

**As Reported by the House Finance Committee**

**136th General Assembly**

**Regular Session**

**2025-2026**

**Sub. S. B. No. 315**

**Senators Schaffer, Craig**

**Cosponsors: Senators Koehler, DeMora, Weinstein, Antonio, Brenner,  
Romanchuk, Blackshear, Cirino, Hicks-Hudson, Ingram, Johnson, Lang, Liston,  
O'Brien, Patton, Reineke, Reynolds, Roegner, Smith, Timken**

**Representatives Dovilla, Hall, T., Williams**

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

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

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

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

**Sec. 109.85.** (A) Upon the written request of the governor, 43  
the general assembly, the auditor of state, the medicaid 44  
director, the director of health, or the director of budget and 45  
management, or upon the attorney general's becoming aware of 46  
criminal or improper activity related to Chapter 3721. of the 47  
Revised Code and the medicaid program, the attorney general 48  
shall investigate any criminal or civil violation of law related 49  
to Chapter 3721. of the Revised Code or the medicaid program. In 50

any investigation conducted pursuant to this section the 51  
attorney general may administer oaths, subpoena witnesses, 52  
adduce evidence, and subpoena the production of any book, 53  
document, record, or other relevant matter. 54

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

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

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

(D) Any person who is subpoenaed as a witness or to 79  
produce relevant matter pursuant to division (A) of this section 80

shall comply with the terms of the subpoena unless the court 81  
orders otherwise prior to the date specified for the return of 82  
the subpoena or, if applicable, that date as extended. If a 83  
person fails without lawful excuse to obey a subpoena, the 84  
attorney general may apply to the same court of common pleas as 85  
designated in division (C) of this section for an order that 86  
does one or more of the following: 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 90  
person obeys the subpoena. 91

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

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

and any assistant or special counsel designated by the attorney 110  
general for that purpose, have all rights, privileges, and 111  
powers of prosecuting attorneys. The attorney general shall have 112  
exclusive supervision and control of all investigations and 113  
prosecutions initiated by the attorney general under this 114  
section. The forfeiture provisions of Chapter 2981. of the 115  
Revised Code apply in relation to any such criminal action 116  
initiated and prosecuted by the attorney general. 117

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

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

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

(2) The private institution, association, board, or 138  
corporation requests that the auditor of state audit some or all 139

of its other funds or accounts;	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	143
corporation failed to separately and independently account for	144
the public money in its possession, in violation of section	145
117.431 of the Revised Code;	146
(5) The auditor of state has a reasonable belief that the	147
private institution, association, board, or corporation	148
illegally expended, converted, misappropriated, or otherwise	149
cannot account for the public money it received from a public	150
office and that it is necessary to audit its other funds or	151
accounts to make that determination.	152
(B) If the auditor of state performs or contracts for the	153
performance of an audit, including a special audit, of the	154
public employees retirement system, school employees retirement	155
system, state teachers retirement system, state highway patrol	156
retirement system, or Ohio police and fire pension fund, the	157
auditor of state shall make a timely report of the results of	158
the audit to the Ohio retirement study council.	159
(C) The auditor of state may audit the accounts of any	160
medicaid provider, as defined in section 5164.01 of the Revised	161
Code.	162
(D) If a public office has been audited by an agency of	163
the United States government, the auditor of state may, if	164
satisfied that the federal audit has been conducted according to	165
principles and procedures not contrary to those of the auditor	166
of state, use and adopt the federal audit and report in lieu of	167
an audit by the auditor of state's own office.	168

(E) Within thirty days after the creation or dissolution 169  
or the winding up of the affairs of any public office, that 170  
public office shall notify the auditor of state in writing that 171  
this action has occurred. 172

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

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

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

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

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

(3) "Disabled adult" and "elderly person" have the same 197

meanings as in section 2913.01 of the Revised Code.	198
(4) "Electronic monitoring" and "electronic monitoring device" have the same meanings as in section 2929.01 of the Revised Code.	199 200 201
(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"	226
has the same meaning as in section 2919.27 of the Revised Code.	227
(9) "Tracking application" means any software program that	228
permits a person to remotely determine or track the position or	229
movement of another person or another person's property.	230
(10) "Tracking device" means an electronic or mechanical	231
device that permits a person to remotely determine or track the	232
position or movement of another person or another person's	233
property, including an electronic monitoring device.	234
(B) Except as otherwise provided in division (D) of this	235
section, no person shall knowingly do either of the following:	236
(1) Install a tracking device or tracking application on	237
another person's property without the other person's consent or	238
cause a tracking device or tracking application to track the	239
position or movement of another person or another person's	240
property without the other person's consent;	241
(2) If the person installed a tracking device or tracking	242
application on another's property with the other person's	243
consent and the other person subsequently revokes that consent,	244
fail to remove or ensure the removal of the device or	245
application after the other person revokes the consent.	246
(C) (1) For purposes of this section, if a person has given	247
consent for another to install a tracking device or tracking	248
application on the consenting person's property, it is presumed	249
that the consenting person has revoked that consent if any of	250
the following applies:	251
(a) The consenting person and the person to whom consent	252
was given are lawfully married and one of them files a complaint	253
for divorce or a petition for dissolution of marriage from the	254

other. Not later than seventy-two hours after being served with 255  
a complaint for divorce or a petition for dissolution of 256  
marriage, the person to whom consent was given shall lawfully 257  
uninstall or discontinue use of the tracking device or tracking 258  
application. If the person to whom consent was given cannot 259  
lawfully uninstall or discontinue use of the tracking device or 260  
tracking application, the person to whom consent was given shall 261  
notify the court in which the complaint for divorce or the 262  
petition for dissolution of marriage was filed in writing. 263

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

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

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

(1) A law enforcement officer, or any law enforcement 284

agency, that installs a tracking device or tracking application 285  
on another person's property or causes a tracking device or 286  
tracking application to track the position or movement of 287  
another person or another person's property as part of a 288  
criminal investigation, or a probation officer, parole officer, 289  
or employee of the department of rehabilitation and correction, 290  
a halfway house, or a community-based correctional facility when 291  
engaged in the lawful performance of the officer's or employee's 292  
official duties; 293

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

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

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

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

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

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

application or one parent revokes consent, if the consenting 314  
parent only uses the tracking device or tracking application 315  
during that parent's parenting or custodial time and disables or 316  
removes the tracking device or application during the 317  
nonconsenting parent's parenting or custodial time. 318

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

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

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

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

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

(iii) Locating lost or stolen property or other assets 341  
that have been awarded by the court; 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	371

device or tracking application on any fixed wing aircraft or 372  
rotorcraft operated or managed by the person or business entity 373  
pursuant to 14 C.F.R. part 91 or part 135 to track the position 374  
or movement of the fixed wing aircraft or rotorcraft; 375

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

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

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

(b) Validating a claim for medicaid payment; 393

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

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

following apply: 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 404  
monitoring device on that person in accordance with the court's 405  
or department's imposition of electronic monitoring of that 406  
person. 407

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

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

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

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

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

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

dangerousness.	429
(d) The offender has a history of violence toward the	430
victim or a history of other violent acts towards the victim.	431
<b>Sec. 2913.40.</b> (A) As used in this section:	432
(1) "Statement or representation" means any oral, written,	433
electronic, electronic impulse, or magnetic communication that	434
is used to identify an item of goods or a service for which	435
reimbursement may be made under the medicaid program or that	436
states income and expense and is or may be used to determine a	437
rate of reimbursement under the medicaid program.	438
(2) "Provider" means any person who has signed a provider	439
agreement with the department of medicaid to provide goods or	440
services pursuant to the medicaid program or any person who has	441
signed an agreement with a party to such a provider agreement	442
under which the person agrees to provide goods or services that	443
are reimbursable under the medicaid program.	444
(3) "Provider agreement" has the same meaning as in	445
section 5164.01 of the Revised Code.	446
(4) "Recipient" means any individual who receives goods or	447
services from a provider under the medicaid program.	448
(5) "Records" means any medical, professional, financial,	449
or business records relating to the treatment or care of any	450
recipient, to goods or services provided to any recipient, or to	451
rates paid for goods or services provided to any recipient and	452
any records that are required by the rules of the medicaid	453
director to be kept for the medicaid program.	454
<u>(6) "Presumption that a prison term shall be imposed"</u>	455
<u>means a presumption, as described in division (D) of section</u>	456

2929.13 of the Revised Code, that a prison term is a necessary 457  
sanction for a felony in order to comply with the purposes and 458  
principles of sentencing under section 2929.11 of the Revised 459  
Code. 460

(B) No person shall knowingly make or cause to be made a 461  
false or misleading statement or representation for use in 462  
obtaining reimbursement from the medicaid program. 463

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

(1) Contrary to the terms of the person's provider 467  
agreement, charge, solicit, accept, or receive for goods or 468  
services that the person provides under the medicaid program any 469  
property, money, or other consideration in addition to the 470  
amount of reimbursement under the medicaid program and the 471  
person's provider agreement for the goods or services and any 472  
cost-sharing expenses authorized by section 5162.20 of the 473  
Revised Code or rules adopted by the medicaid director regarding 474  
the medicaid program. 475

(2) Solicit, offer, or receive any remuneration, other 476  
than any cost-sharing expenses authorized by section 5162.20 of 477  
the Revised Code or rules adopted by the medicaid director 478  
regarding the medicaid program, in cash or in kind, including, 479  
but not limited to, a kickback or rebate, in connection with the 480  
furnishing of goods or services for which whole or partial 481  
reimbursement is or may be made under the medicaid program. 482

(D) No person, having submitted a claim for or provided 483  
goods or services under the medicaid program, shall do either of 484  
the following for a period of at least six years after a 485

reimbursement pursuant to that claim, or a reimbursement for 486  
those goods or services, is received under the medicaid program: 487

(1) Knowingly alter, falsify, destroy, conceal, or remove 488  
any records that are necessary to fully disclose the nature of 489  
all goods or services for which the claim was submitted, or for 490  
which reimbursement was received, by the person; 491

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

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

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

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

(3) If the value of the property, services, or funds 515  
obtained in violation of this section is ~~one hundred fifty~~ 516  
~~seventy-five~~ thousand dollars or more and is less than one 517  
hundred fifty thousand dollars, medicaid fraud is a felony of 518  
the third degree and there is a presumption for a prison term. 519  
Notwithstanding section 2929.18 of the Revised Code, the court 520  
shall impose as the fine for the offense a fine of seventy-five 521  
thousand dollars. 522

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

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

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

defendant is ordered to pay pursuant to this division shall be 545  
in addition to any other penalties for the receipt of that 546  
reimbursement that are provided in this section, section 5164.35 547  
of the Revised Code, or any other provision of law. 548

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

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

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

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

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

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

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

(B) "Costs of investigation and prosecution" and "costs of 569  
investigation and litigation" mean all of the costs incurred by 570  
the state or a county or municipal corporation under sections 571  
2923.31 to 2923.36 of the Revised Code in the prosecution and 572

investigation of any criminal action or in the litigation and 573  
investigation of any civil action, and includes, but is not 574  
limited to, the costs of resources and personnel. 575

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

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

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

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

For the purposes of the criminal penalties that may be 603  
imposed pursuant to section 2923.32 of the Revised Code, at 604  
least one of the incidents forming the pattern shall constitute 605  
a felony under the laws of this state in existence at the time 606  
it was committed or, if committed in violation of the laws of 607  
the United States or of any other state, shall constitute a 608  
felony under the law of the United States or the other state and 609  
would be a criminal offense under the law of this state if 610  
committed in this state. 611

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

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

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

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

(1) Conduct defined as "racketeering activity" under the 630  
"Organized Crime Control Act of 1970," 84 Stat. 941, 18 U.S.C. 631

1961(1)(B), (1)(C), (1)(D), and (1)(E), as amended; 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, 635  
2905.11, 2905.22, 2905.32 as specified in division (I)(2)(g) of 636  
this section, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 637  
2909.22, 2909.23, 2909.24, 2909.26, 2909.27, 2909.28, 2909.29, 638  
2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2911.31, 2913.05, 639  
2913.06, 2913.30, 2921.02, 2921.03, 2921.04, 2921.11, 2921.12, 640  
2921.32, 2921.41, 2921.42, 2921.43, 2923.12, or 2923.17; 641  
division (F)(1)(a), (b), or (c) of section 1315.53; division (A) 642  
(1) or (2) of section 1707.042; division (B), (C)(4), (D), (E), 643  
or (F) of section 1707.44; division (A)(1) or (2) of section 644  
2923.20; division (E) or (G) of section 3772.99; division (J)(1) 645  
of section 4712.02; section 4719.02, 4719.05, or 4719.06; 646  
division (C), (D), or (E) of section 4719.07; section 4719.08; 647  
or division (A) of section 4719.09 of the Revised Code. 648

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

(c) Any violation of section 2907.21, 2907.22, 2907.31, 659  
2913.02, 2913.11, 2913.21, 2913.31, 2913.32, 2913.34, 2913.40, 660  
2913.42, 2913.47, 2913.51, 2915.03, 2925.03, 2925.04, 2925.05, 661

or 2925.37 of the Revised Code, any violation of section 2925.11 662  
of the Revised Code that is a felony of the first, second, 663  
third, or fourth degree and that occurs on or after July 1, 664  
1996, any violation of section 2915.02 of the Revised Code that 665  
occurred prior to July 1, 1996, any violation of section 2915.02 666  
of the Revised Code that occurs on or after July 1, 1996, and 667  
that, had it occurred prior to that date, would not have been a 668  
violation of section 3769.11 of the Revised Code as it existed 669  
prior to that date, any violation of section 2915.06 of the 670  
Revised Code as it existed prior to July 1, 1996, or any 671  
violation of division (B) of section 2915.05 of the Revised Code 672  
as it exists on and after July 1, 1996, when the proceeds of the 673  
violation, the payments made in the violation, the amount of a 674  
claim for payment or for any other benefit that is false or 675  
deceptive and that is involved in the violation, or the value of 676  
the contraband or other property illegally possessed, sold, or 677  
purchased in the violation exceeds one thousand dollars, or any 678  
combination of violations described in division (I) (2) (c) of 679  
this section when the total proceeds of the combination of 680  
violations, payments made in the combination of violations, 681  
amount of the claims for payment or for other benefits that is 682  
false or deceptive and that is involved in the combination of 683  
violations, or value of the contraband or other property 684  
illegally possessed, sold, or purchased in the combination of 685  
violations exceeds one thousand dollars; 686

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

(e) Any violation or combination of violations of section 689  
2907.32 of the Revised Code involving any material or 690  
performance containing a display of bestiality or of sexual 691  
conduct, as defined in section 2907.01 of the Revised Code, that 692

is explicit and depicted with clearly visible penetration of the 693  
genitals or clearly visible penetration by the penis of any 694  
orifice when the total proceeds of the violation or combination 695  
of violations, the payments made in the violation or combination 696  
of violations, or the value of the contraband or other property 697  
illegally possessed, sold, or purchased in the violation or 698  
combination of violations exceeds one thousand dollars; 699

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

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

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

proceeding in the other state;	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	727
any law of any state other than this state, that is	728
substantially similar to organized retail theft, and that if	729
committed in this state would be organized retail theft, if the	730
defendant was convicted of or pleaded guilty to the conduct in a	731
criminal proceeding in the other state.	732
(b) By enacting division (I) (5) (a) of this section, it is	733
the intent of the general assembly to add organized retail theft	734
and the conduct described in division (I) (5) (a) (ii) of this	735
section as conduct constituting corrupt activity. The enactment	736
of division (I) (5) (a) of this section and the addition by	737
division (I) (5) (a) of this section of organized retail theft and	738
the conduct described in division (I) (5) (a) (ii) of this section	739
as conduct constituting corrupt activity does not limit or	740
preclude, and shall not be construed as limiting or precluding,	741
any prosecution for a violation of section 2923.32 of the	742
Revised Code that is based on one or more violations of section	743
2913.02 or 2913.51 of the Revised Code, one or more similar	744
offenses under the laws of this state or any other state, or any	745
combination of any of those violations or similar offenses, even	746
though the conduct constituting the basis for those violations	747
or offenses could be construed as also constituting organized	748
retail theft or conduct of the type described in division (I) (5)	749
(a) (ii) of this section.	750
(J) "Real property" means any real property or any	751

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

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

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

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

(3) Any successor trustee. 761

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

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

(M) "Animal activity" means any activity that involves the 778  
use of animals or animal parts, including, but not limited to, 779  
hunting, fishing, trapping, traveling, camping, the production, 780

preparation, or processing of food or food products, clothing or 781  
garment manufacturing, medical research, other research, 782  
entertainment, recreation, agriculture, biotechnology, or 783  
service activity that involves the use of animals or animal 784  
parts. 785

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

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

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

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

deliver, or transfer that property to a retail property fence. 811

(R) "Retail property" means any tangible personal property 812  
displayed, held, stored, or offered for sale in or by a retail 813  
establishment. 814

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

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

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

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

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

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

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

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

(2) To the extent permitted by federal law and except as 839  
otherwise provided in this division, each payer shall submit its 840  
claims to the superintendent for inclusion in the database. Such 841  
claims shall be submitted in the format and according to the 842  
schedule prescribed by the superintendent in rule. 843

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

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

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

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

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

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

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

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

The superintendent may adopt any other rules the 864  
superintendent considers necessary to implement this section. 865

All rules shall be adopted in accordance with Chapter 119. of 866

the Revised Code. 867

(D) Notwithstanding any provision of section 121.95 of the 868  
Revised Code to the contrary, a regulatory restriction contained 869  
in a rule adopted under division (C) of this section is not 870  
subject to sections 121.95 to 121.953 of the Revised Code. 871

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

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

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

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

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

(iv) The person holds a supervisory position within a 895

local public office. 896

(v) The person is employed in the department or office 897  
responsible for processing any revenue or expenses of the local 898  
public office. 899

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

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

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

(f) If a person becomes aware in the course of the 919  
person's employment of a violation of any state or federal 920  
statute or any ordinance or regulation of a political 921  
subdivision that the person's employer has authority to correct, 922  
and the person reasonably believes that the violation is a 923  
criminal offense that is likely to cause an imminent risk of 924

physical harm to persons or a hazard to public health or safety, 925  
a felony, or an improper solicitation for a contribution, the 926  
person orally shall notify the person's supervisor or other 927  
responsible officer of the person's employer of the violation 928  
and subsequently shall file with that supervisor or officer a 929  
written report that provides sufficient detail to identify and 930  
describe the violation. If the employer does not correct the 931  
violation or make a reasonable and good faith effort to correct 932  
the violation within twenty-four hours after the oral 933  
notification or the receipt of the report, whichever is earlier, 934  
the person may file a written report that provides sufficient 935  
detail to identify and describe the violation with the 936  
prosecuting authority of the county or municipal corporation 937  
where the violation occurred, with a peace officer, with the 938  
inspector general if the violation is within the inspector 939  
general's jurisdiction, with the auditor of state's fraud- 940  
reporting system under section 117.103 of the Revised Code if 941  
applicable, or with any other appropriate public official or 942  
agency that has regulatory authority over the employer and the 943  
industry, trade, or business in which the employer is engaged. 944

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

(2) If a person becomes aware in the course of the 954  
person's employment of a violation of Chapter 3704., 3734., 955

6109., or 6111. of the Revised Code that is a criminal offense, 956  
the person directly may notify, either orally or in writing, any 957  
appropriate public official or agency that has regulatory 958  
authority over the employer and the industry, trade, or business 959  
in which the employer is engaged. 960

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

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

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

authorized by division (A) (3) of this section if the person made 986  
a reasonable and good faith effort to determine the accuracy of 987  
any information so reported, or as a result of the person's 988  
having made any inquiry or taken any other action to ensure the 989  
accuracy of any information reported under that division. For 990  
purposes of this division, disciplinary or retaliatory action by 991  
the employer includes, without limitation, doing any of the 992  
following: 993

- (1) Removing or suspending the person from employment; 994
- (2) Withholding from the person salary increases or 995  
employee benefits to which the person is otherwise entitled; 996
- (3) Transferring or reassigning the person; 997
- (4) Denying the person a promotion that otherwise would 998  
have been received; 999
- (5) Reducing the person in pay or position. 1000

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

(D) If an employer takes any disciplinary or retaliatory 1009  
action against ~~an~~ a person as a result of the person's having 1010  
filed a report under division (A) of this section, the person 1011  
may bring a civil action for appropriate injunctive relief or 1012  
for the remedies set forth in division (E) of this section, or 1013  
both, within one hundred eighty days after the date the 1014

disciplinary or retaliatory action was taken, in a court of 1015  
common pleas in accordance with the Rules of Civil Procedure. A 1016  
civil action under this division is not available to a person as 1017  
a remedy for any disciplinary or retaliatory action taken by an 1018  
appointing authority against the person as a result of the 1019  
person's having filed a report under division (A) of section 1020  
124.341 of the Revised Code. 1021

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

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

(G) As used in this section: 1042

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

(2) "Improper solicitation for a contribution" means a 1045  
solicitation for a contribution that satisfies all of the 1046  
following: 1047

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

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

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

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

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

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

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

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

**Sec. 5101.542.** (A) Immediately following a county 1072

department of job and family services' certification that a 1073  
household determined under division (B) of section 5101.54 of 1074  
the Revised Code to be in immediate need of nutrition assistance 1075  
is eligible for the supplemental nutrition assistance program, 1076  
the department of job and family services shall provide for the 1077  
household to be sent by regular United States mail an electronic 1078  
benefit transfer card containing the amount of benefits the 1079  
household is eligible to receive under the program. The card 1080  
shall be sent to the member of the household in whose name 1081  
application for the supplemental nutrition assistance program 1082  
was made or that member's authorized representative. 1083

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

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

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

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

(E) On the effective date of this amendment, the 1103  
department shall begin the transition to chip-enabled 1104  
supplemental nutrition assistance program electronic benefit 1105  
transfer cards. In implementing this transition, the department 1106  
shall ensure that all new electronic benefit transfer cards that 1107  
are issued are chip-enabled and shall replace existing 1108  
electronic benefit transfer cards with chip-enabled cards under 1109  
the department's ordinary timeframe for replacing electronic 1110  
benefit transfer cards. 1111

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

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

Sec. 5162.139. (A) As used in this section, "electronic 1123  
visit verification" or "EVV" has the same meaning as in section 1124  
1903(1) of the "Social Security Act," 42 U.S.C. 1903(1). 1125

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

<u>(1) Provider utilization rates;</u>	1133
<u>(2) Provider compliance rates;</u>	1134
<u>(3) The number and percentage of claims or service visits with complete EVV data;</u>	1135 1136
<u>(4) The number and percentage of claims or service visits with missing, incomplete, manually entered, modified, late, or unmatched EVV data;</u>	1137 1138 1139
<u>(5) The number of claims denied or paid due to EVV compliance status;</u>	1140 1141
<u>(6) Compliance trends by provider type and geographic region;</u>	1142 1143
<u>(7) Enforcement or corrective actions taken by the department;</u>	1144 1145
<u>(8) Any recommendations to improve EVV utilization, compliance, payment integrity, and fraud prevention.</u>	1146 1147
<u>(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.</u>	1148 1149 1150 1151 1152 1153 1154
<u>(D) Nothing in this section shall be construed to limit the authority of the auditor of state under Chapter 117. of the Revised Code.</u>	1155 1156 1157
<u>Sec. 5162.1311. The department of medicaid shall prepare and submit an annual report to the general assembly in</u>	1158 1159

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

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

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

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

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

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

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

(3) Provider compliance trends; 1184

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

(5) Aggregate statistics regarding manually adjusted EVV 1187

<u>entries;</u>	1188
<u>(6) Any other metrics the department determines</u>	1189
<u>appropriate for monitoring compliance, fraud prevention, and</u>	1190
<u>program integrity.</u>	1191
<u>(C) The department shall make aggregate statewide data</u>	1192
<u>available to the public on the department's internet web site.</u>	1193
<u>(D) The department shall use information collected and</u>	1194
<u>maintained under this section to identify providers that may</u>	1195
<u>require technical assistance, additional training, corrective</u>	1196
<u>action, or program integrity review. The department may provide</u>	1197
<u>provider-specific compliance information through a secure</u>	1198
<u>provider portal or dashboard.</u>	1199
<u>(E) The medicaid director may adopt rules under section</u>	1200
<u>5162.02 of the Revised Code to implement this section.</u>	1201
<b>Sec. 5162.19.</b> <u>(A) As used in this section, "alternative</u>	1202
<u>primary insurance coverage source" means an insurance coverage</u>	1203
<u>source that is not coverage under the medicaid program,</u>	1204
<u>including coverage under the medicare program or coverage under</u>	1205
<u>a health benefit plan as defined in section 3922.01 of the</u>	1206
<u>Revised Code.</u>	1207
<u>(B) Prior to the issuance of any payment on a claim for</u>	1208
<u>services provided under either the fee-for-service component of</u>	1209
<u>the medicaid program or the care management system established</u>	1210
<u>under Chapter 5167. of the Revised Code, the department of</u>	1211
<u>medicaid shall require that all claims be electronically</u>	1212
<u>evaluated to determine whether an alternative primary insurance</u>	1213
<u>coverage source exists that is responsible for payment of the</u>	1214
<u>claim.</u>	1215
<u>(C) An evaluation conducted under division (B) of this</u>	1216

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

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

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

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

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

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

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

(3) "Generative artificial intelligence" means an 1245

<u>artificial intelligence technology system that satisfies all of</u>	1246
<u>the following:</u>	1247
<u>(a) The system is trained on data.</u>	1248
<u>(b) The system is designed to simulate human conversation</u>	1249
<u>with a consumer through text, audio, or visual communication.</u>	1250
<u>(c) The system generates nonscripted outputs similar to</u>	1251
<u>outputs created by a human, with limited or no human oversight.</u>	1252
<u>(B) When implementing sections 5162.17 to 5162.19 of the</u>	1253
<u>Revised Code, if the department of medicaid uses any automated</u>	1254
<u>review tools, all of the following shall occur:</u>	1255
<u>(1) No action shall be taken automatically without human</u>	1256
<u>review as a result of the automated review tool's determination</u>	1257
<u>or decision.</u>	1258
<u>(2) The appropriate department employee responsible for</u>	1259
<u>overseeing the determination or decision shall review the</u>	1260
<u>findings of the automated review tool to confirm the tool made</u>	1261
<u>the correct determination or decision.</u>	1262
<u><b>Sec. 5163.05.</b> No individual is eligible to participate in</u>	1263
<u>the medicaid program in this state unless that individual is</u>	1264
<u>eligible to participate in the medicaid program under section</u>	1265
<u>1903(v) (5) of the "Social Security Act," 42 U.S.C. 1396b(v) (5).</u>	1266
<u><b>Sec. 5164.11.</b> (A) As used in this section:</u>	1267
<u>(1) "Artificial intelligence" means a machine-based system</u>	1268
<u>that, for explicit or implicit objectives, infers, from the</u>	1269
<u>input it receives, how to generate outputs such as predictions,</u>	1270
<u>content, recommendations, or decisions that can influence</u>	1271
<u>physical or virtual environments. "Artificial intelligence"</u>	1272
<u>includes generative artificial intelligence.</u>	1273

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

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

(a) The system is trained on data. 1281

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

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

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

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

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

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

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

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

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

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

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

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

(C) (1) To initiate a request for prior authorization under 1323  
this section, an independent provider shall submit a signed and 1324  
dated request to the department. An employee of a waiver agency 1325  
shall submit a signed and dated request to the waiver agency, 1326  
and the waiver agency shall submit the request to the 1327  
department. 1328

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

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

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

(D) (1) Within ten business days of receiving a request 1340  
under division (C) of this section, the department shall notify 1341  
the independent provider or waiver agency if additional 1342  
information is needed to make a determination. The independent 1343  
provider or waiver agency shall submit the additional 1344  
information to the department within five business days of 1345  
receiving notification from the department. 1346

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

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

(E) When reviewing a request submitted under division (C) 1355  
of this section, the department shall determine whether the 1356  
services for which prior authorization is requested are 1357  
medically necessary. The department shall determine services to 1358  
be medically necessary if the services satisfy the following: 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 1388  
the denial in accordance with procedures established by the 1389  
medicaid director under rules adopted under division (J) of this 1390  
section. 1391

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

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

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

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

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

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

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

<u>(d) Dentists licensed under Chapter 4715. of the Revised</u>	1416
<u>Code;</u>	1417
<u>(e) Optometrists licensed under Chapter 4725. of the</u>	1418
<u>Revised Code;</u>	1419
<u>(f) Pharmacists licensed under Chapter 4729. of the</u>	1420
<u>Revised Code;</u>	1421
<u>(g) Chiropractors licensed under Chapter 4734. of the</u>	1422
<u>Revised Code;</u>	1423
<u>(h) Acupuncturists licensed under Chapter 4762. of the</u>	1424
<u>Revised Code;</u>	1425
<u>(i) Clinical nurse specialists, certified nurse-midwives,</u>	1426
<u>or certified nurse practitioners licensed under Chapter 4723. of</u>	1427
<u>the Revised Code;</u>	1428
<u>(j) Licensed independent social workers, licensed</u>	1429
<u>independent marriage and family therapists, or licensed</u>	1430
<u>professional clinical counselors licensed under Chapter 4757. of</u>	1431
<u>the Revised Code;</u>	1432
<u>(k) Licensed independent chemical dependency counselors</u>	1433
<u>licensed under Chapter 4758. of the Revised Code;</u>	1434
<u>(l) Certified Ohio behavior analysts licensed under</u>	1435
<u>Chapter 4783. of the Revised Code;</u>	1436
<u>(m) Audiologists and speech-language pathologists licensed</u>	1437
<u>under Chapter 4753. of the Revised Code;</u>	1438
<u>(n) Occupational therapists and physical therapists</u>	1439
<u>licensed under Chapter 4755. of the Revised Code;</u>	1440
<u>(o) Dietitians licensed under Chapter 4759. of the Revised</u>	1441
<u>Code.</u>	1442

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

(a) Access to the standard provider credentialing 1447  
application form used by the council for affordable quality 1448  
healthcare in accordance with section 3963.05 of the Revised 1449  
Code within one hundred eighty days prior to credentialing date; 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 1456  
applicable; 1457

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

(i) Sanctions or limitations on licensure; 1460

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

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

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

<u>(b) Hospitals as defined in Chapter 3727. of the Revised Code;</u>	1469
	1470
<u>(c) Hospice care programs licensed under Chapter 3712. of the Revised Code;</u>	1471
	1472
<u>(d) Home health agencies licensed by the department of health under Chapter 3740. of the Revised Code;</u>	1473
	1474
<u>(e) Ambulatory surgical facilities as defined in section 3702.30 of the Revised Code;</u>	1475
	1476
<u>(f) Community mental health services providers and community addiction services providers as defined in Chapter 5119. of the Revised Code;</u>	1477
	1478
	1479
<u>(g) Freestanding dialysis centers and freestanding radiation therapy centers licensed by the department of health under Chapter 3702. of the Revised Code;</u>	1480
	1481
	1482
<u>(h) Residential facilities as defined in Chapter 5119. of the Revised Code.</u>	1483
	1484
<u>(2) Facilities described in division (C) (1) of this section shall provide the department or department's credentialing designee with all of the following about the facility in accordance with this section:</u>	1485
	1486
	1487
	1488
<u>(a) The standardized credentialing form part B maintained by the department of insurance;</u>	1489
	1490
<u>(b) Active provider licensing information;</u>	1491
<u>(c) Certification through an accrediting body or a site visit completed by a state designated agency;</u>	1492
	1493
<u>(d) Eligibility for participation in medicare and medicaid, if applicable;</u>	1494
	1495

<u>(e) Verification of good standing with applicable state</u>	1496
<u>and federal bodies;</u>	1497
<u>(f) Active malpractice insurance.</u>	1498
<u>(D) The department of medicaid shall require a provider or</u>	1499
<u>facility to provide the information described in this section to</u>	1500
<u>the department or the department's credentialing designee sooner</u>	1501
<u>than every twenty-four months if required under federal law or</u>	1502
<u>if the medicaid director determines that a shorter time frame is</u>	1503
<u>necessary.</u>	1504
<u>(E) Nothing in this section prohibits the department from</u>	1505
<u>requesting additional clarifying information at any time during</u>	1506
<u>the credentialing or recredentialing process from a provider or</u>	1507
<u>facility.</u>	1508
<b>Sec. 5164.302.</b> <u>(A) Before entering into a provider</u>	1509
<u>agreement with a medicaid provider that seeks initial enrollment</u>	1510
<u>as a provider of home and community-based services under the</u>	1511
<u>medicaid program, the department of medicaid shall conduct an</u>	1512
<u>in-person review of the individual or site inspection of the</u>	1513
<u>entity seeking enrollment as a provider. The department shall</u>	1514
<u>thereafter conduct a subsequent in-person review or site</u>	1515
<u>inspection every three years.</u>	1516
<u>(B) The department shall deny, refuse to revalidate,</u>	1517
<u>suspend, or terminate a provider agreement if the department</u>	1518
<u>determines that an individual or entity seeking enrollment as a</u>	1519
<u>provider of home and community-based services under the medicaid</u>	1520
<u>program is principally located at the same address as more than</u>	1521
<u>six other active home and community-based services medicaid</u>	1522
<u>providers or is principally located at the same address as</u>	1523
<u>another home and community-based services medicaid provider when</u>	1524

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

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

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

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

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

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

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

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

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

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

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

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

section. The rules shall be consistent with subpart E of 42 1583  
C.F.R. Part 455 and include a process for revalidating medicaid 1584  
providers' continued enrollments as providers. All of the 1585  
following apply to the revalidation process: 1586

(1) The department shall refuse to revalidate a provider's 1587  
provider agreement when the provider fails to file a complete 1588  
application for revalidation within the time and in the manner 1589  
required under the revalidation process. 1590

(2) If a provider files a complete application for 1591  
revalidation within the time and in the manner required under 1592  
the revalidation process, but the provider agreement expires 1593  
before the department acts on the application or before the 1594  
effective date of the department's decision on the application, 1595  
the provider, subject to division (B)(3) of this section, may 1596  
continue operating under the terms of the expired provider 1597  
agreement until the effective date of the department's decision. 1598

(3) If a provider continues operating under the terms of 1599  
an expired provider agreement pursuant to division (B)(2) of 1600  
this section and the department denies the provider's 1601  
application for revalidation, medicaid payments shall not be 1602  
made for services or items the provider provides during the 1603  
period beginning on the date the provider agreement expired and 1604  
ending on the effective date of a subsequent provider agreement, 1605  
if any, the department enters into with the provider. 1606

**Sec. 5164.33.** ~~(A)~~(A) (1) The medicaid director may do the 1607  
following for any reason permitted or required by federal law 1608  
and when the director determines that the action is in the best 1609  
interests of medicaid recipients or the state: 1610

~~(1)~~(a) Deny, refuse to revalidate, suspend, or terminate a 1611

provider agreement; 1612

~~(2)~~(b) Exclude an individual, provider of services or 1613  
goods, or other entity from participation in the medicaid 1614  
program; 1615

(c) Place a provider or entity at a high risk of fraud on 1616  
heightened scrutiny when suspension, termination, or exclusion 1617  
of the provider will result in access to care issues for 1618  
medicaid recipients. Heightened scrutiny shall include close 1619  
monitoring of billing and claims, increased compliance through 1620  
corrective action plans, and the potential for termination or 1621  
exclusion if violations occur. 1622

(d) Deny an application for a provider agreement or refuse 1623  
to revalidate a provider agreement, including applications or 1624  
revalidations where the applicant is an owner of, or individual 1625  
that resides with an owner of, a current or former medicaid 1626  
provider whose provider agreement was terminated or suspended by 1627  
the department. 1628

(2) The medicaid director shall suspend a provider 1629  
agreement of any provider who has not submitted a claim for 1630  
payment to the department for a period of one year. 1631

(3) Whenever a temporary moratorium on the enrollment of 1632  
new providers or provider types is issued pursuant to 42 C.F.R. 1633  
424.570, the medicaid director shall issue a similar moratorium 1634  
and deny all pending applications for provider agreements, 1635  
including applications that were pending prior to the issuance 1636  
of the temporary moratorium and were still awaiting approval 1637  
when the moratorium was issued. In issuing a moratorium under 1638  
this section, the director shall comply with the requirements 1639  
specified in 42 C.F.R. 455.470. 1640

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

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

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

(3) During the period of exclusion, receive direct 1648  
payments under the medicaid program or indirect payments of 1649  
medicaid funds in the form of salary, shared fees, contracts, 1650  
kickbacks, or rebates from or through any other medicaid 1651  
provider or risk contractor. 1652

(C) An individual, provider, or entity excluded from 1653  
participation in the medicaid program under this section may 1654  
request a reconsideration of the exclusion. The director shall 1655  
adopt rules under section 5164.02 of the Revised Code governing 1656  
the process for requesting a reconsideration. 1657

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

(E) To the extent permitted under state or federal law, 1660  
the department of medicaid shall share information concerning 1661  
the director's decision to deny, refuse to revalidate, suspend, 1662  
or terminate a provider agreement under this section with any 1663  
other state board or commission responsible for regulating a 1664  
component of the health care industry. 1665

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

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.

(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.

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

(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.

(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:

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

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

(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.

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

(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.

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

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

(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:

(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) <u>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:</u>	1745 1746 1747 1748
(a) <u>Suspend medicaid payments to the provider in whole, in part, or as applied to targeted payments;</u>	1749 1750
(b) <u>Require pre-payment review of the provider's claims.</u>	1751
(4) <u>The suspension of a provider agreement or medicaid payments shall continue in effect until the latest of the</u>	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. 1810

With respect to the evidence described in division (C) (1) 1811  
of this section, the department shall grant, prior to 1812  
suspension, the provider or owner an opportunity to submit the 1813  
written evidence to the department. 1814

With respect to a demonstration of good cause described in 1815  
division (C) (2) of this section, the department shall specify in 1816  
rules adopted under section 5164.02 of the Revised Code what 1817  
constitutes good cause and the information, documents, or other 1818  
evidence that must be submitted to the department as part of the 1819  
demonstration. 1820

~~(D)~~ (D) (1) After suspending a provider agreement under 1821  
division ~~(B)~~ (B) (1) of this section, the department shall send 1822  
notice of the suspension to the affected medicaid provider or, 1823  
if the provider is a noninstitutional provider, the owner in 1824  
accordance with the following time frames: 1825

~~(1)~~ (a) Not later than five days after the suspension, 1826  
unless a law enforcement agency makes a written request to 1827  
temporarily delay the notice; 1828

~~(2)~~ (b) If a law enforcement agency makes a written request 1829  
to temporarily delay the notice, not later than thirty days 1830  
after the suspension occurs subject to the conditions specified 1831  
in division (E) of this section. 1832

(2) If medicaid payments are suspended in accordance with 1833  
division (B) (3) of this section, the medicaid provider or, if 1834  
the provider is a noninstitutional provider, the owner shall be 1835  
entitled to a hearing and independent administrative review of 1836  
the suspension. 1837

(E) A written request for a temporary delay described in 1838

division ~~(D)~~ ~~(2)~~ (D) (1) (b) of this section may be renewed in 1839  
writing by a law enforcement agency not more than two times 1840  
except that under no circumstances shall the notice be issued 1841  
more than ninety days after the suspension occurs. 1842

(F) The notice required by division (D) of this section 1843  
shall do all of the following: 1844

(1) State that payments are being suspended in accordance 1845  
with this section and 42 C.F.R. 455.23; 1846

(2) Set forth the general allegations related to the 1847  
nature of the conduct leading to the suspension, except that it 1848  
is not necessary to disclose any specific information concerning 1849  
an ongoing investigation; 1850

(3) State that the suspension continues to be in effect 1851  
until the latest of the circumstances specified in division ~~(B)~~ 1852  
~~(3)~~ (B) (4) of this section occur; 1853

(4) Specify, if applicable, the type or types of medicaid 1854  
claims or business units of the medicaid provider that are 1855  
affected by the suspension; 1856

(5) Inform the medicaid provider or owner of the 1857  
opportunity to submit to the department, not later than thirty 1858  
days after receiving the notice, a request for reconsideration 1859  
of the suspension in accordance with division (G) of this 1860  
section. 1861

(G) (1) Pursuant to the procedure specified in division (G) 1862  
(2) of this section, a medicaid provider subject to a suspension 1863  
under this section or, if the provider is a noninstitutional 1864  
provider, the owner may request a reconsideration of the 1865  
suspension. The request shall be made not later than thirty days 1866  
after receipt of a notice required by division ~~(D)~~ (D) (1) of this 1867

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

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

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

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

(H) The department shall review the information and 1879  
documents submitted in a request made under division (G) of this 1880  
section for reconsideration of a suspension. After the review, 1881  
the suspension may be affirmed, reversed, or modified, in whole 1882  
or in part. The department shall notify the affected provider or 1883  
owner of the results of the review. 1884

(I) Rules adopted under section 5164.02 of the Revised 1885  
Code may specify circumstances under which the department would 1886  
not suspend a provider agreement pursuant to this section. The 1887  
department shall adopt rules establishing expedited appeal 1888  
procedures for purposes of an administrative review conducted 1889  
under division (D) (2) of this section. 1890

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

(A) "Electronic verification system" means an electronic 1893  
system capable of recording and verifying data elements related 1894  
to the delivery of health care services covered by the medicaid 1895  
program. 1896

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

(C) "Nonemergency medical transportation" means 1899  
transportation for which immediate response is not needed for 1900  
the provision of medical treatment and is provided to a medicaid 1901  
recipient in accordance with 42 C.F.R. 431.53. "Nonemergency 1902  
medical transportation" does not include transportation 1903  
conducted by an emergency medical service organization or 1904  
nonemergency medical service organization as defined in section 1905  
4766.01 of the Revised Code that is licensed by the state board 1906  
of emergency medical, fire, and transportation services. 1907

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

(1) Establish an internal electronic verification system; 1915

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

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

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

(1) Utilize a ride dispatch system that is similar to 1923  
other private transportation services; 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  
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(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  
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(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  
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(E) (1) Not later than six months after the effective date 1953

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

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

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

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

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

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

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

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

(B) The department shall establish a process by which a 1992  
nonemergency medical transportation service provider may seek an 1993  
exemption from utilizing an electronic verification system. The 1994  
department may permit an exemption for any of the following 1995  
reasons: 1996

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

(2) Emergencies; 1999

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

(C) Before granting an exemption under division (B) of 2001  
this section, the department shall require a nonemergency 2002  
medical transportation service provider to submit written 2003  
documentation detailing why an exemption should be granted. The 2004  
department shall routinely monitor the number of exemptions 2005  
requested by a provider. 2006

**Sec. 5164.403.** (A) Not later than five years after the 2007  
effective date of this section, the department of medicaid shall 2008  
develop and implement a system by which global positioning 2009  
system coordinates data received from a nonemergency medical 2010  
transportation service provider may be cross-referenced with 2011

claims for medicaid payment submitted to the department by other 2012  
medicaid providers. The system established in accordance with 2013  
this section shall be capable of verifying all of the following: 2014

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

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

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

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

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

<u>(1) The seeking and approval of repeated exceptions under</u>	2041
<u>section 5164.402 of the Revised Code;</u>	2042
<u>(2) Anomalous or irregular patterns by nonemergency</u>	2043
<u>medical transportation service providers;</u>	2044
<u>(3) Discrepancies between location data and submitted</u>	2045
<u>claims.</u>	2046
<u>(B) The department shall conduct periodic audits and</u>	2047
<u>investigations concerning data collected through use of the</u>	2048
<u>electronic verification systems under section 5164.401 of the</u>	2049
<u>Revised Code and fraud-detection tools implemented under this</u>	2050
<u>section. The department may suspend a medicaid provider's</u>	2051
<u>provider agreement for failing to comply with an audit or</u>	2052
<u>investigation conducted under this section.</u>	2053
<u>(C) If an audit or investigation conducted in accordance</u>	2054
<u>with this section results in a credible allegation of fraud as</u>	2055
<u>defined in section 5164.36 of the Revised Code, the department</u>	2056
<u>shall handle the credible allegation in accordance with that</u>	2057
<u>section and refer the credible allegation to the attorney</u>	2058
<u>general for investigation.</u>	2059
<b><u>Sec. 5164.405.</u></b> <u>Annually, the department of medicaid shall</u>	2060
<u>submit a report to the general assembly detailing electronic</u>	2061
<u>verification systems developed, procured, certified, or approved</u>	2062
<u>under section 5164.401 of the Revised Code. The report shall be</u>	2063
<u>submitted to the general assembly in accordance with section</u>	2064
<u>101.68 of the Revised Code and detail all of the following:</u>	2065
<u>(A) The verified number of service claims submitted</u>	2066
<u>through electronic verification systems;</u>	2067
<u>(B) The number of claims denied or recouped;</u>	2068

<u>(C) The number of cases of fraud referred to the medicaid fraud control unit as a result of electronic verification systems;</u>	2069
	2070
	2071
<u>(D) The number of provider sanctions issued as a result of electronic verification system data;</u>	2072
	2073
<u>(E) The total amount of cost savings to the medicaid program achieved as a result of electronic verification systems;</u>	2074
	2075
<u>(F) Any impacts to medicaid recipient access to medicaid services that result from the use of electronic verification systems;</u>	2076
	2077
	2078
<u>(G) Any additional information or data the department considers relevant concerning electronic verification systems.</u>	2079
	2080
<u><b>Sec. 5164.406.</b> 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:</u>	2081
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	2083
	2084
<u>(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;</u>	2085
	2086
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	2089
<u>(B) Procedures by which a provider may seek an exemption from electronic verification requirements under section 5164.402 of the Revised Code;</u>	2090
	2091
	2092
<u>(C) Protocols by which the department will conduct audits and enforcement of electronic verification requirements under section 5164.404 of the Revised Code;</u>	2093
	2094
	2095
<u>(D) Other standards and procedures as necessary to</u>	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  
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(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  
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(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  
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(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  
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Sec. 5164.42. (A) As used in this section and section 5164.421 of the Revised Code: 2122  
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(1) "Electronic visit verification" has the same meaning 2124  
as in section 1903(1) of the "Social Security Act," 42 U.S.C. 2125  
1396b(1). 2126

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

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

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

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

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

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

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

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

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

<u>following:</u>	2152
<u>(I) It is attributable to a mental or physical impairment</u>	2153
<u>or a combination of mental and physical impairments, other than</u>	2154
<u>a mental or physical impairment solely caused by mental illness,</u>	2155
<u>as defined in division (A) of section 5122.01 of the Revised</u>	2156
<u>Code.</u>	2157
<u>(II) It is likely to continue indefinitely.</u>	2158
<u>(III) It results in one of the following: in the case of a</u>	2159
<u>person under three years of age, at least one developmental</u>	2160
<u>delay, as defined in rules adopted under section 5123.011 of the</u>	2161
<u>Revised Code, or a diagnosed physical or mental condition that</u>	2162
<u>has a high probability of resulting in a developmental delay, as</u>	2163
<u>defined in those rules; in the case of a person at least three</u>	2164
<u>years of age but under six years of age, at least two</u>	2165
<u>developmental delays, as defined in rules adopted under section</u>	2166
<u>5123.011 of the Revised Code; in the case of a person six years</u>	2167
<u>of age or older, a substantial functional limitation in at least</u>	2168
<u>three of the following areas of major life activity, as</u>	2169
<u>appropriate for the person's age: self-care, receptive and</u>	2170
<u>expressive language, learning, mobility, self-direction,</u>	2171
<u>capacity for independent living, and, if the person is at least</u>	2172
<u>sixteen years of age, capacity for economic self-sufficiency.</u>	2173
<u>(IV) It causes the person to need a combination and</u>	2174
<u>sequence of special, interdisciplinary, or other type of care,</u>	2175
<u>treatment, or provision of services for an extended period of</u>	2176
<u>time that is individually planned and coordinated for the</u>	2177
<u>person.</u>	2178
<u>(iii) The services are provided in an ICF/IID or provided</u>	2179
<u>under the assisted living program as defined in section 173.51</u>	2180

of the Revised Code. 2181

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

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

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

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

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

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

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

<u>(6) Phased implementation schedules by provider type or</u>	2238
<u>service category;</u>	2239
<u>(7) Standards for denying, suspending, deferring, or</u>	2240
<u>recouping payment for claims not supported by validated</u>	2241
<u>electronic visit verification records.</u>	2242
<u>(F) Nothing in this section prohibits the department, the</u>	2243
<u>auditor of state, the attorney general, or any other authorized</u>	2244
<u>state or federal entity from conducting a post-payment review,</u>	2245
<u>audit, investigation, enforcement action, or recovery action</u>	2246
<u>related to a claim subject to electronic visit verification</u>	2247
<u>requirements.</u>	2248
<b>Sec. 5164.421.</b> <u>(A) In addition to the electronic visit</u>	2249
<u>verification system described in section 5165.42 of the Revised</u>	2250
<u>Code, the department of medicaid shall establish requirements</u>	2251
<u>under which high risk in-home care service providers are</u>	2252
<u>required to verify data regarding the services provided to a</u>	2253
<u>medicaid recipient.</u>	2254
<u>(B) The department shall establish criteria under which an</u>	2255
<u>in-home care service provider is considered to be a high-risk</u>	2256
<u>provider. The criteria shall at a minimum include all of the</u>	2257
<u>following:</u>	2258
<u>(1) Repeated mismatches in check-in data;</u>	2259
<u>(2) Data that indicates impossible travel times;</u>	2260
<u>(3) Claims data that overlaps with a medicaid recipient's</u>	2261
<u>stay in a hospital for services that were not provided in</u>	2262
<u>accordance with an authorized individual service plan;</u>	2263
<u>(4) Unusual outliers in billing data;</u>	2264
<u>(5) Other data indicators that demonstrate a high risk of</u>	2265

fraud. 2266

(C) Each in-home care service provider classified by the 2267  
department as a high risk provider shall satisfy the 2268  
requirements established under this section, including that the 2269  
high-risk provider utilize fingerprint scanning, facial 2270  
recognition, vocal recognition, a secure personal identification 2271  
number, or other approved verification method as a condition of 2272  
receiving payment for services provided under the medicaid 2273  
program. 2274

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

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

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

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

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

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

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

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

(2) In the case of a hospital medicaid provider, if the 2304  
department determines as a result of a medicare or medicaid cost 2305  
report settlement that the provider received an amount under the 2306  
medicaid program to which the provider is not entitled, the 2307  
department may recover the overpayment if the department 2308  
notifies the provider of the overpayment during the later of the 2309  
following: 2310

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

(b) The one-year period immediately following the date the 2313  
department receives from the United States centers for medicare 2314  
and medicaid services a completed, audited, medicare cost report 2315  
for the provider that applies to the state fiscal year in which 2316  
the overpayment was made. 2317

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

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

(2) Payment for a day of service at a full per diem rate 2322  
that should have been paid at a percentage of the full per diem 2323

rate; 2324

(3) Payment for a medicaid service, or day of service, 2325  
that was paid by, or partially paid by, a third party, as 2326  
defined in section 5160.35 of the Revised Code, and the third 2327  
party's payment or partial payment was not offset against the 2328  
amount paid by the medicaid program to reduce or eliminate the 2329  
amount that was paid by the medicaid program; 2330

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) The department shall designate the medicaid recipients 2375  
who are required or permitted to participate in the care 2376  
management system. Those who shall be required to participate in 2377  
the system include medicaid recipients who receive cognitive 2378  
behavioral therapy as described in division (A) (2) of section 2379  
5167.16 of the Revised Code. Except as provided in section 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, 2410  
waste, and abuse in the medicaid program. Upon the 2411  
identification of credible evidence of fraud, waste, or abuse, 2412  
or materially inconsistent billing, each medicaid managed care 2413  
organization shall make a report to the department of medicaid. 2414  
The department shall refer potential fraud in a timely manner to 2415  
the attorney general for investigation. 2416

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 117.10 of the Revised Code as amended by both H.B.	2499
59 and S.B. 67 of the 130th General Assembly.	2500
Section 2923.31 of the Revised Code as amended by both	2501
H.B. 199 and H.B. 405 of the 132nd General Assembly.	2502