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136th General Assembly
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Sub. S. B. No. 315

To amend sections 109.85, 117.10, 2903.216, 2913.40, 2923.31, 4113.52, 5101.542, 5164.32, 5164.33, 5164.36, 5164.57, 5167.03, and 5167.18 and to enact sections 103.413, 3901.93, 5101.5411, 5162.138, 5162.139, 5162.1311, 5162.17, 5162.19, 5162.90, 5163.05, 5164.11, 5164.12, 5164.13, 5164.292, 5164.302, 5164.303, 5164.304, 5164.305, 5164.331, 5164.332, 5164.40, 5164.401, 5164.402, 5164.403, 5164.404, 5164.405, 5164.406, 5164.41, 5164.42, 5164.421, 5164.43, and 5167.23 of the Revised Code regarding program integrity for certain components of the Medicaid program, regarding the authority of the Attorney General and Auditor of State, to require Ohio's SNAP program to begin using chip-enabled EBT cards, and to name section 5101.542 of the Revised Code as amended in this act and section 5101.5411 of the Revised Code as enacted in this act the Enhanced Cybersecurity for SNAP Act and to name the remainder of this act the Ohio Medicaid Program Integrity and Fraud Prevention Act. 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

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

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Section 1. That sections 109.85, 117.10, 2903.216, 2913.40, 2923.31, 4113.52, 5101.542, 5164.32, 5164.33, 5164.36, 5164.57, 5167.03, and 5167.18 be amended and sections 103.413, 3901.93, 5101.5411, 5162.138, 5162.139, 5162.1311, 5162.17, 5162.19, 5162.90, 5163.05, 5164.11, 5164.12, 5164.13, 5164.292, 5164.302, 5164.303, 5164.304, 5164.305, 5164.331, 5164.332, 5164.40, 5164.401, 5164.402, 5164.403, 5164.404, 5164.405, 5164.406, 5164.41, 5164.42, 5164.421, 5164.43, and 5167.23 of the Revised Code be enacted to read as follows: 23 24 25 26 27 28 29 30 31

Sec. 103.413. Annually, the standing committees of the house of representatives and the senate that primarily consider legislation governing the medicaid program shall meet jointly and conduct a review of one-quarter of the medicaid waiver components as defined in section 5166.01 of the Revised Code operating within the medicaid program. The review shall focus on the waiver's purpose and evaluate the waiver's success at achieving the desired purpose. The standing committees shall review all medicaid waiver components within the medicaid program before conducting a subsequent review of any medicaid waiver component. 32 33 34 35 36 37 38 39 40 41 42

Sec. 109.85. (A) Upon the written request of the governor, the general assembly, the auditor of state, the medicaid director, the director of health, or the director of budget and management, or upon the attorney general's becoming aware of criminal or improper activity related to Chapter 3721. of the Revised Code and the medicaid program, the attorney general shall investigate any criminal or civil violation of law related to Chapter 3721. of the Revised Code or the medicaid program. In any investigation conducted pursuant to this section the attorney general may administer oaths, subpoena witnesses, adduce evidence, and subpoena the production of any book, 43 44 45 46 47 48 49 50 51 52 53

document, record, or other relevant matter. 54

~~(B)~~ (B)(1) If the attorney general under division (A) of this section subpoenas the production of any relevant matter that is located outside this state, the attorney general may designate a representative, including an official of the state in which that relevant matter is located, to inspect the relevant matter on the attorney general's behalf. The attorney general may carry out similar requests received from officials of other states. 55 56 57 58 59 60 61 62

(2) Any person who is subpoenaed to produce relevant matter pursuant to division (A) of this section shall make that relevant matter available at a convenient location within this state or the state of the representative designated under division (B)(1) of this section. 63 64 65 66 67

(C) Any person who is subpoenaed as a witness or to produce relevant matter pursuant to division (A) of this section may file in the court of common pleas of Franklin county, the county in this state in which the person resides, or the county in this state in which the person's principal place of business is located a petition to extend for good cause shown the date on which the subpoena is to be returned or to modify or quash for good cause shown that subpoena. The person may file the petition at any time prior to the date specified for the return of the subpoena or within twenty days after the service of the subpoena, whichever is earlier. 68 69 70 71 72 73 74 75 76 77 78

(D) Any person who is subpoenaed as a witness or to produce relevant matter pursuant to division (A) of this section shall comply with the terms of the subpoena unless the court orders otherwise prior to the date specified for the return of the subpoena or, if applicable, that date as extended. If a 79 80 81 82 83

person fails without lawful excuse to obey a subpoena, the attorney general may apply to the same court of common pleas as designated in division (C) of this section for an order that does one or more of the following: 84 85 86 87

(1) Compels the requested discovery; 88

(2) Adjudges the person in contempt of court; 89

(3) Grants other relief that may be required until the person obeys the subpoena. 90 91

(E) If the court finds that a person's failure to comply with a subpoena issued under this section was in bad faith or for the purpose of delay, it may order the person to pay to the attorney general the reasonable expenses incurred in obtaining the order, including attorney's fees, and may invoke the sanctions provided by Rule 37 of the Rules of Civil Procedure. 92 93 94 95 96 97

(F) When it appears to the attorney general, as a result of an investigation under division (A) of this section, that there is cause to prosecute for the commission of a crime or to pursue a civil remedy, the attorney general may refer the evidence to the prosecuting attorney having jurisdiction of the matter, or to a regular grand jury drawn and impaneled pursuant to sections 2939.01 to 2939.24 of the Revised Code, or to a special grand jury drawn and impaneled pursuant to section 2939.17 of the Revised Code, or the attorney general may initiate and prosecute any necessary criminal or civil actions in any court or tribunal of competent jurisdiction in this state. When proceeding under this section, the attorney general, and any assistant or special counsel designated by the attorney general for that purpose, have all rights, privileges, and powers of prosecuting attorneys. The attorney general shall have 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112

exclusive supervision and control of all investigations and prosecutions initiated by the attorney general under this section. The forfeiture provisions of Chapter 2981. of the Revised Code apply in relation to any such criminal action initiated and prosecuted by the attorney general. 113 114 115 116 117

~~(C)~~ (G) Nothing in this section shall prevent a county prosecuting attorney from investigating and prosecuting criminal activity related to Chapter 3721. of the Revised Code and the medicaid program. The forfeiture provisions of Chapter 2981. of the Revised Code apply in relation to any prosecution of criminal activity related to the medicaid program undertaken by the prosecuting attorney. 118 119 120 121 122 123 124

Sec. 117.10. (A) The auditor of state shall audit all public offices as provided in this chapter. The auditor of state also may audit the specific funds or accounts of private institutions, associations, boards, and corporations into which has been placed or deposited public money from a public office and may require of them annual reports in such form as the auditor of state prescribes. The auditor of state may audit some or all of the other funds or accounts of a private institution, association, board, or corporation that has received public money from a public office only if one or more of the following applies: 125 126 127 128 129 130 131 132 133 134 135

(1) The audit is specifically required or authorized by the Revised Code; 136 137

(2) The private institution, association, board, or corporation requests that the auditor of state audit some or all of its other funds or accounts; 138 139 140

(3) All of the revenue of the private institution, 141

association, board, or corporation is composed of public money; 142

(4) The private institution, association, board, or corporation failed to separately and independently account for the public money in its possession, in violation of section 117.431 of the Revised Code; 143 144 145 146

(5) The auditor of state has a reasonable belief that the private institution, association, board, or corporation illegally expended, converted, misappropriated, or otherwise cannot account for the public money it received from a public office and that it is necessary to audit its other funds or accounts to make that determination. 147 148 149 150 151 152

(B) If the auditor of state performs or contracts for the performance of an audit, including a special audit, of the public employees retirement system, school employees retirement system, state teachers retirement system, state highway patrol retirement system, or Ohio police and fire pension fund, the auditor of state shall make a timely report of the results of the audit to the Ohio retirement study council. 153 154 155 156 157 158 159

(C) The auditor of state may audit the accounts of any medicaid provider, as defined in section 5164.01 of the Revised Code. 160 161 162

(D) If a public office has been audited by an agency of the United States government, the auditor of state may, if satisfied that the federal audit has been conducted according to principles and procedures not contrary to those of the auditor of state, use and adopt the federal audit and report in lieu of an audit by the auditor of state's own office. 163 164 165 166 167 168

(E) Within thirty days after the creation or dissolution or the winding up of the affairs of any public office, that 169 170

public office shall notify the auditor of state in writing that this action has occurred. 171 172

(F) The auditor of state may issue subpoenas compelling the production of books, records, accounts, documents, electronically-stored information, testimony, or other information relevant to any audit, examination, special audit, investigation, or review within the authority of the auditor of state under this chapter. Upon request of the auditor of state, the attorney general shall bring an action in a court of competent jurisdiction to enforce compliance with any subpoena issued pursuant to this section. 173 174 175 176 177 178 179 180 181

(G) Nothing in this section precludes the auditor of state from issuing to a private institution, association, board, or corporation a subpoena and compulsory process for the attendance of witnesses or the production of records under section 117.18 of the Revised Code if the subpoena and compulsory process is in furtherance of an audit the auditor of state is authorized by law to perform. 182 183 184 185 186 187 188

Sec. 2903.216. (A) As used in this section: 189

(1) "Business entity" means any form of corporation, partnership, association, cooperative, joint venture, business trust, or sole proprietorship that conducts business in this state. 190 191 192 193

(2) "Business of private investigation" and "private investigator" have the same meanings as in section 4749.01 of the Revised Code. 194 195 196

(3) "Disabled adult" and "elderly person" have the same meanings as in section 2913.01 of the Revised Code. 197 198

(4) "Electronic monitoring" and "electronic monitoring 199

device" have the same meanings as in section 2929.01 of the Revised Code. 200 201

(5) "Law enforcement agency" means any organization or unit comprised of law enforcement officers, and also includes any federal or military law enforcement agency. 202 203 204

(6) "Person" means an individual, but does not include a business entity. 205 206

(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: 207 208 209 210 211 212

(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; 213 214 215

(b) As a term or condition of a person's release under section 2929.20 of the Revised Code; 216 217

(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; 218 219 220

(d) As a term of supervision for a person transferred to transitional control under section 2967.26 of the Revised Code; 221 222

(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. 223 224 225

(8) "Protection order issued by a court of another state" has the same meaning as in section 2919.27 of the Revised Code. 226 227

(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. 228 229 230

(10) "Tracking device" means an electronic or mechanical device that permits a person to remotely determine or track the position or movement of another person or another person's property, including an electronic monitoring device. 231 232 233 234

(B) Except as otherwise provided in division (D) of this section, no person shall knowingly do either of the following: 235 236

(1) Install a tracking device or tracking application on another person's property without the other person's consent or cause a tracking device or tracking application to track the position or movement of another person or another person's property without the other person's consent; 237 238 239 240 241

(2) If the person installed a tracking device or tracking application on another's property with the other person's consent and the other person subsequently revokes that consent, fail to remove or ensure the removal of the device or application after the other person revokes the consent. 242 243 244 245 246

(C)(1) For purposes of this section, if a person has given consent for another to install a tracking device or tracking application on the consenting person's property, it is presumed that the consenting person has revoked that consent if any of the following applies: 247 248 249 250 251

(a) The consenting person and the person to whom consent was given are lawfully married and one of them files a complaint for divorce or a petition for dissolution of marriage from the other. Not later than seventy-two hours after being served with a complaint for divorce or a petition for dissolution of 252 253 254 255 256

marriage, the person to whom consent was given shall lawfully uninstall or discontinue use of the tracking device or tracking application. If the person to whom consent was given cannot lawfully uninstall or discontinue use of the tracking device or tracking application, the person to whom consent was given shall notify the court in which the complaint for divorce or the petition for dissolution of marriage was filed in writing. 257 258 259 260 261 262 263

(b) The consenting person or the person to whom consent was given files an Ohio protection order against the other person or an Ohio protection order is issued against the other person, and the person to be protected under the order is the consenting person. Not later than seventy-two hours after being served with the Ohio protection order, the person to whom consent was given shall lawfully uninstall or discontinue use of the tracking device or tracking application. If the person to whom consent was given cannot lawfully uninstall or discontinue use of the tracking device or tracking application, the person to whom consent was given shall notify the court that issued the Ohio protection order in writing that the person to whom consent was given has installed or is using a tracking device or tracking application on the previously consenting person's person or the person's property and cannot uninstall or discontinue its use without violating the Ohio protection order. 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279

(2) Revocation of consent under this division is effective upon the service of the petition or motion or an Ohio protection order. 280 281 282

(D) This section does not apply to any of the following: 283

(1) A law enforcement officer, or any law enforcement agency, that installs a tracking device or tracking application on another person's property or causes a tracking device or 284 285 286

tracking application to track the position or movement of another person or another person's property as part of a criminal investigation, or a probation officer, parole officer, or employee of the department of rehabilitation and correction, a halfway house, or a community-based correctional facility when engaged in the lawful performance of the officer's or employee's official duties; 287 288 289 290 291 292 293

(2) A parent or legal guardian of a minor child who installs or uses a tracking device or tracking application to track the minor child if any of the following applies: 294 295 296

(a) The parents or legal guardians of the child are lawfully married to each other and are not separated or otherwise living apart, and either of those parents or legal guardians consents to the installation of the tracking device or tracking application; 297 298 299 300 301

(b) The parent or legal guardian of the child is the sole surviving parent or legal guardian of the child; 302 303

(c) The parent or legal guardian of the child has sole custody of the child; 304 305

(d) The parents or legal guardians of the child are divorced, separated, or otherwise living apart and neither parent has sole custody of the child, and both consent to the installation of the tracking device or tracking application; 306 307 308 309

(e) The parents or legal guardians of the child are divorced, separated, or otherwise living apart, neither parent has sole custody of the child, and either only one parent consents to the installation of the tracking device or tracking application or one parent revokes consent, if the consenting parent only uses the tracking device or tracking application 310 311 312 313 314 315

during that parent's parenting or custodial time and disables or removes the tracking device or application during the nonconsenting parent's parenting or custodial time. 316 317 318

(3) A caregiver of an elderly person or disabled adult, if the elderly person's or disabled adult's treating physician certifies that the installation of a tracking device or tracking application onto the elderly person's or disabled adult's property is necessary to ensure the safety of the elderly person or disabled adult; 319 320 321 322 323 324

(4) A person acting in good faith on behalf of a business entity for a legitimate business purpose, provided that this division does not apply to a private investigator engaged in the business of private investigation on behalf of another person; 325 326 327 328

(5)(a) A private investigator or other person licensed under section 4749.03 of the Revised Code, who is acting in the normal course of the investigator's business of private investigation on behalf of another person and who has the consent of the owner of the property upon which the tracking device or tracking application is installed, for the purpose of obtaining information with reference to any of the following: 329 330 331 332 333 334 335

(i) Criminal offenses committed, threatened, or suspected against the United States, a territory of the United States, a state, or any person or legal entity; 336 337 338

(ii) Locating an individual known to be a fugitive from justice; 339 340

(iii) Locating lost or stolen property or other assets that have been awarded by the court; 341 342

(iv) Investigating claims related to workers' compensation. 343 344

(b) This division does not apply if the person on whose behalf the private investigator is working is the subject of an Ohio protection order or a protection order issued by a court of another state or if the private investigator knows or reasonably should know that the person on whose behalf the private investigator is working seeks the investigator's services to aid in the commission of a crime. 345 346 347 348 349 350 351

(6) An owner or lessee of a motor vehicle who installs, or directs the installation of, a tracking device or tracking application on the vehicle during the period of ownership or lease, if any of the following applies: 352 353 354 355

(a) The tracking device or tracking application is removed before the vehicle's title is transferred or the vehicle's lease expires; 356 357 358

(b) The new owner of the vehicle, in the case of a sale, or the lessor of the vehicle, in the case of an expired lease, consents in writing to the non-removal of the tracking device or tracking application; 359 360 361 362

(c) The owner of the vehicle at the time of the installation of the tracking device or tracking application was the original manufacturer of the vehicle. 363 364 365

(7) A person who installs a tracking device or application on property in which the person has an ownership or contractual interest, unless the person is the subject of a protective order and the property is likely to be used by the person who obtained the protective order; 366 367 368 369 370

(8) A person or business entity that installs a tracking device or tracking application on any fixed wing aircraft or rotorcraft operated or managed by the person or business entity 371 372 373

pursuant to 14 C.F.R. part 91 or part 135 to track the position or movement of the fixed wing aircraft or rotorcraft; 374 375

(9) A surety bail bond agent, or any employee or contractor of a surety bail bond agent, that installs a tracking device or tracking application on another person's property or causes a tracking device or tracking application to track the position or movement of another person or another person's property as part of the surety bail bond agent's, employee's, or contractor's official responsibilities or duties; 376 377 378 379 380 381 382

(10) The use of location verification technology by the department of medicaid, a medicaid provider, a provider's employee or contractor, or an electronic visit verification vendor when the technology is used solely to comply with electronic visit verification requirements under state or federal law including all of the following, provided that verification technology is not used for continuous tracking outside of the delivery of medicaid-covered services: 383 384 385 386 387 388 389 390

(a) Verification of the beginning or ending of a medicaid-covered service; 391 392

(b) Validating a claim for medicaid payment; 393

(c) Support for integrity of the medicaid program including audit, investigation, payment, or recovery activities. 394 395

(E) For purposes of division (D)(1) of this section, a probation officer, parole officer, or employee of the department of rehabilitation and correction, a halfway house, or a community-based correctional facility is engaged in the lawful performance of the officer's or employee's duties if both of the following apply: 396 397 398 399 400 401

(1) The court or the department of rehabilitation and 402

correction imposes electronic monitoring on a person. 403

(2) The officer or employee installs or uses an electronic monitoring device on that person in accordance with the court's or department's imposition of electronic monitoring of that person. 404 405 406 407

(F) Whoever violates this section is guilty of illegal use of a tracking device or application. 408 409

(1) Except as otherwise provided in division (F)(2) of this section, illegal use of a tracking device or application is a misdemeanor of the first degree. 410 411 412

(2) Illegal use of a tracking device or application is a felony of the fourth degree if any of the following applies: 413 414

(a) The offender previously has been convicted of or pleaded guilty to a violation of this section or section 2903.211 of the Revised Code. 415 416 417

(b) At the time of the commission of the offense, the offender was the subject of a protection order issued under section 2903.213 or 2903.214 of the Revised Code, regardless of whether the person to be protected under the order is the victim of the offense or another person. 418 419 420 421 422

(c) Prior to committing the offense, the offender had been determined to represent a substantial risk of physical harm to others as manifested by evidence of then-recent homicidal or other violent behavior, evidence of then-recent threats that placed another in reasonable fear of violent behavior and serious physical harm, or other evidence of then-present dangerousness. 423 424 425 426 427 428 429

(d) The offender has a history of violence toward the 430

victim or a history of other violent acts towards the victim. 431

Sec. 2913.40. (A) As used in this section: 432

(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. 433 434 435 436 437 438

(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. 439 440 441 442 443 444

(3) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code. 445 446

(4) "Recipient" means any individual who receives goods or services from a provider under the medicaid program. 447 448

(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. 449 450 451 452 453 454

(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 455 456 457 458 459

Code. 460

(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. 461 462 463

(C) No person, with purpose to commit fraud or knowing that the person is facilitating a fraud, shall do either of the following: 464 465 466

(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. 467 468 469 470 471 472 473 474 475

(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. 476 477 478 479 480 481 482

(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: 483 484 485 486 487

(1) Knowingly alter, falsify, destroy, conceal, or remove 488

any records that are necessary to fully disclose the nature of all goods or services for which the claim was submitted, or for which reimbursement was received, by the person; 489 490 491

(2) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to disclose fully all income and expenditures upon which rates of reimbursements were based for the person. 492 493 494 495

(E) Whoever violates this section is guilty of medicaid fraud. Except as otherwise provided in this division, medicaid fraud is a misdemeanor of the first felony of the fifth degree and, notwithstanding section 2929.18 of the Revised Code, the court shall impose as the fine for the offense a fine of one thousand dollars. If 496 497 498 499 500 501

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

(2) If the value of property, services, or funds obtained in violation of this section is seven thousand five hundred dollars or more and is less than one hundred fifty seventy-five thousand dollars, medicaid fraud is a felony of the fourth third degree and, notwithstanding section 2929.18 of the Revised Code, the court shall impose as the fine for the offense a fine of twenty-five thousand dollars. If 508 509 510 511 512 513 514

(3) If the value of the property, services, or funds obtained in violation of this section is one hundred fifty seventy-five thousand dollars or more and is less than one 515 516 517

hundred fifty thousand dollars, medicaid fraud is a felony of the third degree and there is a presumption for a prison term. Notwithstanding section 2929.18 of the Revised Code, the court shall impose as the fine for the offense a fine of seventy-five thousand dollars. 518 519 520 521 522

(4) If the value of the property, services, or funds obtained in violation of this section is one hundred fifty thousand dollars or more and is less than seven hundred fifty thousand dollars, medicaid fraud is a felony of the second degree and there is a presumption of a prison term. Notwithstanding section 2929.18 of the Revised Code, the court shall impose as the fine for the offense a fine of one hundred fifty thousand dollars. 523 524 525 526 527 528 529 530

(5) If the value of the property or services stolen is seven hundred fifty thousand dollars or more, medicaid fraud is a felony of the first degree and there is a presumption of a prison term. Notwithstanding section 2929.18 of the Revised Code, the court shall impose as the fine for the offense a fine of one hundred fifty thousand dollars. 531 532 533 534 535 536

(F) Upon application of the governmental agency, office, or other entity that conducted the investigation and prosecution in a case under this section, the court shall order any person who is convicted of a violation of this section for receiving any reimbursement for furnishing goods or services under the medicaid program to which the person is not entitled to pay to the applicant its cost of investigating and prosecuting the case. The costs of investigation and prosecution that a defendant is ordered to pay pursuant to this division shall be in addition to any other penalties for the receipt of that reimbursement that are provided in this section, section 5164.35 537 538 539 540 541 542 543 544 545 546 547

of the Revised Code, or any other provision of law. 548

(G) The provisions of this section are not intended to be exclusive remedies and do not preclude the use of any other criminal or civil remedy for any act that is in violation of this section. 549 550 551 552

Sec. 2923.31. As used in sections 2923.31 to 2923.36 of the Revised Code: 553 554

(A) "Beneficial interest" means any of the following: 555

(1) The interest of a person as a beneficiary under a trust in which the trustee holds title to personal or real property; 556 557 558

(2) The interest of a person as a beneficiary under any other trust arrangement under which any other person holds title to personal or real property for the benefit of such person; 559 560 561

(3) The interest of a person under any other form of express fiduciary arrangement under which any other person holds title to personal or real property for the benefit of such person. 562 563 564 565

"Beneficial interest" does not include the interest of a stockholder in a corporation or the interest of a partner in either a general or limited partnership. 566 567 568

(B) "Costs of investigation and prosecution" and "costs of investigation and litigation" mean all of the costs incurred by the state or a county or municipal corporation under sections 2923.31 to 2923.36 of the Revised Code in the prosecution and investigation of any criminal action or in the litigation and investigation of any civil action, and includes, but is not limited to, the costs of resources and personnel. 569 570 571 572 573 574 575

(C) "Enterprise" includes any individual, sole proprietorship, partnership, limited partnership, corporation, trust, union, government agency, or other legal entity, or any organization, association, or group of persons associated in fact although not a legal entity. "Enterprise" includes illicit as well as licit enterprises. 576 577 578 579 580 581

(D) "Innocent person" includes any bona fide purchaser of property that is allegedly involved in a violation of section 2923.32 of the Revised Code, including any person who establishes a valid claim to or interest in the property in accordance with division (E) of section 2981.04 of the Revised Code, and any victim of an alleged violation of that section or of any underlying offense involved in an alleged violation of that section. 582 583 584 585 586 587 588 589

(E) "Pattern of corrupt activity" means two or more incidents of corrupt activity, whether or not there has been a prior conviction, that are related to the affairs of the same enterprise, are not isolated, and are not so closely related to each other and connected in time and place that they constitute a single event. 590 591 592 593 594 595

At least one of the incidents forming the pattern shall occur on or after January 1, 1986. Unless any incident was an aggravated murder or murder, the last of the incidents forming the pattern shall occur within six years after the commission of any prior incident forming the pattern, excluding any period of imprisonment served by any person engaging in the corrupt activity. 596 597 598 599 600 601 602

For the purposes of the criminal penalties that may be imposed pursuant to section 2923.32 of the Revised Code, at least one of the incidents forming the pattern shall constitute 603 604 605

a felony under the laws of this state in existence at the time it was committed or, if committed in violation of the laws of the United States or of any other state, shall constitute a felony under the law of the United States or the other state and would be a criminal offense under the law of this state if committed in this state. 606 607 608 609 610 611

(F) "Pecuniary value" means money, a negotiable instrument, a commercial interest, or anything of value, as defined in section 1.03 of the Revised Code, or any other property or service that has a value in excess of one hundred dollars. 612 613 614 615 616

(G) "Person" means any person, as defined in section 1.59 of the Revised Code, and any governmental officer, employee, or entity. 617 618 619

(H) "Personal property" means any personal property, any interest in personal property, or any right, including, but not limited to, bank accounts, debts, corporate stocks, patents, or copyrights. Personal property and any beneficial interest in personal property are deemed to be located where the trustee of the property, the personal property, or the instrument evidencing the right is located. 620 621 622 623 624 625 626

(I) "Corrupt activity" means engaging in, attempting to engage in, conspiring to engage in, or soliciting, coercing, or intimidating another person to engage in any of the following: 627 628 629

(1) Conduct defined as "racketeering activity" under the "Organized Crime Control Act of 1970," 84 Stat. 941, 18 U.S.C. 1961(1)(B), (1)(C), (1)(D), and (1)(E), as amended; 630 631 632

(2) Conduct constituting any of the following: 633

(a) A violation of section 1315.55, 1322.07, 2903.01, 634

2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2905.01, 2905.02, 2905.11, 2905.22, 2905.32 as specified in division (I)(2)(g) of this section, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 2909.22, 2909.23, 2909.24, 2909.26, 2909.27, 2909.28, 2909.29, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2911.31, 2913.05, 2913.06, 2913.30, 2921.02, 2921.03, 2921.04, 2921.11, 2921.12, 2921.32, 2921.41, 2921.42, 2921.43, 2923.12, or 2923.17; division (F)(1)(a), (b), or (c) of section 1315.53; division (A)(1) or (2) of section 1707.042; division (B), (C)(4), (D), (E), or (F) of section 1707.44; division (A)(1) or (2) of section 2923.20; division (E) or (G) of section 3772.99; division (J)(1) of section 4712.02; section 4719.02, 4719.05, or 4719.06; division (C), (D), or (E) of section 4719.07; section 4719.08; or division (A) of section 4719.09 of the Revised Code. 635 636 637 638 639 640 641 642 643 644 645 646 647 648

(b) Any violation of section 3769.11, 3769.15, 3769.16, or 3769.19 of the Revised Code as it existed prior to July 1, 1996, any violation of section 2915.02 of the Revised Code that occurs on or after July 1, 1996, and that, had it occurred prior to that date, would have been a violation of section 3769.11 of the Revised Code as it existed prior to that date, or any violation of section 2915.05 of the Revised Code that occurs on or after July 1, 1996, and that, had it occurred prior to that date, would have been a violation of section 3769.15, 3769.16, or 3769.19 of the Revised Code as it existed prior to that date. 649 650 651 652 653 654 655 656 657 658

(c) Any violation of section 2907.21, 2907.22, 2907.31, 2913.02, 2913.11, 2913.21, 2913.31, 2913.32, 2913.34, 2913.40, 2913.42, 2913.47, 2913.51, 2915.03, 2925.03, 2925.04, 2925.05, or 2925.37 of the Revised Code, any violation of section 2925.11 of the Revised Code that is a felony of the first, second, third, or fourth degree and that occurs on or after July 1, 1996, any violation of section 2915.02 of the Revised Code that 659 660 661 662 663 664 665

occurred prior to July 1, 1996, any violation of section 2915.02 of the Revised Code that occurs on or after July 1, 1996, and that, had it occurred prior to that date, would not have been a violation of section 3769.11 of the Revised Code as it existed prior to that date, any violation of section 2915.06 of the Revised Code as it existed prior to July 1, 1996, or any violation of division (B) of section 2915.05 of the Revised Code as it exists on and after July 1, 1996, when the proceeds of the violation, the payments made in the violation, the amount of a claim for payment or for any other benefit that is false or deceptive and that is involved in the violation, or the value of the contraband or other property illegally possessed, sold, or purchased in the violation exceeds one thousand dollars, or any combination of violations described in division (I)(2)(c) of this section when the total proceeds of the combination of violations, payments made in the combination of violations, amount of the claims for payment or for other benefits that is false or deceptive and that is involved in the combination of violations, or value of the contraband or other property illegally possessed, sold, or purchased in the combination of violations exceeds one thousand dollars; 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686

(d) Any violation of section 5743.112 of the Revised Code when the amount of unpaid tax exceeds one hundred dollars; 687 688

(e) Any violation or combination of violations of section 2907.32 of the Revised Code involving any material or performance containing a display of bestiality or of sexual conduct, as defined in section 2907.01 of the Revised Code, that is explicit and depicted with clearly visible penetration of the genitals or clearly visible penetration by the penis of any orifice when the total proceeds of the violation or combination of violations, the payments made in the violation or combination 689 690 691 692 693 694 695 696

of violations, or the value of the contraband or other property illegally possessed, sold, or purchased in the violation or combination of violations exceeds one thousand dollars; 697 698 699

(f) Any combination of violations described in division (I)(2)(c) of this section and violations of section 2907.32 of the Revised Code involving any material or performance containing a display of bestiality or of sexual conduct, as defined in section 2907.01 of the Revised Code, that is explicit and depicted with clearly visible penetration of the genitals or clearly visible penetration by the penis of any orifice when the total proceeds of the combination of violations, payments made in the combination of violations, amount of the claims for payment or for other benefits that is false or deceptive and that is involved in the combination of violations, or value of the contraband or other property illegally possessed, sold, or purchased in the combination of violations exceeds one thousand dollars; 700 701 702 703 704 705 706 707 708 709 710 711 712 713

(g) Any violation of section 2905.32 of the Revised Code to the extent the violation is not based solely on the same conduct that constitutes corrupt activity pursuant to division (I)(2)(c) of this section due to the conduct being in violation of section 2907.21 of the Revised Code. 714 715 716 717 718

(3) Conduct constituting a violation of any law of any state other than this state that is substantially similar to the conduct described in division (I)(2) of this section, provided the defendant was convicted of the conduct in a criminal proceeding in the other state; 719 720 721 722 723

(4) Animal or ecological terrorism; 724

(5)(a) Conduct constituting any of the following: 725

(i) Organized retail theft; 726

(ii) Conduct that constitutes one or more violations of any law of any state other than this state, that is substantially similar to organized retail theft, and that if committed in this state would be organized retail theft, if the defendant was convicted of or pleaded guilty to the conduct in a criminal proceeding in the other state. 727 728 729 730 731 732

(b) By enacting division (I)(5)(a) of this section, it is the intent of the general assembly to add organized retail theft and the conduct described in division (I)(5)(a)(ii) of this section as conduct constituting corrupt activity. The enactment of division (I)(5)(a) of this section and the addition by division (I)(5)(a) of this section of organized retail theft and the conduct described in division (I)(5)(a)(ii) of this section as conduct constituting corrupt activity does not limit or preclude, and shall not be construed as limiting or precluding, any prosecution for a violation of section 2923.32 of the Revised Code that is based on one or more violations of section 2913.02 or 2913.51 of the Revised Code, one or more similar offenses under the laws of this state or any other state, or any combination of any of those violations or similar offenses, even though the conduct constituting the basis for those violations or offenses could be construed as also constituting organized retail theft or conduct of the type described in division (I)(5)(a)(ii) of this section. 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750

(J) "Real property" means any real property or any interest in real property, including, but not limited to, any lease of, or mortgage upon, real property. Real property and any beneficial interest in it is deemed to be located where the real property is located. 751 752 753 754 755

(K) "Trustee" means any of the following: 756

(1) Any person acting as trustee under a trust in which the trustee holds title to personal or real property; 757 758

(2) Any person who holds title to personal or real property for which any other person has a beneficial interest; 759 760

(3) Any successor trustee. 761

"Trustee" does not include an assignee or trustee for an insolvent debtor or an executor, administrator, administrator with the will annexed, testamentary trustee, guardian, or committee, appointed by, under the control of, or accountable to a court. 762 763 764 765 766

(L) "Unlawful debt" means any money or other thing of value constituting principal or interest of a debt that is legally unenforceable in this state in whole or in part because the debt was incurred or contracted in violation of any federal or state law relating to the business of gambling activity or relating to the business of lending money at an usurious rate unless the creditor proves, by a preponderance of the evidence, that the usurious rate was not intentionally set and that it resulted from a good faith error by the creditor, notwithstanding the maintenance of procedures that were adopted by the creditor to avoid an error of that nature. 767 768 769 770 771 772 773 774 775 776 777

(M) "Animal activity" means any activity that involves the use of animals or animal parts, including, but not limited to, hunting, fishing, trapping, traveling, camping, the production, preparation, or processing of food or food products, clothing or garment manufacturing, medical research, other research, entertainment, recreation, agriculture, biotechnology, or service activity that involves the use of animals or animal 778 779 780 781 782 783 784

parts. 785

(N) "Animal facility" means a vehicle, building, structure, nature preserve, or other premises in which an animal is lawfully kept, handled, housed, exhibited, bred, or offered for sale, including, but not limited to, a zoo, rodeo, circus, amusement park, hunting preserve, or premises in which a horse or dog event is held. 786 787 788 789 790 791

(O) "Animal or ecological terrorism" means the commission of any felony that involves causing or creating a substantial risk of physical harm to any property of another, the use of a deadly weapon or dangerous ordnance, or purposely, knowingly, or recklessly causing serious physical harm to property and that involves an intent to obstruct, impede, or deter any person from participating in a lawful animal activity, from mining, foresting, harvesting, gathering, or processing natural resources, or from being lawfully present in or on an animal facility or research facility. 792 793 794 795 796 797 798 799 800 801

(P) "Research facility" means a place, laboratory, institution, medical care facility, government facility, or public or private educational institution in which a scientific test, experiment, or investigation involving the use of animals or other living organisms is lawfully carried out, conducted, or attempted. 802 803 804 805 806 807

(Q) "Organized retail theft" means the theft of retail property with a retail value of one thousand dollars or more from one or more retail establishments with the intent to sell, deliver, or transfer that property to a retail property fence. 808 809 810 811

(R) "Retail property" means any tangible personal property displayed, held, stored, or offered for sale in or by a retail 812 813

establishment. 814

(S) "Retail property fence" means a person who possesses, procures, receives, or conceals retail property that was represented to the person as being stolen or that the person knows or believes to be stolen. 815 816 817 818

(T) "Retail value" means the full retail value of the retail property. In determining whether the retail value of retail property equals or exceeds one thousand dollars, the value of all retail property stolen from the retail establishment or retail establishments by the same person or persons within any one-hundred-eighty-day period shall be aggregated. 819 820 821 822 823 824 825

Sec. 3901.93. (A) As used in this section: 826

(1) "Department" has the same meaning as in section 121.01 of the Revised Code. 827 828

(2) "Health plan issuer" has the same meaning as in section 3922.01 of the Revised Code. 829 830

(3) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code. 831 832

(4) "Payer" includes a health plan issuer, a medicaid managed care organization, the medicaid program, and the medicare program. 833 834 835

(B)(1) Not later than one year after the effective date of this section, the superintendent of insurance shall establish and administer an all-payer claims database. 836 837 838

(2) To the extent permitted by federal law and except as otherwise provided in this division, each payer shall submit its claims to the superintendent for inclusion in the database. Such 839 840 841

claims shall be submitted in the format and according to the schedule prescribed by the superintendent in rule. 842 843

In the case of a payer that is a health plan issuer, the requirement to submit claims begins January 1, 2028. 844 845

(3) The superintendent shall include in the database each claim the superintendent receives. 846 847

(4) The superintendent shall make claims information included in the database available to any person or government entity. The superintendent may require a person to obtain a subscription with the department of insurance to access information included in the database in accordance with section 149.43 of the Revised Code. 848 849 850 851 852 853

(C) The superintendent shall adopt rules to implement this section, including rules establishing standards and procedures for the following: 854 855 856

(1) Submitting claims for inclusion in the database, including the prescribed format and schedule; 857 858

(2) Maintaining the privacy and security of personal and health information contained in claims; 859 860

(3) Making available to persons or government entities claims information from the database; 861 862

(4) Imposing penalties when claims are not submitted. 863

The superintendent may adopt any other rules the superintendent considers necessary to implement this section. All rules shall be adopted in accordance with Chapter 119. of the Revised Code. 864 865 866 867

(D) Notwithstanding any provision of section 121.95 of the 868

Revised Code to the contrary, a regulatory restriction contained in a rule adopted under division (C) of this section is not subject to sections 121.95 to 121.953 of the Revised Code. 869 870 871

Sec. 4113.52. (A)(1)(a) All state officials and employees employed by or appointed to a state agency as defined in division (D) of section 121.41 of the Revised Code shall report alleged fraud, theft in office, or the misuse or misappropriation of public money by a state official or employee ~~to the inspector general. All other state employees and elected officials shall report fraud, theft in office, or the misuse or misappropriation of public money~~ to the auditor of state's fraud-reporting system under section 117.103 of the Revised Code. An official or employee of the auditor of state may report alleged fraud, theft in office, or the misuse or misappropriation of public money to the inspector general. Nothing in this division prohibits the auditor of state or the inspector general from referring a report to the other office when appropriate. 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886

(b) A person is required to make a report under division (A)(1)(c) of this section if the person meets any of the following: 887 888 889

(i) The person is elected to local public office. 890

(ii) The person is appointed to or within a local public office. 891 892

(iii) The person has a fiduciary duty to a local public office. 893 894

(iv) The person holds a supervisory position within a local public office. 895 896

(v) The person is employed in the department or office 897

responsible for processing any revenue or expenses of the local public office. 898 899

(c) If a person identified in division (A)(1)(b) of this section, during the person's term of office or in the course of the person's employment, becomes aware of fraud, theft in office, or the misuse or misappropriation of public money, the person shall timely notify the auditor of state via the auditor of state's fraud-reporting system under section 117.103 of the Revised Code or via other means. 900 901 902 903 904 905 906

(d) A person who serves as legal counsel, or who is employed as legal counsel, for a local public office or a state official or employee employed by or appointed to a state agency is not required to make a report under division (A)(1)(a) or (c) of this section concerning any communication received from a client in an attorney-client relationship. 907 908 909 910 911 912

(e) Divisions (A)(1)(a), (b), and (c) of this section do not apply to a prosecuting attorney, director of law, village solicitor, or similar chief legal officer of a municipal corporation, or to any employee of the prosecuting attorney, director of law, village solicitor, or similar chief legal officer of a municipal corporation. 913 914 915 916 917 918

(f) If a person becomes aware in the course of the person's employment of a violation of any state or federal statute or any ordinance or regulation of a political subdivision that the person's employer has authority to correct, and the person reasonably believes that the violation is a criminal offense that is likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety, a felony, or an improper solicitation for a contribution, the person orally shall notify the person's supervisor or other 919 920 921 922 923 924 925 926 927

responsible officer of the person's employer of the violation and subsequently shall file with that supervisor or officer a written report that provides sufficient detail to identify and describe the violation. If the employer does not correct the violation or make a reasonable and good faith effort to correct the violation within twenty-four hours after the oral notification or the receipt of the report, whichever is earlier, the person may file a written report that provides sufficient detail to identify and describe the violation with the prosecuting authority of the county or municipal corporation where the violation occurred, with a peace officer, with the inspector general if the violation is within the inspector general's jurisdiction, with the auditor of state's fraud-reporting system under section 117.103 of the Revised Code if applicable, or with any other appropriate public official or agency that has regulatory authority over the employer and the industry, trade, or business in which the employer is engaged. 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944

(g) If a person makes a report under division (A)(1)(f) of this section, the employer, within twenty-four hours after the oral notification was made or the report was received or by the close of business on the next regular business day following the day on which the oral notification was made or the report was received, whichever is later, shall notify the person, in writing, of any effort of the employer to correct the alleged violation or hazard or of the absence of the alleged violation or hazard. 945 946 947 948 949 950 951 952 953

(2) If a person becomes aware in the course of the person's employment of a violation of Chapter 3704., 3734., 6109., or 6111. of the Revised Code that is a criminal offense, the person directly may notify, either orally or in writing, any appropriate public official or agency that has regulatory 954 955 956 957 958

authority over the employer and the industry, trade, or business in which the employer is engaged. 959 960

(3) If a person becomes aware in the course of the person's employment of a violation by a fellow employee of any state or federal statute, any ordinance or regulation of a political subdivision, or any work rule or company policy of the person's employer and the person reasonably believes that the violation is a criminal offense that is likely to cause an imminent risk of physical harm to persons or a hazard to public health or safety, a felony, or an improper solicitation for a contribution, the person orally shall notify the person's supervisor or other responsible officer of the person's employer of the violation and subsequently shall file with that supervisor or officer a written report that provides sufficient detail to identify and describe the violation. 961 962 963 964 965 966 967 968 969 970 971 972 973

(4) The reporting requirements under division (A) of this section are not intended to infringe, and should not be interpreted as infringing on, the constitutional right against self-incrimination. 974 975 976 977

(B) Except as otherwise provided in division (C) of this section, no employer shall take any disciplinary or retaliatory action against ~~an~~ a person for making any report authorized by division (A)(1) or (2) of this section, or as a result of the person's having made any inquiry or taken any other action to ensure the accuracy of any information reported under either such division. No employer shall take any disciplinary or retaliatory action against a person for making any report authorized by division (A)(3) of this section if the person made a reasonable and good faith effort to determine the accuracy of any information so reported, or as a result of the person's 978 979 980 981 982 983 984 985 986 987 988

having made any inquiry or taken any other action to ensure the accuracy of any information reported under that division. For purposes of this division, disciplinary or retaliatory action by the employer includes, without limitation, doing any of the following: 989 990 991 992 993

(1) Removing or suspending the person from employment; 994

(2) Withholding from the person salary increases or employee benefits to which the person is otherwise entitled; 995 996

(3) Transferring or reassigning the person; 997

(4) Denying the person a promotion that otherwise would have been received; 998 999

(5) Reducing the person in pay or position. 1000

(C) A person shall make a reasonable and good faith effort to determine the accuracy of any information reported under division (A)(1) or (2) of this section. If the person who makes a report under either division fails to make such an effort, the person may be subject to disciplinary action by the person's employer, including suspension or removal, for reporting information without a reasonable basis to do so under division (A)(1) or (2) of this section. 1001 1002 1003 1004 1005 1006 1007 1008

(D) If an employer takes any disciplinary or retaliatory action against ~~an~~ a person as a result of the person's having filed a report under division (A) of this section, the person may bring a civil action for appropriate injunctive relief or for the remedies set forth in division (E) of this section, or both, within one hundred eighty days after the date the disciplinary or retaliatory action was taken, in a court of common pleas in accordance with the Rules of Civil Procedure. A civil action under this division is not available to a person as 1009 1010 1011 1012 1013 1014 1015 1016 1017

a remedy for any disciplinary or retaliatory action taken by an appointing authority against the person as a result of the person's having filed a report under division (A) of section 124.341 of the Revised Code. 1018 1019 1020 1021

(E) The court, in rendering a judgment for the person in an action brought pursuant to division (D) of this section, may order, as it determines appropriate, reinstatement of the person to the same position that the person held at the time of the disciplinary or retaliatory action and at the same site of employment or to a comparable position at that site, the payment of back wages, full reinstatement of fringe benefits and seniority rights, or any combination of these remedies. The court also may award the prevailing party all or a portion of the costs of litigation and, if the person who brought the action prevails in the action, may award the prevailing person reasonable attorney's fees, witness fees, and fees for experts who testify at trial, in an amount the court determines appropriate. If the court determines that an employer deliberately has violated division (B) of this section, the court, in making an award of back pay, may include interest at the rate specified in section 1343.03 of the Revised Code. 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038

(F) Any report filed with the inspector general under this section shall be filed as a complaint in accordance with section 121.46 of the Revised Code. 1039 1040 1041

(G) As used in this section: 1042

(1) "Contribution" has the same meaning as in section 3517.01 of the Revised Code. 1043 1044

(2) "Improper solicitation for a contribution" means a solicitation for a contribution that satisfies all of the 1045 1046

following: 1047

(a) The solicitation violates division (B), (C), or (D) of section 3517.092 of the Revised Code; 1048 1049

(b) The solicitation is made in person by a public official or by an employee who has a supervisory role within the public office; 1050 1051 1052

(c) The public official or employee knowingly made the solicitation, and the solicitation violates division (B), (C), or (D) of section 3517.092 of the Revised Code; 1053 1054 1055

(d) The employee reporting the solicitation is an employee of the same public office as the public official or the employee with the supervisory role who is making the solicitation. 1056 1057 1058

(3) "Misappropriation of public money" means knowingly using public money or public property for an unauthorized, improper, or unlawful purpose to serve a private or personal benefit or interest. 1059 1060 1061 1062

(4) "Misuse of public money" means knowingly using public money or public property in a manner not authorized by law. 1063 1064

(5) "Public office" has the same meaning as in section 117.01 of the Revised Code. 1065 1066

(H) Nothing in this section shall be construed to limit the authority of an auditor to make inquiries or interview state or local government employees or officials or otherwise perform audit procedures related to fraud during the course of an audit or attestation engagement. 1067 1068 1069 1070 1071

Sec. 5101.542. (A) Immediately following a county department of job and family services' certification that a household determined under division (B) of section 5101.54 of 1072 1073 1074

the Revised Code to be in immediate need of nutrition assistance is eligible for the supplemental nutrition assistance program, the department of job and family services shall provide for the household to be sent by regular United States mail an electronic benefit transfer card containing the amount of benefits the household is eligible to receive under the program. The card shall be sent to the member of the household in whose name application for the supplemental nutrition assistance program was made or that member's authorized representative. 1075 1076 1077 1078 1079 1080 1081 1082 1083

(B) Except as provided in division (C) of this section, the department shall replace any electronic benefit transfer card that is reported by a household to be lost, stolen, or damaged, within two business days of receiving notice of the card's condition, in accordance with 7 C.F.R. 274.6(b). 1084 1085 1086 1087 1088

(C)(1) The department shall implement the option described in 7 C.F.R. 274.6(b)(5) and shall withhold a replacement electronic benefit transfer card from a household that requests four or more replacement cards during a twelve-month period until the requirements specified in 7 C.F.R. 274.6(b)(5) have been satisfied. 1089 1090 1091 1092 1093 1094

(2) The department shall not withhold a replacement card as described under division (C)(1) of this section if the individual requesting the replacement has a disability directly related to the loss of the card. 1095 1096 1097 1098

(D) The department shall establish a process as part of the department's existing customer service telephone hotline that allows individuals to lock or unlock an electronic benefit transfer card that has been lost or stolen. 1099 1100 1101 1102

(E) On the effective date of this amendment, the 1103

department shall begin the transition to chip-enabled supplemental nutrition assistance program electronic benefit transfer cards. In implementing this transition, the department shall ensure that all new electronic benefit transfer cards that are issued are chip-enabled and shall replace existing electronic benefit transfer cards with chip-enabled cards under the department's ordinary timeframe for replacing electronic benefit transfer cards. 1104 1105 1106 1107 1108 1109 1110 1111

Sec. 5101.5411. The director of job and family services shall ensure that the department of job and family services' web site contains a mechanism that allows supplemental nutrition assistance program benefit recipients to report alleged fraudulent transactions to the department. 1112 1113 1114 1115 1116

Sec. 5162.138. The department of medicaid shall annually prepare and submit a report to the chairpersons and ranking members of the committees of the house of representatives and senate with jurisdiction over medicaid detailing the department's efforts to ensure integrity within the medicaid program. 1117 1118 1119 1120 1121 1122

Sec. 5162.139. (A) As used in this section, "electronic visit verification" or "EVV" has the same meaning as in section 1903(l) of the "Social Security Act," 42 U.S.C. 1903(l). 1123 1124 1125

(B) Not later than the first day of March annually, the medicaid director shall submit a report to the governor, the speaker of the house of representatives, the president of the senate, and the auditor of state regarding electronic visit verification utilization and compliance for the immediately preceding calendar year. The report shall, at a minimum, include all of the following: 1126 1127 1128 1129 1130 1131 1132

(1) Provider utilization rates; 1133

(2) Provider compliance rates; 1134

(3) The number and percentage of claims or service visits with complete EVV data; 1135 1136

(4) The number and percentage of claims or service visits with missing, incomplete, manually entered, modified, late, or unmatched EVV data; 1137 1138 1139

(5) The number of claims denied or paid due to EVV compliance status; 1140 1141

(6) Compliance trends by provider type and geographic region; 1142 1143

(7) Enforcement or corrective actions taken by the department; 1144 1145

(8) Any recommendations to improve EVV utilization, compliance, payment integrity, and fraud prevention. 1146 1147

(C) The department of medicaid shall make the report publicly available on the department's internet web site not later than thirty days after submitting the report in accordance with division (B) of this section, except that the department shall redact any information that is confidential under state or federal law or would otherwise compromise an ongoing audit, investigation, or enforcement action. 1148 1149 1150 1151 1152 1153 1154

(D) Nothing in this section shall be construed to limit the authority of the auditor of state under Chapter 117. of the Revised Code. 1155 1156 1157

Sec. 5162.1311. The department of medicaid shall prepare and submit an annual report to the general assembly in 1158 1159

accordance with section 101.68 of the Revised Code that details any billing code that represents an increase or decrease of greater than fifty per cent in the utilization rate or total expenditures for a particular service from the previous state fiscal year. As part of the report, the department shall also provide data concerning any identified billing code or utilization rate or expenditure data for an identified service from the five years preceding the report. 1160 1161 1162 1163 1164 1165 1166 1167

Sec. 5162.17. (A) As used in this section: 1168

(1) "Electronic visit verification" or "EVV" has the same meaning as in section 1903(l) of the "Social Security Act," 42 U.S.C. 1396b(l). 1169 1170 1171

(2) "Provider" means a medicaid provider required by state or federal law to utilize an electronic visit verification system as a condition of payment for services provided under the medicaid program. 1172 1173 1174 1175

(B) The department of medicaid shall maintain a statewide electronic visit verification performance dashboard. The dashboard shall include all of the following information, updated not less than quarterly: 1176 1177 1178 1179

(1) Statewide utilization rates of electronic visit verification; 1180 1181

(2) Rates of successful matching between EVV records and submitted claims for medicaid payment; 1182 1183

(3) Provider compliance trends; 1184

(4) The percentage of claims that are supported by verified EVV documentation; 1185 1186

(5) Aggregate statistics regarding manually adjusted EVV 1187

entries; 1188

(6) Any other metrics the department determines appropriate for monitoring compliance, fraud prevention, and program integrity. 1189 1190 1191

(C) The department shall make aggregate statewide data available to the public on the department's internet web site. 1192 1193

(D) The department shall use information collected and maintained under this section to identify providers that may require technical assistance, additional training, corrective action, or program integrity review. The department may provide provider-specific compliance information through a secure provider portal or dashboard. 1194 1195 1196 1197 1198 1199

(E) The medicaid director may adopt rules under section 5162.02 of the Revised Code to implement this section. 1200 1201

Sec. 5162.19. (A) As used in this section, "alternative primary insurance coverage source" means an insurance coverage source that is not coverage under the medicaid program, including coverage under the medicare program or coverage under a health benefit plan as defined in section 3922.01 of the Revised Code. 1202 1203 1204 1205 1206 1207

(B) Prior to the issuance of any payment on a claim for services provided under either the fee-for-service component of the medicaid program or the care management system established under Chapter 5167. of the Revised Code, the department of medicaid shall require that all claims be electronically evaluated to determine whether an alternative primary insurance coverage source exists that is responsible for payment of the claim. 1208 1209 1210 1211 1212 1213 1214 1215

(C) An evaluation conducted under division (B) of this 1216

section shall use automated algorithmic analysis and insurance discovery engines capable of identifying alternative primary insurance coverage sources associated with the medicaid recipient prior to any payment being issued. 1217 1218 1219 1220

(D) Neither the department nor a medicaid managed care organization shall issue payment for a claim that has not been subjected to an evaluation under this section. 1221 1222 1223

(E) If an alternative primary insurance coverage source is identified, the claim shall be redirected to the identified alternative primary insurance coverage source prior to any medicaid payment for the claim, consistent with all medicaid payer-of-last-resort requirements under state and federal law. 1224 1225 1226 1227 1228

(F) The department shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement the requirements of this section, including standards for approved insurance discovery engines, claims processing timelines, and reporting requirements. 1229 1230 1231 1232 1233

Sec. 5162.90. (A) As used in this section: 1234

(1) "Artificial intelligence" means a machine-based system that, for explicit or implicit objectives, infers, from the input it receives, how to generate outputs such as predictions, content, recommendations, or decisions that can influence physical or virtual environments. "Artificial intelligence" includes generative artificial intelligence. 1235 1236 1237 1238 1239 1240

(2) "Automated review tools" include artificial intelligence, automated fraud detection tools, automated algorithmic analysis, or any other electronic automated review tool, system, or service. 1241 1242 1243 1244

(3) "Generative artificial intelligence" means an 1245

artificial intelligence technology system that satisfies all of the following: 1246 1247

(a) The system is trained on data. 1248

(b) The system is designed to simulate human conversation with a consumer through text, audio, or visual communication. 1249 1250

(c) The system generates nonscripted outputs similar to outputs created by a human, with limited or no human oversight. 1251 1252

(B) When implementing sections 5162.17 to 5162.19 of the Revised Code, if the department of medicaid uses any automated review tools, all of the following shall occur: 1253 1254 1255

(1) No action shall be taken automatically without human review as a result of the automated review tool's determination or decision. 1256 1257 1258

(2) The appropriate department employee responsible for overseeing the determination or decision shall review the findings of the automated review tool to confirm the tool made the correct determination or decision. 1259 1260 1261 1262

Sec. 5163.05. No individual is eligible to participate in the medicaid program in this state unless that individual is eligible to participate in the medicaid program under section 1903(v)(5) of the "Social Security Act," 42 U.S.C. 1396b(v)(5). 1263 1264 1265 1266

Sec. 5164.11. (A) As used in this section: 1267

(1) "Artificial intelligence" means a machine-based system that, for explicit or implicit objectives, infers, from the input it receives, how to generate outputs such as predictions, content, recommendations, or decisions that can influence physical or virtual environments. "Artificial intelligence" includes generative artificial intelligence. 1268 1269 1270 1271 1272 1273

(2) "Automated review tools" mean artificial intelligence, automated fraud detection tools, automated algorithmic analysis, or any other electronic automated review tool, system, or service. 1274 1275 1276 1277

(3) "Generative artificial intelligence" means an artificial intelligence technology system that satisfies all of the following: 1278 1279 1280

(a) The system is trained on data. 1281

(b) The system is designed to simulate human conversation with a consumer through text, audio, or visual communication. 1282 1283

(c) The system generates nonscripted outputs similar to outputs created by a human, with limited or no human oversight. 1284 1285

(B) When implementing sections 5164.292, 5164.302, 5164.32, 5164.33 to 5164.332, 5164.36, 5164.40 to 5164.407, 5164.41 to 5164.43, 5164.54, and 5164.57 of the Revised Code, if the department of medicaid uses any automated review tools, all of the following shall occur: 1286 1287 1288 1289 1290

(1) No action shall be taken automatically without human review as a result of the automated review tool's determination or decision. 1291 1292 1293

(2) The appropriate department employee responsible for overseeing the determination or decision shall review the findings of the automated review tool to confirm the tool made the correct determination or decision. 1294 1295 1296 1297

Sec. 5164.12. The department of medicaid shall impose a prior authorization requirement on all therapeutic behavioral services that are provided under the medicaid program. 1298 1299 1300

Sec. 5164.13. (A) As used in this section: 1301

(1) "Independent provider" has the same meaning as in section 5164.341 of the Revised Code. 1302 1303

(2) "Personal care services" means any service reimbursed under the medicaid program that assists a recipient who is not an inpatient in a hospital or a resident of a nursing facility or ICF/IID with activities of daily living, instrumental activities of daily living, supervision, homemaker tasks, attendant care, personal support services, or substantially similar in-home support services that are not medical services. 1304 1305 1306 1307 1308 1309 1310

(3) "Prior authorization" means advance written approval issued by the department of medicaid, a medicaid managed care organization, or other entity contracted to perform utilization review functions before medicaid payment may be made. 1311 1312 1313 1314

(4) "Waiver agency" has the same meaning as in section 5164.342 of the Revised Code. 1315 1316

(B) Subject to division (I) of this section, the department of medicaid shall require prior authorization for personal care services provided under the medicaid program when the personal care services that are requested exceed the amount or scope of services described in a written plan of care or individual service plan for an individual. 1317 1318 1319 1320 1321 1322

(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. 1323 1324 1325 1326 1327 1328

(2) Included in a request, the independent provider or waiver agency employee shall submit supporting documentation 1329 1330

that provides evidence that the requested services are medically necessary in accordance with the standards established under division (E) of this section. 1331 1332 1333

(3) An independent provider or waiver agency employee shall include in a request submitted under division (C)(1) of this section if the services for which prior authorization is requested are urgent care services for which a forty-eight hour determination is necessary under division (D)(3) of this section. 1334 1335 1336 1337 1338 1339

(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. 1340 1341 1342 1343 1344 1345 1346

(2) The department shall review the request and make a determination within ten business days of receiving all necessary information. 1347 1348 1349

(3) If an independent provider or waiver agency employee submits a request for urgent care services under division (C)(3) of this section, the department shall review the request and make a determination within forty-eight hours of receiving all necessary information. 1350 1351 1352 1353 1354

(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: 1355 1356 1357 1358 1359

(1) The services are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes. 1360 1361 1362

(2) The services are of an appropriate type, amount, duration, scope, and intensity. 1363 1364

(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. 1365 1366 1367 1368

(4) The services protect the individual from substantial harm expected to occur if the requested services are not authorized. 1369 1370 1371

(F) After conducting a review of a request received under this section, the department shall do one of the following: 1372 1373

(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; 1374 1375 1376

(2) Deny the request; 1377

(3) Approve the request in part if some of the criteria set forth in division (E) of this section are satisfied. 1378 1379

(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. 1380 1381 1382 1383 1384 1385 1386

(H) If a request for prior authorization is denied, an 1387

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 section. 1388 1389 1390 1391

(I) This section does not apply to personal care services provided under a medicaid waiver component administered by the department of developmental disabilities. 1392 1393 1394

(J) The medicaid director shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. 1395 1396 1397

Sec. 5164.292. (A) The department of medicaid shall require the providers and facilities described in this section to provide the department or the department's credentialing designee with the information described in divisions (B) and (C) of this section every twenty-four months, or sooner if required under division (D) of this section, as a condition of continued participation in the medicaid program. 1398 1399 1400 1401 1402 1403 1404

(B)(1) Each of the following providers shall provide the department or the department's credentialing designee with the information described in division (B)(2) of this section as required by this section: 1405 1406 1407 1408

(a) Physicians licensed under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery; 1409 1410 1411

(b) Psychologists licensed under Chapter 4732. of the Revised Code; 1412 1413

(c) Physician assistants licensed under Chapter 4730. of the Revised Code; 1414 1415

(d) Dentists licensed under Chapter 4715. of the Revised Code; 1416 1417

(e) Optometrists licensed under Chapter 4725. of the Revised Code; 1418 1419

(f) Pharmacists licensed under Chapter 4729. of the Revised Code; 1420 1421

(g) Chiropractors licensed under Chapter 4734. of the Revised Code; 1422 1423

(h) Acupuncturists licensed under Chapter 4762. of the Revised Code; 1424 1425

(i) Clinical nurse specialists, certified nurse-midwives, or certified nurse practitioners licensed under Chapter 4723. of the Revised Code; 1426 1427 1428

(j) Licensed independent social workers, licensed independent marriage and family therapists, or licensed professional clinical counselors licensed under Chapter 4757. of the Revised Code; 1429 1430 1431 1432

(k) Licensed independent chemical dependency counselors licensed under Chapter 4758. of the Revised Code; 1433 1434

(l) Certified Ohio behavior analysts licensed under Chapter 4783. of the Revised Code; 1435 1436

(m) Audiologists and speech-language pathologists licensed under Chapter 4753. of the Revised Code; 1437 1438

(n) Occupational therapists and physical therapists licensed under Chapter 4755. of the Revised Code; 1439 1440

(o) Dietitians licensed under Chapter 4759. of the Revised Code. 1441 1442

(2) Providers described in division (B)(1) of this section shall provide the department or department's credentialing designee with all of the following about the provider in accordance with this section: 1443 1444 1445 1446

(a) Access to the standard provider credentialing application form used by the council for affordable quality healthcare in accordance with section 3963.05 of the Revised Code within one hundred eighty days prior to credentialing date; 1447 1448 1449 1450

(b) Active provider licensing information; 1451

(c) Board certification, if applicable; 1452

(d) Educational background; 1453

(e) Clinical privileges, if applicable; 1454

(f) Medical malpractice insurance; 1455

(g) Drug enforcement administration certification, if applicable; 1456 1457

(h) National practitioner data bank information regarding malpractice and clinical privilege actions; 1458 1459

(i) Sanctions or limitations on licensure; 1460

(j) Eligibility for participation in medicare and medicaid, if applicable. 1461 1462

(C)(1) Each of the following facilities shall provide the department or the department's credentialing designee with the information described in division (C)(2) of this section as required by this section: 1463 1464 1465 1466

(a) Nursing facilities as defined in Chapter 5165. of the Revised Code; 1467 1468

(b) Hospitals as defined in Chapter 3727. of the Revised Code; 1469 1470

(c) Hospice care programs licensed under Chapter 3712. of the Revised Code; 1471 1472

(d) Home health agencies licensed by the department of health under Chapter 3740. of the Revised Code; 1473 1474

(e) Ambulatory surgical facilities as defined in section 3702.30 of the Revised Code; 1475 1476

(f) Community mental health services providers and community addiction services providers as defined in Chapter 5119. of the Revised Code; 1477 1478 1479

(g) Freestanding dialysis centers and freestanding radiation therapy centers licensed by the department of health under Chapter 3702. of the Revised Code; 1480 1481 1482

(h) Residential facilities as defined in Chapter 5119. of the Revised Code. 1483 1484

(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: 1485 1486 1487 1488

(a) The standardized credentialing form part B maintained by the department of insurance; 1489 1490

(b) Active provider licensing information; 1491

(c) Certification through an accrediting body or a site visit completed by a state designated agency; 1492 1493

(d) Eligibility for participation in medicare and medicaid, if applicable; 1494 1495

(e) Verification of good standing with applicable state and federal bodies; 1496 1497

(f) Active malpractice insurance. 1498

(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. 1499 1500 1501 1502 1503 1504

(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. 1505 1506 1507 1508

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. 1509 1510 1511 1512 1513 1514 1515 1516

(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 1517 1518 1519 1520 1521 1522 1523 1524

the address contains less than one thousand square feet of space. 1525 1526

(C) The department of medicaid shall make a referral to the auditor of state whenever it is determined that a single address is the principal place of business for more than six home and community-based services medicaid providers. 1527 1528 1529 1530

Sec. 5164.303. (A) The department of medicaid shall coordinate with the attorney general to create a disclaimer form that provides an affirmative and explicit explanation of the penalties specified in section 2913.40 of the Revised Code for medicaid fraud. 1531 1532 1533 1534 1535

(B) The department shall provide a copy of the disclaimer form to each person or government entity seeking to participate in the medicaid program as a provider. The department shall not enter into a provider agreement with a person or government entity until the person or government entity has signed and returned the disclaimer form to the department, acknowledging that the person or government entity has received and reviewed the form. 1536 1537 1538 1539 1540 1541 1542 1543

Sec. 5164.304. The department of medicaid shall establish a standardized onboarding process for all providers with a valid provider agreement with the department. The onboarding process shall provide a link to the relevant administrative rules that describe the provider agreement requirements for participation in the medicaid program. 1544 1545 1546 1547 1548 1549

Sec. 5164.305. (A) As a condition of entering into a provider agreement with the department of medicaid or revalidating an existing provider agreement, each person or government entity seeking to enroll in the medicaid program as a 1550 1551 1552 1553

provider or to revalidate an existing provider agreement shall disclose to the department the identity of each person with at least a five per cent direct or indirect ownership interest in the person or entity. 1554 1555 1556 1557

(B) The department shall verify all ownership disclosures under division (A) of this section against the exclusion list maintained by the United States department of health and human services office of inspector general, prior medicaid sanctions imposed by another state, and any prior convictions for fraud that a person may have. 1558 1559 1560 1561 1562 1563

(C) The department shall enter into all agreements necessary to share information and data obtained under this section with medicaid managed care organizations to enable parallel verification by medicaid managed care organizations. An agreement entered into between the department and a medicaid managed care organization under this section shall ensure confidentiality and privacy of the information and data in accordance with state and federal law. 1564 1565 1566 1567 1568 1569 1570 1571

(D) In implementing this section, the department may implement best practices from other states' medicaid programs. 1572 1573

Sec. 5164.32. (A) Each medicaid provider agreement shall expire not later than ~~five~~ three years from its effective date or sooner if determined necessary by the medicaid director. ~~If a provider agreement entered into before the effective date of this amendment does not have a time limit, the department of medicaid shall convert the agreement to a provider agreement with a time limit.~~ 1574 1575 1576 1577 1578 1579 1580

(B) The medicaid director shall adopt rules under section 5164.02 of the Revised Code as necessary to implement this 1581 1582

section. The rules shall be consistent with subpart E of 42 C.F.R. Part 455 and include a process for revalidating medicaid providers' continued enrollments as providers. All of the following apply to the revalidation process:

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

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

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

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

~~(1)~~ (a) Deny, refuse to revalidate, suspend, or terminate a

provider agreement; 1612

~~(2)~~ (b) Exclude an individual, provider of services or goods, or other entity from participation in the medicaid program; 1613-1615

(c) Place a provider or entity at a high risk of fraud on heightened scrutiny when suspension, termination, or exclusion of the provider will result in access to care issues for medicaid recipients. Heightened scrutiny shall include close monitoring of billing and claims, increased compliance through corrective action plans, and the potential for termination or exclusion if violations occur. 1616-1622

(d) Deny an application for a provider agreement or refuse to revalidate a provider agreement, including applications or revalidations where the applicant is an owner of, or individual that resides with an owner of, a current or former medicaid provider whose provider agreement was terminated or suspended by the department. 1623-1628

(2) The medicaid director shall suspenda provider agreement of any provider who has not submitted a claim for payment to the department for a period of one year. 1629-1631

(3) Whenever a temporary moratorium on the enrollment of new providers or provider types is issued pursuant to 42 C.F.R. 424.570, the medicaid director shall issue a similar moratorium and deny all pending applications for provider agreements, including applications that were pending prior to the issuance of the temporary moratorium and were still awaiting approval when the moratorium was issued. In issuing a moratorium under this section, the director shall comply with the requirements specified in 42 C.F.R. 455.470. 1632-1640

(B) No individual, provider, or entity excluded from participation in the medicaid program under this section shall do any of the following: 1641 1642 1643

(1) Own, or provide services to, any other medicaid provider or risk contractor; 1644 1645

(2) Arrange for, render, or order services for medicaid recipients during the period of exclusion; 1646 1647

(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. 1648 1649 1650 1651 1652

(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. 1653 1654 1655 1656 1657

(D) Nothing in this section limits the applicability of section 5164.38 of the Revised Code to a medicaid provider. 1658 1659

(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. 1660 1661 1662 1663 1664 1665

(F) The medicaid director may adopt rules under section 5164.02 of the Revised Code as necessary to implement this section. 1666 1667 1668

Sec. 5164.331. The department of medicaid shall conduct an investigation if the department determines that an individual or entity seeking initial enrollment as a provider shares the same address or telephone number as a current provider. If an investigation conducted by the department determines it necessary, the department shall take the actions described in section 5164.302 of the Revised Code with regard to the individual or entity seeking initial enrollment as a provider. 1669 1670 1671 1672 1673 1674 1675 1676

Sec. 5164.332. (A) The department of medicaid shall impose a temporary suspension of medicaid payments and conduct an investigation if the department determines there is a suspicious increase in the number of claims for payment submitted by a provider in the first sixty days of the provider entering into a provider agreement with the department. 1677 1678 1679 1680 1681 1682

(B) The department shall flag and investigate any time the department determines that the number of claims for payment submitted by a provider in a month increases by more than one hundred per cent without a corresponding increase in the number of medicaid enrollees receiving services from the provider. 1683 1684 1685 1686 1687

Sec. 5164.36. (A) As used in this section: 1688

(1) "Credible allegation of fraud" has the same meaning as in 42 C.F.R. 455.2, except that for purposes of this section any reference in that regulation to the "state" or the "state medicaid agency" means the department of medicaid. A "credible allegation of fraud" includes falsified or fake check-ins, forged paperwork, double billing for medicaid services, identity misuse, impossible travel patterns, claims that overlap with a hospital stay that are not provided in accordance with an authorized individual service plan, and coordinated billing rings. 1689 1690 1691 1692 1693 1694 1695 1696 1697 1698

(2) "Disqualifying indictment" means an indictment of a medicaid provider or its officer, authorized agent, associate, manager, employee, or, if the provider is a noninstitutional provider, its owner, if either of the following applies: 1699 1700 1701 1702

(a) The indictment charges the person with committing an act to which both of the following apply: 1703 1704

(i) The act would be a felony or misdemeanor under the laws of this state or the jurisdiction within which the act occurred. 1705 1706 1707

(ii) The act relates to or results from furnishing or billing for medicaid services under the medicaid program or relates to or results from performing management or administrative services relating to furnishing medicaid services under the medicaid program. 1708 1709 1710 1711 1712

(b) The indictment charges the person with committing an act that would constitute a disqualifying offense. 1713 1714

(3) "Disqualifying offense" means any of the offenses listed or described in divisions (A)(3)(a) to (e) of section 109.572 of the Revised Code. 1715 1716 1717

(4) "Noninstitutional medicaid provider" means any person or entity with a provider agreement other than a hospital, nursing facility, or ICF/IID. 1718 1719 1720

(5) "Owner" means any person having at least five per cent ownership in a noninstitutional medicaid provider. 1721 1722

(B)(1) Except as provided in division (C) of this section and in rules authorized by this section, the department of medicaid shall suspend the provider agreement held by a medicaid provider on determining either of the following: 1723 1724 1725 1726

(a) There is a credible allegation of fraud against any of the following for which an investigation is pending under the medicaid program: 1727 1728 1729

(i) The medicaid provider; 1730

(ii) The medicaid provider's owner, officer, authorized agent, associate, manager, or employee. 1731 1732

(b) A disqualifying indictment has been issued against any of the following: 1733 1734

(i) The medicaid provider; 1735

(ii) The medicaid provider's officer, authorized agent, associate, manager, or employee; 1736 1737

(iii) If the medicaid provider is a noninstitutional provider, its owner. 1738 1739

(2) Subject to division (C) of this section, the department shall also suspend all medicaid payments to a medicaid provider for services rendered, regardless of the date that the services are rendered, when the department suspends the provider's provider agreement under this section. 1740 1741 1742 1743 1744

(3) Except as otherwise provided in 42 C.F.R. 455.23, when the attorney general or auditor of state submits a credible allegation of fraud with evidence to the department, the department shall take the following actions: 1745 1746 1747 1748

(a) Suspend medicaid payments to the provider in whole, in part, or as applied to targeted payments; 1749 1750

(b) Require pre-payment review of the provider's claims. 1751

(4) The suspension of a provider agreement or medicaid payments shall continue in effect until the latest of the 1752 1753

following occurs: 1754

(a) If the suspension is the result of a credible 1755
allegation of fraud, the department or a prosecuting authority 1756
determines that there is insufficient evidence of fraud by the 1757
medicaid provider; 1758

(b) Regardless of whether the suspension is the result of 1759
a credible allegation of fraud or a disqualifying indictment, 1760
the proceedings in any related criminal case are completed 1761
through dismissal of the indictment or through sentencing after 1762
conviction or entry of a guilty plea or through finding of not 1763
guilty or, if the department commences a process to terminate 1764
the suspended provider agreement, the termination process is 1765
concluded; 1766

(c) The medicaid provider pays in full all fines and debts 1767
due and owing to the department or makes arrangements 1768
satisfactory to the department to fulfill those obligations; 1769

(d) A civil action related to a credible allegation of 1770
fraud or disqualifying indictment is not pending against the 1771
medicaid provider; 1772

(e) If payments are suspended under division (B)(3) of 1773
this section, until the completion of the administrative review 1774
described in division (D)(2) of this section. 1775

~~(4)(a)~~ (5)(a) When a provider agreement is suspended under 1776
this section, none of the following shall take, during the 1777
period of the suspension, any of the actions specified in 1778
division ~~(B)(4)(b)~~ (B)(5)(b) of this section: 1779

(i) The medicaid provider; 1780

(ii) If the suspension is the result of an action taken by 1781

an officer, authorized agent, associate, manager, or employee of 1782
the medicaid provider, that person; 1783

(iii) If the medicaid provider is a noninstitutional 1784
provider and the suspension is the result of an action taken by 1785
the owner of the provider, the owner. 1786

(b) The following are the actions that persons specified 1787
in division ~~(B)(4)(a)~~ (B)(5)(a) of this section cannot take 1788
during the suspension of a provider agreement: 1789

(i) Own any other medicaid provider or risk contractor; 1790

(ii) Arrange, render, or order services on behalf of any 1791
other medicaid provider or risk contractor; 1792

(iii) Arrange or order services for medicaid recipients or 1793
render services to medicaid recipients; 1794

(iv) Receive direct payments under the medicaid program or 1795
indirect payments of medicaid funds in the form of salary, 1796
shared fees, contracts, kickbacks, or rebates from or through 1797
any other medicaid provider or risk contractor. 1798

(C) The department shall not suspend a provider agreement 1799
or medicaid payments under division (B) of this section if 1800
either of the following is the case: 1801

(1) The medicaid provider or, if the provider is a 1802
noninstitutional provider, the owner can demonstrate through the 1803
submission of written evidence that the provider or owner did 1804
not directly or indirectly sanction the action of its authorized 1805
agent, associate, manager, or employee that resulted in the 1806
credible allegation of fraud or disqualifying indictment. 1807

(2) The medicaid provider or, if the provider is a 1808
noninstitutional provider, the owner can demonstrate that good 1809

cause exists not to suspend the provider agreement or payments.

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.

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 demonstration.

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

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

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

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

(E) A written request for a temporary delay described in

division ~~(D)(2)~~ (D)(1)(b) of this section may be renewed in writing by a law enforcement agency not more than two times except that under no circumstances shall the notice be issued more than ninety days after the suspension occurs.

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

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

(2) Set forth the general allegations related to the nature of the conduct leading to the suspension, except that it is not necessary to disclose any specific information concerning an ongoing investigation;

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

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

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

(G)(1) Pursuant to the procedure specified in division (G)(2) of this section, a medicaid provider subject to a suspension under this section or, if the provider is a noninstitutional provider, the owner may request a reconsideration of the suspension. The request shall be made not later than thirty days after receipt of a notice required by division ~~(D)~~ (D)(1) of this

section. The reconsideration is not subject to an adjudication hearing pursuant to Chapter 119. of the Revised Code. 1868 1869

(2) In requesting a reconsideration, the medicaid provider or owner shall submit written information and documents to the department. The information and documents may pertain to either of the following issues: 1870 1871 1872 1873

(a) Whether the determination to suspend the provider agreement was based on a mistake of fact, other than the validity of an indictment in a related criminal case. 1874 1875 1876

(b) If there has been an indictment in a related criminal case, whether the indictment is a disqualifying indictment. 1877 1878

(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. 1879 1880 1881 1882 1883 1884

(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. 1885 1886 1887 1888 1889 1890

Sec. 5164.40. As used in sections 5164.40 to 5164.406 of the Revised Code: 1891 1892

(A) "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. 1893 1894 1895 1896

(B) "GPS-based verification"has the same meaning as in section 5164.42 of the Revised Code. 1897 1898

(C) "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 conducted by an emergency medical service organization or nonemergency medical service organization as defined in section 4766.01 of the Revised Code that is licensed by the state board of emergency medical, fire, and transportation services. 1899 1900 1901 1902 1903 1904 1905 1906 1907

Sec. 5164.401. (A) The department of medicaid shall develop, procure, certify, or approve a process or system to obtain global positioning system coordinates to verify nonemergency medical transportation services provided under the medicaid program to medicaid recipients. In developing, procuring, certifying, or approving a system under this section, the department may do any of the following: 1908 1909 1910 1911 1912 1913 1914

(1) Establish an internal electronic verification system; 1915

(2) Contract with one or more vendors to establish an electronic verification system; 1916 1917

(3) Integrate with existing electronic verification systems utilized by the department. 1918 1919

(B) A system or systems developed, procured, certified, or approved in accordance with this section shall do all of the following: 1920 1921 1922

(1) Utilize a ride dispatch system that is similar to other private transportation services; 1923 1924

(2) Utilize GPS-based verification to track a provider's arrival at a pickup location, initiation of a transport, arrival at a drop-off location, and completion of a transport; 1925 1926 1927

(3) Record timestamps, route data, and total distance traveled during a transport; 1928 1929

(4) Be capable of transmitting data directly to the department as a condition of payment. 1930 1931

(C)(1) An electronic verification system developed, procured, certified, or approved in accordance with this section shall be used to ensure payment integrity within the medicaid program, compliance with state and federal requirements, and serve as a fraud prevention measure within the medicaid program. No data transmitted or stored by an electronic verification system shall be used to conduct unrelated surveillance of medicaid providers or for enforcement purposes unrelated to the medicaid program. 1932 1933 1934 1935 1936 1937 1938 1939 1940

(2) All data transmitted or stored by an electronic verification system shall be encrypted, be subject to role-based access controls and audit logs, and comply with all requirements under state and federal law regarding the protection of patient information. 1941 1942 1943 1944 1945

(D) The department shall integrate any electronic verification system developed, procured, certified, or approved under this section with the department's existing claims and encounters database and systems. If necessary, the department shall coordinate with medicaid managed care organizations and seek any necessary federal approval to facilitate coordination with electronic verification systems in the medicare program. 1946 1947 1948 1949 1950 1951 1952

(E)(1) Not later than six months after the effective date 1953

of this section, the department shall develop technical standards and a plan for implementing the requirement of this section and sections 5164.402 to 5164.406 of the Revised Code. The department shall submit a copy of the plan to the general assembly in accordance with section 101.68 of the Revised Code. 1954 1955 1956 1957 1958

(2) Not later than twelve months after the effective date of this section, the department shall establish a pilot program under which certain medicaid providers must utilize the electronic verification systems established under this section. 1959 1960 1961 1962

(3) Beginning not later than eighteen months after the effective date of this section, the department shall require all nonemergency medical transportation service providers to utilize an electronic verification system established under division (B) of this section. 1963 1964 1965 1966 1967

(F) In establishing and requiring utilization of electronic visit verification systems under this section, the department shall ensure that medicaid recipients are not denied medically necessary services solely on the basis of a provider's failure to utilize a required system. The department shall further ensure that any transition periods that are the result of implementing the requirements of this section do not impact the continuity of care for medicaid recipients. The department shall provide training and technical support to providers to ensure compliance with this section. 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977

Sec. 5164.402. (A) Upon full implementation of the electronic verification systems developed, procured, certified, or approved in accordance with section 5164.401 of the Revised Code, no nonemergency medical transportation service provider shall be eligible to receive medicaid payment for transportation services provided to a medicaid recipient unless the provider 1978 1979 1980 1981 1982 1983

submits all necessary data through an electronic verification system. The department of medicaid shall pay a claim for transportation services submitted through an electronic verification system if both of the following conditions are satisfied: 1984 1985 1986 1987 1988

(1) All required GPS-based verification and timestamp data are present. 1989 1990

(2) No unresolved discrepancies about the claim exist. 1991

(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: 1992 1993 1994 1995 1996

(1) Equipment failure or network unavailability, including rural connectivity issues; 1997 1998

(2) Emergencies; 1999

(3) Concerns for the safety of the medicaid recipient. 2000

(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. 2001 2002 2003 2004 2005 2006

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 2007 2008 2009 2010 2011

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: 2012 2013 2014

(1) The medicaid recipient who received the nonemergency medical transportation services was transported for the purpose of receiving a medicaid service. 2015 2016 2017

(2) The medicaid recipient who received the nonemergency medical transportation services was transported to a medicaid provider with an active and valid provider agreement at the time of transport. 2018 2019 2020 2021

(3) The records are received by the department within an allowable timeframe established under division (B) of this section and reflect an encounter, claim, or billing activity for a service described in division (A)(1) or (2) of this section. 2022 2023 2024 2025

(B) The department shall establish an allowable timeframe under which claims for medicaid payment for transportation claims may be cross-referenced and matched against claims for other medicaid services. The allowable timeframe shall account for documented exceptions that create delays including provider cancellations, appointment rescheduling, emergency diversions, delayed billing, and administrative errors. 2026 2027 2028 2029 2030 2031 2032

Sec. 5164.404. (A) The department of medicaid shall develop and implement automated fraud-detection tools to assist with identifying fraud through the use of the electronic verification systems developed, procured, certified, or approved under section 5164.401 of the Revised Code. Any fraud-detection tools shall be capable of flagging irregular patterns of activity by medicaid providers that are required to utilize the electronic verification systems, including all of the following: 2033 2034 2035 2036 2037 2038 2039 2040

(1) The seeking and approval of repeated exceptions under section 5164.402 of the Revised Code; 2041 2042

(2) Anomalous or irregular patterns by nonemergency medical transportation service providers; 2043 2044

(3) Discrepancies between location data and submitted claims. 2045 2046

(B) The department shall conduct periodic audits and investigations concerning data collected through use of the electronic verification systems under section 5164.401 of the Revised Code and fraud-detection tools implemented under this section. The department may suspend a medicaid provider's provider agreement for failing to comply with an audit or investigation conducted under this section. 2047 2048 2049 2050 2051 2052 2053

(C) If an audit or investigation conducted in accordance with this section results in a credible allegation of fraud as defined in section 5164.36 of the Revised Code, the department shall handle the credible allegation in accordance with that section and refer the credible allegation to the attorney general for investigation. 2054 2055 2056 2057 2058 2059

Sec. 5164.405. Annually, the department of medicaid shall submit a report to the general assembly detailing electronic verification systems developed, procured, certified, or approved under section 5164.401 of the Revised Code. The report shall be submitted to the general assembly in accordance with section 101.68 of the Revised Code and detail all of the following: 2060 2061 2062 2063 2064 2065

(A) The verified number of service claims submitted through electronic verification systems; 2066 2067

(B) The number of claims denied or recouped; 2068

(C) The number of cases of fraud referred to the medicaid fraud control unit as a result of electronic verification systems; 2069 2070 2071

(D) The number of provider sanctions issued as a result of electronic verification system data; 2072 2073

(E) The total amount of cost savings to the medicaid program achieved as a result of electronic verification systems; 2074 2075

(F) Any impacts to medicaid recipient access to medicaid services that result from the use of electronic verification systems; 2076 2077 2078

(G) Any additional information or data the department considers relevant concerning electronic verification systems. 2079 2080

Sec. 5164.406. The department of medicaid shall adopt rules in accordance with Chapter 119. of the Revised Code to implement sections 5164.40 to 5164.406 of the Revised Code. The rules shall address all of the following: 2081 2082 2083 2084

(A) Technical standards for electronic verification systems developed, procured, certified, or approved under section 5164.401 of the Revised Code including GPS intervals, and criteria for certification of electronic verification systems; 2085 2086 2087 2088 2089

(B) Procedures by which a provider may seek an exemption from electronic verification requirements under section 5164.402 of the Revised Code; 2090 2091 2092

(C) Protocols by which the department will conduct audits and enforcement of electronic verification requirements under section 5164.404 of the Revised Code; 2093 2094 2095

(D) Other standards and procedures as necessary to 2096

implement sections 5164.40 to 5164.406 of the Revised Code. 2097

Sec. 5164.41. (A) As used in this section, "home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code. 2098 2099 2100

(B) The department of medicaid shall establish oversight mechanisms concerning services provided by a family caregiver under a home and community-based services medicaid waiver component. Oversight may include any of the following: 2101 2102 2103 2104

(1) Quarterly audits; 2105

(2) Enhanced check-in review; 2106

(3) Annual recertification as a medicaid provider; 2107

(4) Independent case manager verification; 2108

(5) Caps on hours of compensated care absent documented medical necessity; 2109 2110

(6) Forensic review triggers; 2111

(7) Background check monitoring pursuant to section 5164.341 of the Revised Code through the retained applicant fingerprint database established under section 109.5721 of the Revised Code. 2112 2113 2114 2115

(C) The department may require a family caregiver who the department considers to be high risk or who has repeatedly violated the department's requirements concerning family caregivers to provide services through a waiver agency as defined in section 5164.342 of the Revised Code, rather than as an independent provider. 2116 2117 2118 2119 2120 2121

Sec. 5164.42. (A) As used in this section and section 5164.421 of the Revised Code: 2122 2123

(1) "Electronic visit verification" has the same meaning as in section 1903(l) of the "Social Security Act," 42 U.S.C. 1396b(l). 2124 2125 2126

(2) "GPS-based verification" means real-time satellite location data that can be used to confirm the physical presence of a person or device in a specified location. 2127 2128 2129

(3)(a) "In-home care services" include all of the following: 2130 2131

(i) Personal care services as defined in 42 C.F.R. 440.167; 2132 2133

(ii) Home health services covered by the medicaid program as part of the home health services benefit pursuant to 42 C.F.R. 440.70; 2134 2135 2136

(iii) Services provided under a medicaid home and community-based services medicaid waiver component as defined in section 5166.01 of the Revised Code; 2137 2138 2139

(iv) Any other medicaid services that are provided to a medicaid recipient in either a residential or community setting. 2140 2141

(b) To the extent permitted under federal law, "in-home care services" does not include waiver services that are not personal care in nature or services that satisfy any of the following: 2142 2143 2144 2145

(i) The services are residential services billed on a daily rate, habilitation services, or transportation services. 2146 2147

(ii) The services are provided under a home and community-based services medicaid waiver component to an individual with developmental disabilities or to an individual who has a severe, chronic disability that is characterized by all of the 2148 2149 2150 2151

following: 2152

(I) It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness, as defined in division (A) of section 5122.01 of the Revised Code. 2153 2154 2155 2156 2157

(II) It is likely to continue indefinitely. 2158

(III) It results in one of the following: in the case of a person under three years of age, at least one developmental delay, as defined in rules adopted under section 5123.011 of the Revised Code, or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, as defined in those rules; in the case of a person at least three years of age but under six years of age, at least two developmental delays, as defined in rules adopted under section 5123.011 of the Revised Code; in the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency. 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173

(IV) It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person. 2174 2175 2176 2177 2178

(iii) The services are provided in an ICF/IID or provided under the assisted living program as defined in section 173.51 2179 2180

of the Revised Code. 2181

(B)(1) The department of medicaid shall require each claim for a service that is subject to electronic visit verification requirements under state or federal law, including claims submitted by in-home care service providers, to be supported by a validated electronic visit verification record as a condition of payment. 2182 2183 2184 2185 2186 2187

(2) The department shall establish standards and procedures for matching claims for medicaid payment to electronic visit verification records. The standards and procedures shall identify the data elements necessary to validate that the service billed was delivered to a medicaid recipient, including the type of service performed, the individual receiving the service, the date of service, the location of service delivery, the individual providing the service, and the time the service began and ended. 2188 2189 2190 2191 2192 2193 2194 2195 2196

(3) The standards described in division (B)(2) of this section shall do all of the following: 2197 2198

(a) Require in-home care service providers to clock in and clock out when physically present at the location where services are being provided; 2199 2200 2201

(b) Except for in-home care services provided by a family caregiver that resides at the same residence as the individual receiving services, utilize GPS-based verification to track when a provider clocks in and clocks out; 2202 2203 2204 2205

(c) Record timestamps and the total duration of delivered services; 2206 2207

(d) Be capable of transmitting data directly to the department for integration with other claims submissions. 2208 2209

(4) In addition to the standards described in divisions (B)(2) and (3) of this section, all services provided under the self-direction service model shall require a provider to clock in and clock out when physically present at the location where services are being provided. 2210 2211 2212 2213 2214

(C)(1) The department may deny, suspend, defer, or recoup payment for a claim that is not supported by a validated electronic visit verification record. 2215 2216 2217

(2) Prior to taking an action described in division (C)(1) of this section, the department shall provide affected providers with notice, training, technical assistance, and compliance education regarding claim validation requirements established under this section. 2218 2219 2220 2221 2222

(D) The department may establish performance benchmarks or minimum compliance thresholds related to electronic visit verification utilization, matching accuracy, manual entry rates, modified visit rates, late visit entry rates, and unmatched claim rates. 2223 2224 2225 2226 2227

(E) The medicaid director shall adopt rules under section 5164.02 of the Revised Code to implement this section. The rules shall establish all of the following: 2228 2229 2230

(1) Claim validation procedures; 2231

(2) Standards for verified electronic visit verification records; 2232 2233

(3) Good-cause exemptions; 2234

(4) Corrective action processes; 2235

(5) Procedures for technical assistance and provider remediation; 2236 2237

(6) Phased implementation schedules by provider type or service category; 2238 2239

(7) Standards for denying, suspending, deferring, or recouping payment for claims not supported by validated electronic visit verification records. 2240 2241 2242

(F) Nothing in this section prohibits the department, the auditor of state, the attorney general, or any other authorized state or federal entity from conducting a post-payment review, audit, investigation, enforcement action, or recovery action related to a claim subject to electronic visit verification requirements. 2243 2244 2245 2246 2247 2248

Sec. 5164.421. (A) In addition to the electronic visit verification system described in section 5165.42 of the Revised Code, the department of medicaid shall establish requirements under which high risk in-home care service providers are required to verify data regarding the services provided to a medicaid recipient. 2249 2250 2251 2252 2253 2254

(B) The department shall establish criteria under which an in-home care service provider is considered to be a high-risk provider. The criteria shall at a minimum include all of the following: 2255 2256 2257 2258

(1) Repeated mismatches in check-in data; 2259

(2) Data that indicates impossible travel times; 2260

(3) Claims data that overlaps with a medicaid recipient's stay in a hospital for services that were not provided in accordance with an authorized individual service plan; 2261 2262 2263

(4) Unusual outliers in billing data; 2264

(5) Other data indicators that demonstrate a high risk of 2265

fraud. 2266

(C) Each in-home care service provider classified by the department as a high risk provider shall satisfy the requirements established under this section, including that the high-risk provider utilize 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. 2267 2268 2269 2270 2271 2272 2273 2274

(D) The department shall not sell or otherwise distribute any data transmitted or stored as part of a provider's use of electronic visit verification under this section. No such data shall be used for any purpose other than to verify medicaid payment claims submitted by a provider and reduce fraud within the medicaid program. 2275 2276 2277 2278 2279 2280

Sec. 5164.43. (A) As used in this section: 2281

(1) "Employee" means any person who performs a service for wages or other remuneration for an employer. 2282 2283

(2) "Employer" means any person who has one or more employees and includes an agent of an employer, the state or any agency or instrumentality of the state, and any political subdivision or any agency or instrumentality thereof. 2284 2285 2286 2287

(B) No employer shall discharge, demote, reassign, or take any punitive action against an employee because the employee, based on a reasonable belief, submitted a good faith report that an instance of fraud occurred in the medicaid program. 2288 2289 2290 2291

(C) An employee alleging an employer has violated division (B) of this section may commence an action in any court of competent jurisdiction for reinstatement with back pay, if the 2292 2293 2294

action is based on discharge, or for equitable relief, together with reasonable attorney's fees. 2295 2296

Sec. 5164.57. (A)(1) Except as provided in division (A)(2) and division (E) of this section, the department of medicaid may recover a medicaid payment or portion of a payment made to a medicaid provider to which the provider is not entitled if the department notifies the provider of the overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made. 2297 2298 2299 2300 2301 2302 2303

(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: 2304 2305 2306 2307 2308 2309 2310

(a) The five-year period immediately following the end of the state fiscal year in which the overpayment was made; 2311 2312

(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. 2313 2314 2315 2316 2317

(B) Among the overpayments that may be recovered under this section are the following: 2318 2319

(1) Payment for a medicaid service, or a day of service, not rendered; 2320 2321

(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 2322 2323

rate; 2324

(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; 2325 2326 2327 2328 2329 2330

(4) Payment when a medicaid recipient's responsibility for payment was understated and resulted in an overpayment to the provider. 2331 2332 2333

(C) The department may recover an overpayment under this section prior to or after any of the following: 2334 2335

(1) Adjudication of a final fiscal audit that section 5164.38 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code; 2336 2337 2338

(2) Adjudication of a finding under any other provision of state statutes governing the medicaid program or the rules adopted under those statutes; 2339 2340 2341

(3) Expiration of the time to issue a final fiscal audit that section 5164.38 of the Revised Code requires to be conducted in accordance with Chapter 119. of the Revised Code; 2342 2343 2344

(4) Expiration of the time to issue a finding under any other provision of state statutes governing the medicaid program or the rules adopted under those statutes. 2345 2346 2347

(D)(1) Subject to division (D)(2) of this section, the recovery of an overpayment under this section does not preclude the department from subsequently doing the following: 2348 2349 2350

(a) Issuing a final fiscal audit in accordance with 2351

Chapter 119. of the Revised Code, as required under section 5164.38 of the Revised Code; 2352 2353

(b) Issuing a finding under any other provision of state statutes governing the medicaid program or the rules adopted under those statutes. 2354 2355 2356

(2) A final fiscal audit or finding issued subsequent to the recovery of an overpayment under this section shall be reduced by the amount of the prior recovery, as appropriate. 2357 2358 2359

(E) The department shall recover all overpayments to a provider when an audit determines and verifies an impossible claim submitted by the provider, such as when a provider has submitted a claim for providing in-home care services, as defined in section 5164.40 of the Revised Code, on a date when the recipient was in the hospital or when a provider has submitted claims for providing in-home services to recipients located at different addresses at the same time. 2360 2361 2362 2363 2364 2365 2366 2367

(F) Nothing in this section limits the department's authority to recover overpayments pursuant to any other provision of the Revised Code. 2368 2369 2370

Sec. 5167.03. (A) As part of the medicaid program, the department of medicaid shall establish a care management system. The department shall implement the system in some or all counties. 2371 2372 2373 2374

(B) The department shall designate the medicaid recipients who are required or permitted to participate in the care management system. Those who shall be required to participate in the system include medicaid recipients who receive cognitive behavioral therapy as described in division (A)(2) of section 5167.16 of the Revised Code. Except as provided in section 2375 2376 2377 2378 2379 2380

5166.406 of the Revised Code, no medicaid recipient 2381
participating in the healthy Ohio program established under 2382
section 5166.40 of the Revised Code shall participate in the 2383
system. 2384

(C) Except as otherwise provided in this section, the 2385
general assembly's authorization through the enactment of 2386
legislation is needed before home and community-based services 2387
available under a medicaid waiver component or nursing facility 2388
services are included in the care management system. ICDS 2389
participants, or participants in the ICDS successor program, may 2390
be required or permitted to obtain such services under the 2391
system. Medicaid recipients who receive such services may be 2392
designated for voluntary or mandatory participation in the 2393
system in order to receive other health care services included 2394
in the system. 2395

(D) ~~the~~ Subject to division (E) of this section, the 2396
department may require or permit participants in the care 2397
management system to do either or both of the following: 2398

(1) Obtain health care services from providers designated 2399
by the department; 2400

(2) Enroll in a medicaid MCO plan. 2401

(E) Concerning medicaid recipients permitted or required 2402
to participate in the care management system, for a period of 2403
eighteen months beginning on the effective date of this 2404
amendment, the department of medicaid shall ensure that each 2405
medicaid MCO plan participating in the care management system 2406
enrolls at least ten per cent of the total number of 2407
participants participating in the care management system. 2408

Sec. 5167.18. Each medicaid managed care organization 2409

shall comply with federal and state efforts to identify fraud, waste, and abuse in the medicaid program. Upon the identification of credible evidence of fraud, waste, or abuse, or materially inconsistent billing, each medicaid managed care organization shall make a report to the department of medicaid. The department shall refer potential fraud in a timely manner to the attorney general for investigation. 2410 2411 2412 2413 2414 2415 2416

Sec. 5167.23. (A) As used in this section, "deconfliction" means the systematic coordination between medicaid managed care organizations and multiple state and federal oversight agencies to share investigative data, eliminate overlapping inquiries, and streamline the prosecution of fraudulent medicaid providers. 2417 2418 2419 2420 2421

(B) Upon the identification of credible indicators of fraud, waste, or abuse, a medicaid managed care organization may implement reasonable and timely payment integrity actions, including payment suspension and prepayment review and denial. 2422 2423 2424 2425

(C)(1) A medicaid managed care organization shall not initiate prepayment review for a medicaid provider without first obtaining approval from the department of medicaid. Notwithstanding any provision of law to the contrary, a prepayment review initiated under this section may remain in effect for longer than six months without renewal. 2426 2427 2428 2429 2430 2431

(2) A medicaid managed care organization may place suspected high-risk providers, as determined by the medicaid managed care organization, on claims payment suspension during any open investigation or stand-down period. A medicaid managed care organization shall notify and obtain approval from the department or the attorney general prior to implementing claims payment suspension under this section. 2432 2433 2434 2435 2436 2437 2438

(3) A medicaid managed care organization shall provide a provider placed on prepayment review under division (C)(1) of this section or claims payment suspension under division (C)(2) of this section with written notice of the decision and an opportunity for the provider to participate in the organization's grievance process established in accordance with section 5167.11 of the Revised Code. Upon completion of any grievance process, an affected provider may seek an appeal of a medicaid managed care organization's decision with the department of medicaid. 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448

(D) Following the initiation of payment integrity actions, a medicaid managed care organization shall complete all applicable deconfliction procedures in accordance with procedures established by the department. A medicaid managed care organization may take an action described in this section prior to the completion of deconfliction procedures when necessary to prevent continued improper payments and to mitigate a program integrity risk. 2449 2450 2451 2452 2453 2454 2455 2456

(E) A medicaid managed care organization shall maintain documented evidence of credible indicators of fraud, waste, and abuse that are the basis for an action taken under this section. The department shall ensure that all actions taken under this section are consistent with state and federal law. 2457 2458 2459 2460 2461

Section 2. That existing sections 109.85, 117.10, 2903.216, 2913.40, 2923.31, 4113.52, 5101.542, 5164.32, 5164.33, 5164.36, 5164.57, 5167.03, and 5167.18 of the Revised Code are hereby repealed. 2462 2463 2464 2465

Section 3. Not later than thirty days after the effective date of this section, the Department of Medicaid shall submit a report to the General Assembly with a cost estimate to implement 2466 2467 2468

this act. The report shall include a comparison of state funds and expected matching federal funds necessary to develop, procure, certify, or approve electronic verification systems described in section 5164.401 of the Revised Code. The report shall also analyze expected cost savings for the Medicaid program that result from implementation of electronic verification systems. 2469 2470 2471 2472 2473 2474 2475

Section 4. Not later than March 31, 2027, the Department of Medicaid shall prepare and submit a report to the General Assembly in accordance with section 101.68 of the Revised Code regarding the creation of a Medicaid encounter data system and the creation of a risk matrix that may be used to connect individuals with national provider identifier records associated with providers. The report and study shall examine the operation of a potential Medicaid encounter data system and risk matrix, including the scope of work required by the Department to operationalize them. 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485

Section 5. Section 5101.542 of the Revised Code as amended in this act and section 5101.5411 of the Revised Code as enacted in this act shall be known as the Enhanced Cybersecurity for SNAP Act and the remainder of this act shall be known as the Ohio Medicaid Program Integrity and Fraud Prevention Act. 2486 2487 2488 2489 2490

Section 6. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the following sections, presented in this act as composites of the sections as amended by the acts indicated, are the resulting versions of the sections in effect prior to the effective date of the sections as presented in this act: 2491 2492 2493 2494 2495 2496 2497 2498

Section 117.10 of the Revised Code as amended by both H.B. 59 and S.B. 67 of the 130th General Assembly. 2499 2500

Section 2923.31 of the Revised Code as amended by both H.B. 199 and H.B. 405 of the 132nd General Assembly. 2501 2502