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H.B. 795
(I_136_3280-5)
136th General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 795's Bill Analysis

Version: In House Medicaid

Primary Sponsor: Rep. Williams

Local Impact Statement Procedure Required: No

Brandon T. Minster, Senior Economist, and other LBO staff

Highlights

- The Department of Medicaid (ODM) would experience higher administrative costs as they develop a system or process for obtaining global positioning system coordinates for nonemergency medical transportation (NEMT) services. Administrative costs would also increase when ODM uses existing electronic-visit verification (EVV) systems or processes for in-home care services provider visits and cross-references visits and claims data.
- In-person reviews and site inspections would significantly increase ODM administrative action and spending, as would prior authorization of all personal care services.
- As a result of the bill's penalty enhancements for the offense of Medicaid fraud, there may be a marginal annual increase in the size of the prison population that the Department of Rehabilitation and Correction (DRC) will likely absorb by utilizing existing staff and resources.
- The bill's requirements for the Department of Insurance to establish and administer an all-payer claims database would increase costs to the Department by millions of dollars to establish the database and millions of dollars for ongoing administration of the database. Any fees that may be charged to a person who may obtain a subscription with the Department to access information in such a database may offset some of the costs. Currently, the Department's operations are funded by the Department of Insurance Operating Fund (Fund 5540).

Detailed Analysis

Department of Medicaid

The bill contains several provisions which will increase required administrative activity by the Ohio Department of Medicaid (ODM). Among these are provisions which do the following:

- Requires ODM to develop a system or process for obtaining global positioning system coordinates for nonemergency medical transportation (NEMT) services. ODM must also use existing electronic-visit verification (EVV) systems or processes for in-home care service provider visits. The bill specifies that in-home care services exclude residential services billed on a daily rate, habilitation services, transportation services, home- and community-based services (HCBS) provided under a developmental disability level of care, services provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or services provided under the Assisted Living Program. Additionally, ODM must ensure each claim for service subject to EVV requirements be supported by a valid EVV record as a condition of payment and to establish standards and procedures for matching claims to EVV records. The Department must maintain a statewide EVV performance dashboard, updated not less than quarterly, with specific required metrics included. Aggregate statewide data must be available on ODM's website.

- Requires ODM to establish criteria for classifying high risk providers and a verification system under which high risk in-home care service providers are required to verify data regarding the services provided using fingerprint scanning, facial recognition, vocal recognition, a secure personal identification number, or other approved verification method as a condition of receiving payment for services provided under the Medicaid Program. ODM must publish audits, reports of improper payments, and corrective action plans for risk contractors and subcontractors. The bill also clarifies that risk contractors do not include a service provider under an HCBS waiver administered by the Department of Developmental Disabilities (DODD).

- Requires ODM to conduct an in-person review of an individual or a site inspection of an entity before enrolling them in the Medicaid Program as a home- and community-based services (HCBS) provider, and subsequent in-person reviews or site inspections every three years. ODM must cross-check applying providers' location data to ensure no more than six active HCBS providers are located at the same address. When more than six HCBS providers are located at the same address the Department is required to make a referral to the Auditor of State. Also requires the Department to investigate if the number of claims submitted by a provider in a given month increases by more than 100% without a corresponding increase in the number of Medicaid enrollees receiving services from the provider.

- Requires ODM to impose a prior-authorization requirement on all personal care services provided by independent providers or waiver agencies under the Medicaid Program, with the exception of personal care services provided under a Medicaid waiver administered by DODD. The Department of Medicaid must make a determination within ten days of receiving a completed request, provide written notification to the applicant of its decision, and permit the applicant to appeal a denial.

- Requires ODM to coordinate with the Attorney General to create a disclaimer form providing an explicit explanation of penalties for Medicaid fraud, and requires the Department to obtain a signed copy of the disclaimer form from each applicant seeking to enroll as a Medicaid provider. ODM must also create a standardized onboarding process explaining all relevant state and federal laws regarding Medicaid for all providers.
- Permits Medicaid managed care organizations (MCOs) to initiate prepayment review without first obtaining approval from ODM, and requires an MCO notify the provider and provide the opportunity to participate in grievance and appeal processes. Also, MCOs must first obtain Attorney General approval before they place suspected high-risk providers on claims payment suspension and must maintain documented evidence of credible indicators of fraud, waste, and abuse, and to report such to the Department.
- Requires ODM to prepare and submit two reports to the General Assembly by March 31, 2027, one regarding the creation of a Medicaid Encounter Data System, and the other regarding the creation of a risk matrix. Both reports are to include how the potential system would operate and the scope of work required to complete its creation.
- Specifies that no individual is eligible for Ohio Medicaid unless eligible to participate in Medicaid under federal law.

Fiscal effect

ODM will experience one-time costs to develop, procure, certify, or approve new systems and processes for capturing global positioning system coordinates for NEMT services and costs updating or configuring existing systems and processes for EVV in-home personal care services. ODM will also incur costs developing and implementing a system that allows for received data to be cross-referenced with claims submitted by service providers, and developing and using automated fraud detection tools. Similarly, the Department will incur administrative costs creating and using the fraud disclaimer form. The Department will experience ongoing administrative costs maintaining and running these systems. ODM will also face administrative costs creating the report about the creating of a Medicaid Encounter Data System. Provisions related to NEMT may require new investment through procurements, in addition to any costs incurred at the local level for county-administered NEMT.

Some provisions may require the Department to engage in new procedures that will increase operating costs. The creation of an automated fraud-detection tool will involve either amendments to multiple existing vendor contracts or procurement processes.

The required audits for risk contractors and subcontractors may lead to increased state costs when contract bids are solicited for reprocurement, as bidding contractors will have knowledge of the maximum acceptable minimum bid. Also, the requirement for MCOs to track and submit specific information may increase their administrative costs, which may be reflected in the future capitation rates with the state. The bill is expected to reduce ODM's future Medicaid expenditures by detecting and preventing fraudulent claims for NEMT and HCBS care. Anticipated cost savings will not be realized immediately and will require significant upfront investment before any potential savings can be achieved.

Other provisions may help create cost reductions but the magnitude of any reductions will be dependent on individual circumstances that are currently unknown. For instance, prior

authorization requirements for personal care services may reduce spending if requests are denied, but they may also raise overall spending if deferred medical care during the authorization review process leads to a worse condition. Prohibiting individuals from participating in Ohio Medicaid if they are ineligible under federal law is likely to lead to preventing the state from covering individuals funded solely by state money. Any cost reductions will also not be immediate. Within 30 days of the bill's effective date ODM must submit to the General Assembly a cost estimate for implementation. Detailed analysis of any expected increases and decreases in spending will be presented in this initial report.

The state splits any costs and savings from actions approved by the U.S. Centers for Medicare & Medicaid Services with the federal government, according to the Medicaid reimbursement formula. The federal medical assistance percentage (FMAP) for administrative activities varies based on the type of action. Typical administrative costs are split evenly with the federal government, but certain specialized oversight activities can qualify for matching rates of 75%, 90%, or 100%, depending on the specific action.

In the event that uncovered fraud results in refunded funds to ODM, any recovered funds would be shared with the federal government according to the applicable FMAP reimbursement rate. If new spending qualifies for a lower FMAP than applies to recovered funds, savings would need to exceed costs in order to break even. For instance, spending a dollar with a 50% FMAP costs the state 50¢. If that spent dollar recovers a dollar of Medicaid spending that received a 70% FMAP, the state will retain 30¢. Thus, the dollar spent would need to recover $1.67 to pay for itself.

General Assembly

The bill requires the House and Senate Medicaid committees to meet jointly annually for the purpose of reviewing a portion of Medicaid waiver components, with all waiver components being reviewed once every four years.

Criminal penalties

Medicaid fraud

The bill enhances the criminal penalties for Medicaid fraud. The following table details the penalty increases in the bill.

Sentences and Fines for Medicaid Fraud: Current Law

Offense	Degree Level	Fine (up to amounts)	Term of Incarceration
Less than $1,000	Misdemeanor 1st degree	Up to $1,000	Jail, not more than 180 days
$1,000 or more and less than $7,500	Felony 5th degree	Up to $2,500	6, 7, 8, 9, 10, 11, or 12 months definite prison term
$7,500 or more and less than $150,000	Felony 4th degree	Up to $5,000	6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, or 18 months definite prison term

Offense	Degree Level	Fine (up to amounts)	Term of Incarceration
$150,000 or more	Felony 3rd degree	Up to $10,000	9, 12, 18, 24, 30, or 36 months definite prison term

Sentences and Fines for Medicaid Fraud: Under the Bill

Value	Degree Level	Fine (mandatory)	Term of Incarceration
Less than $1,000	Felony 5th degree	$1,000	6, 7, 8, 9, 10, 11, or 12 months definite prison term
$1,000 or more and less than $7,500	Felony 4th degree	$5,000	6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, or 18 months definite prison term
$7,500 or more and less than $75,000	Felony 3rd degree	$25,000	9, 12, 18, 24, 30, or 36 months definite prison term
$75,000 or more and less than $150,000	Felony 3rd degree with a presumption for a prison term	$75,000	9, 12, 18, 24, 30, or 36 months definite prison term (presumption of prison term)
$150,000 or more and less than $750,000	Felony 2nd degree	$150,000	2, 3, 4, 5, 6, 7, or 8 years indefinite prison term (presumption of prison term)
$750,000 or more	Felony 1st degree	$150,000	3, 4, 5, 6, 7, 8, 9, 10, or 11 years indefinite prison term (presumption of prison term)

The bill also expands the definition of "credible allegation of fraud" for purposes of the Medicaid Program enforcement to include (1) falsified or fake check-ins, (2) forged paperwork, (3) double billing for Medicaid services, (4) identity misuse, (5) impossible travel patterns, (6) hospital-overlap claims, and (7) coordinated billing rings, which could potentially lead to more violations of the offense.

Corrupt activity

The bill adds Medicaid fraud to the list of violations defined as "corrupt activity" under the Corrupt Activities Law.

Under continuing law, if certain violations meet the criteria for "engaging in a pattern of corrupt activity" under R.C. 2923.32, the offender may also be subject to the penalties for a first degree felony under the state's Corrupt Activities Law. The sentencing court has the option to:

- Impose a fine in lieu of the general fine for a first degree felony, not exceeding the greater of three times the gross value gained or three times the gross loss caused payable to the state's existing Corrupt Activity Investigation and Prosecution Fund (Fund 6290);
- Assess court costs; and/or
- Assess investigative and prosecutorial costs.

It is unknown how often a sentencing court would impose these types of sanctions or how many cases would be impacted under the bill and subject to the Corrupt Activities Law. Existing data indicates that the option to impose a fine as described in the first bullet above is rarely used. From CY 2000 to date, no deposits have been made to Fund 6290.

Attorney General investigations

The bill clarifies the Attorney General's existing authority to investigate matters involving the Medicaid Program, nursing homes, and other long-term care facilities. It authorizes the Attorney General to (1) administer oaths, subpoena witnesses, adduce evidence, and subpoena any relevant books, documents, or other relevant matters, (2) designate a representative to inspect such subpoenaed materials located outside the state, and (3) seek a court order when a person, without lawful excuse, fails to comply with a subpoena, including recovery of reasonable expenses such as attorney's fees and the ability to seek sanctions if the failure was in bad faith or for the purpose of delay.

Fiscal effect

Unchanged by the bill, the Medicaid Fraud Control Unit (MFCU), within the AGO, has statewide criminal jurisdiction over Medicaid provider fraud investigations and prosecutions. The Unit empanels a special Grand Jury in Franklin County to hear the majority of its Medicaid fraud cases. In 2025, the MFCU received 1,494 allegations of fraud and abuse, posted 153 indictments, 110 criminal convictions, 39 civil settlements, and recovered $27 million in restitution and penalties. As shown in the penalty table above, fraud cases under $1,000 are currently misdemeanors. Under the bill, all types of Medicaid fraud will be considered felonies, with all fraud involving amounts over $75,000 requiring a "presumptive" term in prison.

As a result of the bill's penalty enhancements, DRC's inmate population may increase over time as additional offenders may be committed to prison and other offenders receive longer sentences. Historically, fewer than five offenders are committed annually with Medicaid fraud as their most serious offense based on recent DRC commitment data. The associated annual operating cost increase for DRC is expected to be minimal. For context, in 2025, the marginal cost to house an offender was $13.47 per day. Marginal costs are those that increase or decrease directly on a per-person basis with changes in prison population. Such costs include medical care, food service, clothing and bedding (for inmates), and mental health services. Using the 2025 daily

marginal cost, it costs DRC $4,916.55 ($13.47 x 365) to house an additional individual for one year. The actual increase in costs for DRC will depend on the number of offenders who ultimately serve longer sentences under the bill than they otherwise would have under existing law, the additional length of the term, and the marginal cost per offender in each additional year of that term.

Auditor of State

The bill also requires all state employees to report alleged fraud, theft in office, or misuse of public money by a state employee to the AUD rather than the IGO. Concurrently, the bill also allows AUD employees to report the above to the IGO rather than the AUD. Because the AUD typically assists the IGO in investigating such violations, any additional investigative costs to the AUD associated with the bill would likely be minimal.

Department of Insurance

The bill requires the Superintendent of Insurance to establish and administer an all-payer claims database (APCD) by not later than one year after the bill's effective date. To the extent permitted by federal law and except as otherwise provided under the bill, each payer[1] must submit its claims to the Superintendent for inclusion in the database. Such claims must be submitted in the format and according to the schedule prescribed by the Superintendent in rule. In the case of a payer that is a health plan issuer, the requirement to submit claims would begin on January 1, 2028.

The bill requires the Superintendent to include in the database each claim the Superintendent receives. The Superintendent must make claims information included in the database available to any person or government entity. The Superintendent may require a person to obtain a subscription from the Department of Insurance to access information included in the database in accordance with continuing law governing the availability of public records.

The Superintendent must adopt rules to implement the bill's requirements, including rules establishing standards and procedures for the following: (1) submitting claims for inclusion in the database, including the prescribed format and schedule, (2) maintaining the privacy and security of personal and health information contained in claims, (3) making available to persons or government entities claims information from the database, and (4) imposing penalties when claims are not submitted. The Superintendent may also adopt any other necessary rules to implement the bill's requirements.

[1] Under the bill, a payer is a health plan issuer, a Medicaid managed care organization, the Medicaid Program, and the Medicare Program. A health plan issuer means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of Insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third-party administrator licensed under Chapter 3959 of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

Fiscal effect

The bill's requirements are estimated to increase costs to the Department of Insurance by millions of dollars to establish the database and by millions of dollars for ongoing administration of the database. Any fees that may be charged to a person who may obtain a subscription with the Department to access information in such database may offset some of the costs. The bill does not include an appropriation for establishing and administering the database. Currently, the Department's operations are primarily funded by fees that accompany appointments of insurance agents by insurance companies that are deposited into and appropriated from the Department of Insurance Operating Fund (Fund 5540).

The APCD cost estimates are based on the amounts incurred by Indiana to establish and administer a similar database in the state. Based on a news article regarding an APCD in Indiana, the estimated costs to design and maintain the Indiana APCD starting January 1, 2023, and ending in 2026 was about $8.2 million. In addition, according to Indiana's APCD 2025 Annual Report (PDF), "Operational costs amount to approximately $4 million annually, with ongoing efforts to diversify funding sources."

Synopsis of Fiscal Effect Changes

The newest substitute bill (I_136_3280-5) removes many provisions from the previous version, including a prohibition on family members receiving Medicaid payment for providing personal care services, and the creation of a review process to verify that billed services do not exceed authorized service amounts. This will reduce Ohio Department of Medicaid's (ODM) administrative costs.

The newest substitute bill (I_136_3280-5) removes requirements for electronic-visit verification (EVV) tracking of nonemergency medical transportation (NEMT) services and in-home services, and replaces them with a requirement for ODM to develop a system or process for capturing global positioning system coordinates for NEMT visits and to use existing EVV systems for in-home service visits. This will reduce administrative costs for the Department.

The newest substitute bill (I_136_3280-5) replaces a requirement to create a Medicaid Encounter Data System with a required report on the likely process and cost of creating such a system. Compared to the creation of the system, administrative costs will be lower creating a report.

The newest substitute bill (I_136_3280-5) replaces a requirement to create a risk matrix with a required report on the likely process and cost of creating such a matrix. Compared to the creation of the matrix, administrative costs will be lower creating a report.

The newest substitute bill (I_136_3280-5) removes Supplemental Nutrition Assistance Program (SNAP) provisions that were in the bill. These provisions stated that unless required under federal law, the bill: (1) prohibited the gross income limits for an eligible SNAP household from exceeding the standards established under federal law, and (2) specified that a household was not categorically eligible for SNAP if any members of the household receive or are authorized to receive any noncash, in-kind, or other similar benefit. This would have resulted in both administrative and IT costs with significant upgrades for the Ohio Benefits System. These are removed, so these costs will not be realized.

The newest substitute bill (I_136_3280-5) removes hospice care program provisions that revised existing or imposed new requirements regarding license application and renewal, license suspension and termination, change of ownership, staffing and personnel qualifications, surveys, monitoring and reporting, and a moratorium on new hospice care programs and changes in ownership. This would have resulted in administrative costs to the Ohio Department of Health, as well as a gain in license revenues. Again, these provisions are removed, so impacts will not be realized.

The newest substitute bill (I_136_3280-5) removes mandatory prison terms (substituting instead with presumptive prison terms) that the previous version included for Medicaid fraud. Under both versions, all Medicaid fraud offenses are felonies, and certain penalty enhancements are made based on the value of the fraud. Unchanged by the newest substitute bill, and generally unaffected by the removal of the mandatory terms, these enhancements may marginally increase the number of offenders sentenced to prison, an impact that the Department of Rehabilitation and Correction (DRC) is expected to absorb using existing staff and resources.

The newest substitute bill (I_136_3280-5) removes the Medicaid Program Integrity Fund within the state treasury. This new fund was included in the previous version of the bill and was to consist of all moneys recovered as a result of Medicaid fraud including restitution, civil settlements, forfeitures, and any other fraud-related recoveries. The new substitutes also removes related provisions authorizing the Attorney General to use money from the fund for fraud enforcement, fraud analytics, whistleblower administration, verification oversight, and program integrity operations.

The newest substitute bill (I_136_3280-5) removes the new Fraud Reporting Fund, which was included in the previous version of the bill, and related provisions allowing the Attorney General to issue an award of up to 10% of the amount of the fraud recovery.

The newest substitute bill (I_136_3280-5) removes the Inspector General and a deputy Inspector General from the definition of "peace officer" while either is engaged in the scope of the official's duties related to the investigation of Medicaid fraud, which were included in the previous version of the bill. This was expected to result in improved efficiency and was expected to have minimal, if any, fiscal impact.

The newest substitute bill (I_136_3280-5) removes provisions pertaining to the Department of Commerce, and mechanisms for the Medicaid Director, Job and Family Services Director, and Attorney General to recoup improper payments to Medicaid providers using money under the Unclaimed Funds Program.

The newest substitute bill (I_136_3280-5) changes the subscription requirement to access information in the all-payer claims database (APCD). The changes do not change the fiscal effect from the previous version of the bill.

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