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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, Abrams, Barhorst, Brennan, Click, Craig, Creech, Fischer, Ghanbari, Gross, Hiner, Hoops, John, Johnson, King, Kishman, Lear, Mathews, A., Mathews, T., McClain, Miller, K., Miller, M., Newman, Plummer, Richardson, Ritter, Robb Blasdel, Roemer, Salvo, Santucci, Schmidt, Stewart, Thomas, D., Willis, Workman, Young

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 investigator" have the same meanings as in section 4749.01 of the Revised Code.	194 195 196
(3) "Disabled adult" and "elderly person" have the same meanings as in section 2913.01 of the Revised Code.	197 198
(4) "Electronic monitoring" and "electronic monitoring 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	221

transitional control under section 2967.26 of the Revised Code;	222
(e) As a term or condition of the intervention plan of a	223
person granted intervention in lieu of conviction under section	224
2951.041 of the Revised Code.	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 justice;	339 340
(iii) Locating lost or stolen property or other assets that have been awarded by the court;	341 342
(iv) Investigating claims related to workers' compensation.	343 344
(b) This division does not apply if the person on whose behalf the private investigator is working is the subject of an Ohio protection order or a protection order issued by a court of another state or if the private investigator knows or reasonably should know that the person on whose behalf the private investigator is working seeks the investigator's services to aid in the commission of a crime.	345 346 347 348 349 350 351
(6) An owner or lessee of a motor vehicle who installs, or directs the installation of, a tracking device or tracking application on the vehicle during the period of ownership or lease, if any of the following applies:	352 353 354 355
(a) The tracking device or tracking application is removed before the vehicle's title is transferred or the vehicle's lease expires;	356 357 358
(b) The new owner of the vehicle, in the case of a sale, or the lessor of the vehicle, in the case of an expired lease, consents in writing to the non-removal of the tracking device or tracking application;	359 360 361 362
(c) The owner of the vehicle at the time of the installation of the tracking device or tracking application was the original manufacturer of the vehicle.	363 364 365

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

Sec. 2913.40. (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

(6) "Presumption that a prison term shall be imposed" 455
means a presumption, as described in division (D) of section 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 investigation and litigation" mean all of the costs incurred by the state or a county or municipal corporation under sections 2923.31 to 2923.36 of the Revised Code in the prosecution and investigation of any criminal action or in the litigation and investigation of any civil action, and includes, but is not limited to, the costs of resources and personnel.

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

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

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

At least one of the incidents forming the pattern shall occur on or after January 1, 1986. Unless any incident was an aggravated murder or murder, the last of the incidents forming

the pattern shall occur within six years after the commission of 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 2907.32 of the Revised Code involving any material or performance containing a display of bestiality or of sexual conduct, as defined in section 2907.01 of the Revised Code, that is explicit and depicted with clearly visible penetration of the genitals or clearly visible penetration by the penis of any orifice when the total proceeds of the violation or combination of violations, the payments made in the violation or combination of violations, or the value of the contraband or other property illegally possessed, sold, or purchased in the violation or combination of violations exceeds one thousand dollars;

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

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

(3) Conduct constituting a violation of any law of any state other than this state that is substantially similar to the conduct described in division (I) (2) of this section, provided the defendant was convicted of the conduct in a criminal proceeding in the other state;	719 720 721 722 723
(4) Animal or ecological terrorism;	724
(5) (a) Conduct constituting any of the following:	725
(i) Organized retail theft;	726
(ii) Conduct that constitutes one or more violations of any law of any state other than this state, that is substantially similar to organized retail theft, and that if committed in this state would be organized retail theft, if the defendant was convicted of or pleaded guilty to the conduct in a criminal proceeding in the other state.	727 728 729 730 731 732
(b) By enacting division (I) (5) (a) of this section, it is the intent of the general assembly to add organized retail theft and the conduct described in division (I) (5) (a) (ii) of this section as conduct constituting corrupt activity. The enactment of division (I) (5) (a) of this section and the addition by division (I) (5) (a) of this section of organized retail theft and the conduct described in division (I) (5) (a) (ii) of this section as conduct constituting corrupt activity does not limit or preclude, and shall not be construed as limiting or precluding, any prosecution for a violation of section 2923.32 of the Revised Code that is based on one or more violations of section 2913.02 or 2913.51 of the Revised Code, one or more similar offenses under the laws of this state or any other state, or any combination of any of those violations or similar offenses, even though the conduct constituting the basis for those violations	733 734 735 736 737 738 739 740 741 742 743 744 745 746 747

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

<u>(4) Imposing penalties when claims are not submitted.</u>	863
<u>The superintendent may adopt any other rules the</u>	864
<u>superintendent considers necessary to implement this section.</u>	865
<u>All rules shall be adopted in accordance with Chapter 119. of</u>	866
<u>the Revised Code.</u>	867
<u>(D) Notwithstanding any provision of section 121.95 of the</u>	868
<u>Revised Code to the contrary, a regulatory restriction contained</u>	869
<u>in a rule adopted under division (C) of this section is not</u>	870
<u>subject to sections 121.95 to 121.953 of the Revised Code.</u>	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. <u>An official or employee of the auditor of state may report</u>	881
<u>alleged fraud, theft in office, or the misuse or</u>	882
<u>misappropriation of public money to the inspector general.</u>	883
<u>Nothing in this division prohibits the auditor of state or the</u>	884
<u>inspector general from referring a report to the other office</u>	885
<u>when appropriate.</u>	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 office.	893 894
(iv) The person holds a supervisory position within a local public office.	895 896
(v) The person is employed in the department or office responsible for processing any revenue or expenses of the local public office.	897 898 899
(c) If a person identified in division (A) (1) (b) of this section, during the person's term of office or in the course of the person's employment, becomes aware of fraud, theft in office, or the misuse or misappropriation of public money, the person shall timely notify the auditor of state via the auditor of state's fraud-reporting system under section 117.103 of the Revised Code or via other means.	900 901 902 903 904 905 906
(d) A person who serves as legal counsel, or who is employed as legal counsel, for a local public office or a state official or employee employed by or appointed to a state agency is not required to make a report under division (A) (1) (a) or (c) of this section concerning any communication received from a client in an attorney-client relationship.	907 908 909 910 911 912
(e) Divisions (A) (1) (a), (b), and (c) of this section do not apply to a prosecuting attorney, director of law, village solicitor, or similar chief legal officer of a municipal corporation, or to any employee of the prosecuting attorney, director of law, village solicitor, or similar chief legal officer of a municipal corporation.	913 914 915 916 917 918
(f) If a person becomes aware in the course of the person's employment of a violation of any state or federal	919 920

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 3517.01 of the Revised Code.	1043 1044
(2) "Improper solicitation for a contribution" means a solicitation for a contribution that satisfies all of the following:	1045 1046 1047
(a) The solicitation violates division (B), (C), or (D) of section 3517.092 of the Revised Code;	1048 1049
(b) The solicitation is made in person by a public official or by an employee who has a supervisory role within the public office;	1050 1051 1052
(c) The public official or employee knowingly made the solicitation, and the solicitation violates division (B), (C), or (D) of section 3517.092 of the Revised Code;	1053 1054 1055
(d) The employee reporting the solicitation is an employee of the same public office as the public official or the employee with the supervisory role who is making the solicitation.	1056 1057 1058
(3) "Misappropriation of public money" means knowingly using public money or public property for an unauthorized, improper, or unlawful purpose to serve a private or personal benefit or interest.	1059 1060 1061 1062
(4) "Misuse of public money" means knowingly using public money or public property in a manner not authorized by law.	1063 1064
(5) "Public office" has the same meaning as in section 117.01 of the Revised Code.	1065 1066
(H) Nothing in this section shall be construed to limit the authority of an auditor to make inquiries or interview state	1067 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

(1) Provider utilization rates; 1133

(2) Provider compliance rates; 1134

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

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

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

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

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

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

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

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

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

<u>(3) Provider compliance trends;</u>	1184
<u>(4) The percentage of claims that are supported by verified EVV documentation;</u>	1185 1186
<u>(5) Aggregate statistics regarding manually adjusted EVV entries;</u>	1187 1188
<u>(6) Any other metrics the department determines appropriate for monitoring compliance, fraud prevention, and program integrity.</u>	1189 1190 1191
<u>(C) The department shall make aggregate statewide data available to the public on the department's internet web site.</u>	1192 1193
<u>(D) The department shall use information collected and maintained under this section to identify providers that may require technical assistance, additional training, corrective action, or program integrity review. The department may provide provider-specific compliance information through a secure provider portal or dashboard.</u>	1194 1195 1196 1197 1198 1199
<u>(E) The medicaid director may adopt rules under section 5162.02 of the Revised Code to implement this section.</u>	1200 1201
Sec. 5162.19. <u>(A) As used in this section, "alternative primary insurance coverage source" means an insurance coverage source that is not coverage under the medicaid program, including coverage under the medicare program or coverage under a health benefit plan as defined in section 3922.01 of the Revised Code.</u>	1202 1203 1204 1205 1206 1207
<u>(B) Prior to the issuance of any payment on a claim for services provided under either the fee-for-service component of the medicaid program or the care management system established under Chapter 5167. of the Revised Code, the department of</u>	1208 1209 1210 1211

medicaid shall require that all claims be electronically 1212
evaluated to determine whether an alternative primary insurance 1213
coverage source exists that is responsible for payment of the 1214
claim. 1215

(C) An evaluation conducted under division (B) of this 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 intelligence, automated fraud detection tools, automated algorithmic analysis, or any other electronic automated review tool, system, or service. 1241
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(3) "Generative artificial intelligence" means an artificial intelligence technology system that satisfies all of the following: 1245
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(a) The system is trained on data. 1248

(b) The system is designed to simulate human conversation with a consumer through text, audio, or visual communication. 1249
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(c) The system generates nonscripted outputs similar to outputs created by a human, with limited or no human oversight. 1251
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(B) When implementing sections 5162.17 to 5162.19 of the Revised Code, if the department of medicaid uses any automated review tools, all of the following shall occur: 1253
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(1) No action shall be taken automatically without human review as a result of the automated review tool's determination or decision. 1256
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(2) The appropriate department employee responsible for overseeing the determination or decision shall review the findings of the automated review tool to confirm the tool made the correct determination or decision. 1259
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Sec. 5163.05. No individual is eligible to participate in the medicaid program in this state unless that individual is eligible to participate in the medicaid program under section 1903(v) (5) of the "Social Security Act," 42 U.S.C. 1396b(v) (5). 1263
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Sec. 5164.11. (A) As used in this section: 1267

(1) "Artificial intelligence" means a machine-based system 1268
that, for explicit or implicit objectives, infers, from the 1269
input it receives, how to generate outputs such as predictions, 1270
content, recommendations, or decisions that can influence 1271
physical or virtual environments. "Artificial intelligence" 1272
includes generative artificial intelligence. 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 1360
health and welfare needs, living arrangement, circumstances, and 1361
expected outcomes. 1362

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

(3) The services are the most efficient, effective, and 1365
lowest cost alternative that, when combined with other services, 1366
ensure the health and welfare of the individual receiving the 1367
services. 1368

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

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

(1) Approve the request if the department finds that the 1374
services for which prior authorization is requested meet the 1375
criteria established under division (E) of this section; 1376

(2) Deny the request; 1377

(3) Approve the request in part if some of the criteria 1378
set forth in division (E) of this section are satisfied. 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
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(H) If a request for prior authorization is denied, an individual, independent provider, or waiver agency may appeal the denial in accordance with procedures established by the medicaid director under rules adopted under division (J) of this section. 1387
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(I) This section does not apply to personal care services provided under a medicaid waiver component administered by the department of developmental disabilities. 1392
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(J) The medicaid director shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. 1395
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Sec. 5164.292. (A) The department of medicaid shall require the providers and facilities described in this section to provide the department or the department's credentialing designee with the information described in divisions (B) and (C) of this section every twenty-four months, or sooner if required under division (D) of this section, as a condition of continued participation in the medicaid program. 1398
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(B) (1) Each of the following providers shall provide the department or the department's credentialing designee with the information described in division (B) (2) of this section as required by this section: 1405
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<u>(a) Physicians licensed under Chapter 4731. of the Revised</u>	1409
<u>Code to practice medicine and surgery, osteopathic medicine and</u>	1410
<u>surgery, or podiatric medicine and surgery;</u>	1411
<u>(b) Psychologists licensed under Chapter 4732. of the</u>	1412
<u>Revised Code;</u>	1413
<u>(c) Physician assistants licensed under Chapter 4730. of</u>	1414
<u>the Revised Code;</u>	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
<u>(2) Providers described in division (B) (1) of this section</u>	1443
<u>shall provide the department or department's credentialing</u>	1444
<u>designee with all of the following about the provider in</u>	1445
<u>accordance with this section:</u>	1446
<u>(a) Access to the standard provider credentialing</u>	1447
<u>application form used by the council for affordable quality</u>	1448
<u>healthcare in accordance with section 3963.05 of the Revised</u>	1449
<u>Code within one hundred eighty days prior to credentialing date;</u>	1450
<u>(b) Active provider licensing information;</u>	1451
<u>(c) Board certification, if applicable;</u>	1452
<u>(d) Educational background;</u>	1453
<u>(e) Clinical privileges, if applicable;</u>	1454
<u>(f) Medical malpractice insurance;</u>	1455
<u>(g) Drug enforcement administration certification, if</u>	1456
<u>applicable;</u>	1457
<u>(h) National practitioner data bank information regarding</u>	1458
<u>malpractice and clinical privilege actions;</u>	1459
<u>(i) Sanctions or limitations on licensure;</u>	1460
<u>(j) Eligibility for participation in medicare and</u>	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

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

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

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

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

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

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

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

(2) Facilities described in division (C) (1) of this 1485
section shall provide the department or department's 1486
credentialing designee with all of the following about the 1487
facility in accordance with this section: 1488

<u>(a) The standardized credentialing form part B maintained</u>	1489
<u>by the department of insurance;</u>	1490
<u>(b) Active provider licensing information;</u>	1491
<u>(c) Certification through an accrediting body or a site</u>	1492
<u>visit completed by a state designated agency;</u>	1493
<u>(d) Eligibility for participation in medicare and</u>	1494
<u>medicaid, if applicable;</u>	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
Sec. 5164.302. <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

(B) The department shall deny, refuse to revalidate, 1517
suspend, or terminate a provider agreement if the department 1518
determines that an individual or entity seeking enrollment as a 1519
provider of home and community-based services under the medicaid 1520
program is principally located at the same address as more than 1521
six other active home and community-based services medicaid 1522
providers or is principally located at the same address as 1523
another home and community-based services medicaid provider when 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 1669
investigation if the department determines that an individual or 1670
entity seeking initial enrollment as a provider shares the same 1671
address or telephone number as a current provider. If an 1672
investigation conducted by the department determines it 1673
necessary, the department shall take the actions described in 1674
section 5164.302 of the Revised Code with regard to the 1675
individual or entity seeking initial enrollment as a provider. 1676

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

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

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

(1) "Credible allegation of fraud" has the same meaning as 1689
in 42 C.F.R. 455.2, except that for purposes of this section any 1690
reference in that regulation to the "state" or the "state 1691
medicaid agency" means the department of medicaid. A "credible 1692

allegation of fraud" includes falsified or fake check-ins, 1693
forged paperwork, double billing for medicaid services, identity 1694
misuse, impossible travel patterns, claims that overlap with a 1695
hospital stay that are not provided in accordance with an 1696
authorized individual service plan, and coordinated billing 1697
rings. 1698

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

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

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

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

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

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

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

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

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

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

(i) The medicaid provider; 1730

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

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

(i) The medicaid provider; 1735

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

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

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

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

department shall take the following actions: 1748

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

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

(4) The suspension of a provider agreement or medicaid payments shall continue in effect until the latest of the following occurs: 1752
1753
1754

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

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

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

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

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

<u>(3) Integrate with existing electronic verification</u>	1918
<u>systems utilized by the department.</u>	1919
<u>(B) A system or systems developed, procured, certified, or</u>	1920
<u>approved in accordance with this section shall do all of the</u>	1921
<u>following:</u>	1922
<u>(1) Utilize a ride dispatch system that is similar to</u>	1923
<u>other private transportation services;</u>	1924
<u>(2) Utilize GPS-based verification to track a provider's</u>	1925
<u>arrival at a pickup location, initiation of a transport, arrival</u>	1926
<u>at a drop-off location, and completion of a transport;</u>	1927
<u>(3) Record timestamps, route data, and total distance</u>	1928
<u>traveled during a transport;</u>	1929
<u>(4) Be capable of transmitting data directly to the</u>	1930
<u>department as a condition of payment.</u>	1931
<u>(C) (1) An electronic verification system developed,</u>	1932
<u>procured, certified, or approved in accordance with this section</u>	1933
<u>shall be used to ensure payment integrity within the medicaid</u>	1934
<u>program, compliance with state and federal requirements, and</u>	1935
<u>serve as a fraud prevention measure within the medicaid program.</u>	1936
<u>No data transmitted or stored by an electronic verification</u>	1937
<u>system shall be used to conduct unrelated surveillance of</u>	1938
<u>medicaid providers or for enforcement purposes unrelated to the</u>	1939
<u>medicaid program.</u>	1940
<u>(2) All data transmitted or stored by an electronic</u>	1941
<u>verification system shall be encrypted, be subject to role-based</u>	1942
<u>access controls and audit logs, and comply with all requirements</u>	1943
<u>under state and federal law regarding the protection of patient</u>	1944
<u>information.</u>	1945

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

(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

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

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

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

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

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

Sec. 5164.405. Annually, the department of medicaid shall 2060
submit a report to the general assembly detailing electronic 2061

verification systems developed, procured, certified, or approved 2062
under section 5164.401 of the Revised Code. The report shall be 2063
submitted to the general assembly in accordance with section 2064
101.68 of the Revised Code and detail all of the following: 2065

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

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

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

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

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

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

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

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

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

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

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

(D) Other standards and procedures as necessary to 2096
implement sections 5164.40 to 5164.406 of the Revised Code. 2097

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

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

(1) Quarterly audits; 2105

(2) Enhanced check-in review; 2106

(3) Annual recertification as a medicaid provider; 2107

(4) Independent case manager verification; 2108

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

(6) Forensic review triggers; 2111

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

(C) The department may require a family caregiver who the 2116

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

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

(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
following: 2152

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

(II) It is likely to continue indefinitely. 2158

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

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

(iii) The services are provided in an ICF/IID or provided 2179
under the assisted living program as defined in section 173.51 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 2210
(B) (2) and (3) of this section, all services provided under the 2211
self-direction service model shall require a provider to clock 2212
in and clock out when physically present at the location where 2213
services are being provided. 2214

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

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

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

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

<u>(1) Claim validation procedures;</u>	2231
<u>(2) Standards for verified electronic visit verification records;</u>	2232 2233
<u>(3) Good-cause exemptions;</u>	2234
<u>(4) Corrective action processes;</u>	2235
<u>(5) Procedures for technical assistance and provider remediation;</u>	2236 2237
<u>(6) Phased implementation schedules by provider type or service category;</u>	2238 2239
<u>(7) Standards for denying, suspending, deferring, or recouping payment for claims not supported by validated electronic visit verification records.</u>	2240 2241 2242
<u>(F) Nothing in this section prohibits the department, the auditor of state, the attorney general, or any other authorized state or federal entity from conducting a post-payment review, audit, investigation, enforcement action, or recovery action related to a claim subject to electronic visit verification requirements.</u>	2243 2244 2245 2246 2247 2248
Sec. 5164.421. <u>(A) In addition to the electronic visit verification system described in section 5165.42 of the Revised Code, the department of medicaid shall establish requirements under which high risk in-home care service providers are required to verify data regarding the services provided to a medicaid recipient.</u>	2249 2250 2251 2252 2253 2254
<u>(B) The department shall establish criteria under which an in-home care service provider is considered to be a high-risk provider. The criteria shall at a minimum include all of the following:</u>	2255 2256 2257 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 stay in a hospital for services that were not provided in accordance with an authorized individual service plan;</u>	2261 2262 2263
<u>(4) Unusual outliers in billing data;</u>	2264
<u>(5) Other data indicators that demonstrate a high risk of fraud.</u>	2265 2266
<u>(C) Each in-home care service provider classified by the department as a high risk provider shall satisfy the requirements established under this section, including that the high-risk provider utilize fingerprint scanning, facial recognition, vocal recognition, a secure personal identification number, or other approved verification method as a condition of receiving payment for services provided under the medicaid program.</u>	2267 2268 2269 2270 2271 2272 2273 2274
<u>(D) The department shall not sell or otherwise distribute any data transmitted or stored as part of a provider's use of electronic visit verification under this section. No such data shall be used for any purpose other than to verify medicaid payment claims submitted by a provider and reduce fraud within the medicaid program.</u>	2275 2276 2277 2278 2279 2280
<u>Sec. 5164.43.</u> (A) <u>As used in this section:</u>	2281
<u>(1) "Employee" means any person who performs a service for wages or other remuneration for an employer.</u>	2282 2283
<u>(2) "Employer" means any person who has one or more employees and includes an agent of an employer, the state or any agency or instrumentality of the state, and any political</u>	2284 2285 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