2760  
the department from subsequently doing the following: 2761

(a) Issuing a final fiscal audit in accordance with 2762  
Chapter 119. of the Revised Code, as required under section 2763  
5164.38 of the Revised Code; 2764

(b) Issuing a finding under any other provision of state 2765  
statutes governing the medicaid program or the rules adopted 2766  
under those statutes. 2767

(2) A final fiscal audit or finding issued subsequent to 2768  
the recovery of an overpayment under this section shall be 2769  
reduced by the amount of the prior recovery, as appropriate. 2770

(E) The department shall recover all overpayments to a 2771  
provider when an audit determines and verifies an impossible 2772  
claim submitted by the provider, such as when a provider has 2773  
submitted a claim for providing in-home care services, as 2774  
defined in section 5164.40 of the Revised Code, on a date when 2775  
the recipient was in the hospital or when a provider has 2776  
submitted claims for providing in-home services to recipients 2777  
located at different addresses at the same time. 2778

(F) Nothing in this section limits the department's 2779  
authority to recover overpayments pursuant to any other 2780  
provision of the Revised Code. 2781

**Sec. 5167.18.** Each medicaid managed care organization 2782  
shall comply with federal and state efforts to identify fraud, 2783  
waste, and abuse in the medicaid program. Upon the 2784  
identification of credible evidence of fraud, waste, or abuse, 2785  
or materially inconsistent billing, each medicaid managed care 2786  
organization shall make a report to the department of medicaid. 2787  
The department shall refer potential fraud in a timely manner to 2788  
the attorney general for investigation. 2789

**Sec. 5167.23.** (A) As used in this section, "deconfliction" 2790  
means the systematic coordination between medicaid managed care 2791  
organizations and multiple state and federal oversight agencies 2792  
to share investigative data, eliminate overlapping inquiries, 2793  
and streamline the prosecution of fraudulent medicaid providers. 2794

(B) Upon the identification of credible indicators of 2795  
fraud, waste, or abuse, a medicaid managed care organization may 2796  
implement reasonable and timely payment integrity actions, 2797  
including payment suspension and prepayment review and denial. 2798

(C) (1) A medicaid managed care organization may initiate 2799

prepayment review for a medicaid provider without first 2800  
obtaining approval from the department of medicaid. 2801  
Notwithstanding any provision of law to the contrary, a 2802  
prepayment review initiated under this section may remain in 2803  
effect for longer than six months without renewal. 2804

(2) A medicaid managed care organization may place 2805  
suspected high-risk providers, as determined by the medicaid 2806  
managed care organization, on claims payment suspension during 2807  
any open investigation or stand-down period. A medicaid managed 2808  
care organization shall notify and obtain approval from the 2809  
department or the attorney general prior to implementing claims 2810  
payment suspension under this section. 2811

(3) A medicaid managed care organization shall provide a 2812  
provider placed on claims payment suspension under division (C) 2813  
(2) of this section with written notice of the decision and an 2814  
opportunity for the provider to participate in the 2815  
organization's grievance process established in accordance with 2816  
section 5167.11 of the Revised Code. Upon completion of any 2817  
grievance process, an affected provider may seek an appeal of a 2818  
medicaid managed care organization's decision with the 2819  
department of medicaid. 2820

(D) Following the initiation of payment integrity actions, 2821  
a medicaid managed care organization shall complete all 2822  
applicable deconfliction procedures in accordance with 2823  
procedures established by the department. A medicaid managed 2824  
care organization may take an action described in this section 2825  
prior to the completion of deconfliction procedures when 2826  
necessary to prevent continued improper payments and to mitigate 2827  
a program integrity risk. 2828

(E) A medicaid managed care organization shall maintain 2829

documented evidence of credible indicators of fraud, waste, and 2830  
abuse that are the basis for an action taken under this section. 2831  
The department shall ensure that all actions taken under this 2832  
section are consistent with state and federal law. 2833

**Section 2.** That existing sections 109.85, 117.10, 2834  
2903.216, 2913.40, 2923.31, 4113.52, 5164.32, 5164.33, 5164.34, 2835  
5164.342, 5164.36, 5164.57, and 5167.18 of the Revised Code are 2836  
hereby repealed. 2837

**Section 3.** Not later than thirty days after the effective 2838  
date of this section, the Department of Medicaid shall submit a 2839  
report to the General Assembly with a cost estimate to implement 2840  
this act. The report shall include a comparison of state funds 2841  
and expected matching federal funds necessary to develop, 2842  
procure, certify, or approve electronic verification systems 2843  
described in section 5164.401 of the Revised Code. The report 2844  
shall also analyze expected cost savings for the Medicaid 2845  
program that result from implementation of electronic 2846  
verification systems. 2847

**Section 4.** Not later than March 31, 2027, the Department 2848  
of Medicaid shall prepare and submit a report to the General 2849  
Assembly in accordance with section 101.68 of the Revised Code 2850  
regarding the creation of a Medicaid encounter data system and 2851  
the creation of a risk matrix that may be used to connect 2852  
individuals with national provider identifier records associated 2853  
with providers. The report and study shall examine the operation 2854  
of a potential Medicaid encounter data system and risk matrix, 2855  
including the scope of work required by the Department to 2856  
operationalize them. 2857

**Section 5.** This act shall be known as the Ohio Medicaid 2858  
Program Integrity and Fraud Prevention Act. 2859

**Section 6.** The General Assembly, applying the principle 2860  
stated in division (B) of section 1.52 of the Revised Code that 2861  
amendments are to be harmonized if reasonably capable of 2862  
simultaneous operation, finds that the following sections, 2863  
presented in this act as composites of the sections as amended 2864  
by the acts indicated, are the resulting versions of the 2865  
sections in effect prior to the effective date of the sections 2866  
as presented in this act: 2867

Section 117.10 of the Revised Code as amended by both H.B. 2868  
59 and S.B. 67 of the 130th General Assembly. 2869

Section 2923.31 of the Revised Code as amended by both 2870  
H.B. 199 and H.B. 405 of the 132nd General Assembly. 2871