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SUMMARY

Medicaid Program Integrity and Fraud Prevention Act

Electronic visit verification (EVV) for in-home care services

- Requires the Department of Medicaid to require each claim for a service that is subject to EVV requirements under state or federal law, including nonexempt services provided by in-home care service providers, to be supported by a validated EVV record as a condition of payment.
- Permits the Department to deny, suspend, defer, or recoup payment for a claim that is not supported by a validated EVV record, after providing an affected provider with notice, training, technical assistance, and compliance education.
- Permits the Department to establish performance benchmarks or minimum compliance thresholds related to EVV.
- Requires the Department to establish additional safeguards for high risk in-home care service providers, under which they are required to utilize supplemental verification methods.

EVV for nonemergency medical transportation services

- Requires the Department to develop, procure, certify, or approve a process or system to obtain global positioning system (GPS) coordinates to verify Medicaid nonemergency medical transportation services.
- Requires the Department to establish a process by which a provider may seek an exemption from using the system.
- Requires the Department to develop and implement automated fraud-detection tools to assist with identifying fraud through use of the system described above.

- Not later than October 6, 2031, requires the Department to develop and implement a system by which GPS data received from a provider may be cross-referenced with Medicaid payment claims submitted to the Department by other Medicaid providers.

EVV dashboard and report

- Requires the Department to maintain a statewide EVV performance dashboard, updated at least quarterly.
- Requires the Department to make aggregate statewide data available on its website and to use the information collected to identify providers that may require technical assistance, additional training, corrective action, or program integrity review.

Nonconsensual tracking exception

- Exempts the use of location verification technology by the Department, a Medicaid provider, the provider's employee or contractor, or an EVV vendor when used solely to comply with Medicaid EVV requirements from the continuing law prohibition against installing a tracking device or application on another person's property without consent.

Medicaid provider enrollment

- Requires the Department to conduct an in-person review of an individual or a site inspection of an entity before enrolling the provider in the Medicaid Program as a home- and community-based services (HCBS) provider, and subsequent reviews or site inspections every three years.
- Requires the Department to deny, refuse to revalidate, suspend, or terminate an HCBS provider agreement if it determines that the provider is principally located at the same address as six other active HCBS providers or at the same address as another HCBS provider when the address contains less than 1,000 square feet of space.
- Requires the Department to make a referral to the Auditor of State whenever it is determined that a single address is the principal place of business for more than six Medicaid HCBS providers.
- Requires the Department to investigate if it determines that an individual or entity seeking initial enrollment as a provider shares the same address or telephone number as a current provider.
- Requires the Department to coordinate with the Attorney General to create a disclaimer form that explains Ohio's Medicaid fraud penalties and prohibits the Department from entering into a provider agreement until the person or government entity has signed and returned the form.
- Requires the Department to establish a standardized onboarding process for all providers that provides a link to the relevant administrative rules.
- As a condition of entering into or revalidating a Medicaid provider agreement, requires each applicant to disclose to the Department the identity of each person with at least a 5% ownership interest in the applicant.

- Requires the Department to verify those ownership disclosures against the exclusion list maintained by the federal government, prior Medicaid sanctions in another state, and prior convictions for fraud.
- Requires the Department to enter into data sharing agreements with Medicaid managed care organizations (MCOs) to enable parallel verification of the ownership disclosures by the MCOs.
- Requires the Department to suspend payment and investigate if it determines there is a suspicious increase in the number of payment claims submitted in the first 60 days of entering into a provider agreement.
- Requires the Department to flag and investigate any time it determines that the number of monthly claims submitted increases by more than 100% without a corresponding increase in the number of Medicaid enrollees receiving services.

Medicaid provider agreement denial, suspension, or termination

- Requires the Medicaid Director to suspend a provider agreement if the provider has not submitted a claim for payment to the Department for one year.
- Requires the Medicaid Director to issue a moratorium and deny all pending provider applications when a moratorium against new Medicaid providers is issued under federal law.
- To the extent permitted under state or federal law, requires the Department to share information concerning the Medicaid Director's decision to deny, refuse to revalidate, suspend, or terminate a provider agreement with any other state board or commission responsible for regulating a component of the health care industry.

Medicaid provider revalidation and credentialing

- Specifies that each Medicaid provider agreement expires not later than three years from its effective date, or sooner if determined necessary by the Medicaid Director.
- Requires the Department to collect specified information from Medicaid professionals and facilities every 24 months or sooner if required under federal law or the Medicaid Director determines a shorter timeframe is necessary.

Medicaid payments

- Before paying any claim, requires the Department to electronically evaluate it using automated algorithmic analysis and insurance discovery engines to determine whether an alternative primary coverage source exists and, if so, requires the claim be redirected to that source before payment.
- Requires the Department to recover all overpayments to a provider when an audit determines and verifies an impossible claim.

Medicaid eligibility

- Specifies that no individual is eligible to participate in the Medicaid Program in Ohio unless that individual is eligible to participate in the Medicaid Program under federal law regarding lawful residency.

Family caregiver oversight

- Requires the Department to establish oversight mechanisms concerning services provided by a family caregiver under an HCBS Medicaid waiver component.
- Permits the Department to require a family caregiver it considers to be high risk or a repeat violator of its family caregiver requirements to provide services through a waiver agency rather than as an independent provider.

Prior authorization for Medicaid services

- Requires the Department of Medicaid to require prior authorization for personal care services when the services requested exceed the amount or scope of the services described in an individual's written plan of care or individual service plan.
- Exempts personal care services provided under a waiver administered by the Department of Developmental Disabilities from the prior authorization requirement described above.
- Requires the Department of Medicaid to make a prior authorization determination not later than ten business days after receiving all necessary information or not later than 48 hours when the request is for urgent care services.
- Permits an individual, independent provider, or waiver agency to appeal the denial of a prior authorization request.
- Requires the Department to impose a prior authorization requirement on all therapeutic behavioral services provided under the Medicaid Program.

Medicaid fraud

- Expands the definition of "credible allegation of fraud" for purposes of Medicaid Program enforcement.
- Generally requires the Department to suspend a provider's Medicaid payments in whole or in part and require prepayment review of the provider's claims when the Attorney General or Auditor of State submits a credible allegation of fraud with evidence to the Department.
- Requires the Department to afford a provider or owner a hearing and independent administrative review of the suspension.
- Increases the penalties for Medicaid fraud.
- Specifies that Medicaid fraud constitutes corrupt activity under Ohio's Corrupt Activities Law under specified circumstances.

- Prohibits an employer from retaliating against an employee for reporting Medicaid fraud and permits such an employee to sue the employer for reinstatement with back pay, equitable relief, and reasonable attorney's fees.

Use of automated review tools

- Requires that, if the Department uses any automated review tools under the act, (1) no action can be taken automatically as a result of the tool's determination or decision and (2) the appropriate Department employee responsible for overseeing the determination or decision must review the findings to confirm the tool was correct.

Medicaid MCOs

- Permits a Medicaid MCO that identifies credible indicators of fraud, waste, or abuse to implement reasonable and timely payment integrity actions, including payment suspension and prepayment review and denial.
- Generally prohibits a Medicaid MCO from initiating prepayment review for a Medicaid provider without first obtaining approval from the Department.
- Authorizes a Medicaid MCO to place suspected high-risk providers on claims payment suspension during any open investigation or stand-down period after notifying and receiving approval from the Department or Attorney General.
- Requires a Medicaid MCO to give a provider written notice of the prepayment review or suspension and an opportunity to participate in the MCO's established grievance process and, once that process has been exhausted, to appeal the decision to the Department.
- Requires each Medicaid MCO to report to the Department credible evidence of fraud, waste, or abuse or materially inconsistent billing.
- Requires the Department to refer any information received concerning potential fraud to the Attorney General for investigation.
- Until April 6, 2028, requires the Department to ensure that each Medicaid MCO plan enrolls at least 10% of the total number of managed care participants.

Reports

- Requires the Medicaid Director to submit an annual report by March 1 to the Governor, Speaker of the House of Representatives, Senate President, and Auditor of State regarding EVV utilization and compliance.
- Requires the Department of Medicaid to submit an annual report to the General Assembly detailing the electronic verification systems for nonemergency medical transportation service providers.
- Requires the Department to prepare and submit a report to the General Assembly by March 31, 2027, regarding the creation of a Medicaid encounter data system and risk matrix.

- Requires the Department to prepare and submit an annual report to the chairpersons and ranking members of the committees of the House and Senate with jurisdiction over Medicaid detailing its efforts to ensure integrity within the Medicaid Program.
- Requires the Department to prepare and submit an annual report to the General Assembly detailing all billing codes that represent an increase or decrease of greater than 50% from the previous state fiscal year in either the utilization rate or total expenditures for a particular service and to include data from the preceding five years.
- Requires the Department to submit a report to the General Assembly by November 5, 2026, with a cost estimate to implement the act.

General Assembly review of Medicaid waivers

- Requires the standing committees of the House and Senate that primarily consider Medicaid legislation to meet jointly on an annual basis to review $\frac{1}{4}$ of the state's Medicaid waivers and to review all Medicaid waivers before conducting a subsequent review of any waiver.

All-payer claims database

- Requires, by October 6, 2027, the Superintendent of Insurance to establish and administer an all-payer claims database under which health plan issuers, pharmacy benefit managers, Medicaid MCOs, and the Medicaid and Medicare Programs must submit their claims to the Superintendent for inclusion in the database.
- With respect to health plan issuers, delays the requirement to submit claims until January 1, 2028.
- Permits the Superintendent to require a person to obtain a subscription from the Department of Insurance to access information in the database.
- Directs the Superintendent to adopt rules to implement the act's requirements, including those establishing standards for imposing penalties when claims are not submitted and for maintaining the privacy and security of personal or health information contained in claims.

Auditor of State

- Authorizes the Auditor of State to issue subpoenas compelling the production of books, records, accounts, documents, electronically stored information, testimony, or other information relevant to any audit, examination, special audit, investigation, or review.
- Requires the Attorney General, on the Auditor's request, to bring a court action to enforce compliance with a subpoena.
- Requires all state officials and employees to report to the Auditor of State, rather than to the Inspector General, alleged fraud, theft in office, or the misuse or misappropriation of public money by a state official or employee.

Attorney General investigations

- In conducting an investigation concerning Medicaid or long-term care facilities under continuing law, authorizes the Attorney General to administer oaths, subpoena witnesses, adduce evidence, and subpoena the production of any book, document, record, or other relevant matter.
- Permits the Attorney General to designate a representative to inspect any relevant matter that is the subject of a subpoena issued above, if it is located outside Ohio.
- If a person fails without lawful excuse to obey a subpoena, permits the Attorney General to seek an order that compels requested discovery, adjudges the person in contempt of court, or grants other relief that may be required until the person obeys the subpoena.
- If a court finds that a person's failure to comply with a subpoena was in bad faith or for the purpose of delay, authorizes the court to order the person to pay the reasonable expenses of the Attorney General, including attorney's fees, and invoke sanctions.

Enhanced Cybersecurity for SNAP Act

- Requires the Ohio Department of Job and Family Services (ODJFS) to ensure that new SNAP electronic benefit transfer (EBT) cards are chip-enabled and to replace existing EBT cards with chip-enabled cards under its ordinary timeframe for replacing cards.
- Requires the ODJFS Director to ensure that the ODJFS website contains a mechanism for SNAP benefit recipients to report fraud.

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DETAILED ANALYSIS

Medicaid Program Integrity and Fraud Prevention Act

Electronic visit verification (EVV) for in-home care services

Under federal law, a state must require the use of electronic visit verification (EVV) for personal care services and home health services or face a reduction in federal Medicaid payments.¹ The act codifies EVV requirements for in-home care services. “In-home care services” include personal care services and home health services as specified under federal law, as well as services provided under a Medicaid home- and community-based services (HCBS) waiver and any other Medicaid services that are provided to a Medicaid recipient in either a residential or community setting. To the extent permitted under federal law, “in-home care services” excludes waiver services that are not personal care in nature or that satisfy any of the following:

- The services are residential services billed on a daily rate, habilitation services, or transportation services;
- The services are provided under a Medicaid HCBS waiver to an individual with a developmental disability or to an individual who meets all criteria for a developmental disability other than that the disability manifested before age 22;
- The services are provided in an intermediate care facility for individuals with intellectual disabilities or under the Assisted Living Program.²

EVV requirements

The act requires that each claim for a Medicaid service that is subject to EVV under state or federal law, including claims submitted by in-home care service providers, must be supported by a validated EVV record as a condition of payment. The Department of Medicaid must establish standards and procedures for matching claims for payment to EVV records. The standards must identify the data elements necessary to validate that the service billed was delivered to a Medicaid recipient, including (1) the type of service performed, (2) the individual receiving the service, (3) the date of the service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service began and ended.

Specifically, the act requires that the standards described above do all of the following:

- Require in-home care service providers to clock in and clock out when physically present at the location where services are being provided;
- Except for in-home care services that are provided by a family caregiver who resides at the same residence as the individual receiving services, utilize global positioning system (GPS)-based verification to track when a provider clocks in and clocks out;

¹ 42 United States Code (U.S.C.) 1396b(l).

² R.C. 5164.42(A)(3); see also R.C. 5123.01(Q), not in the act.

- Record timestamps and the total duration of delivered services;
- Be capable of transmitting data directly to the Department for integration with other claims submissions.

In addition to these standards, the act requires that all services provided under the [self-direction service model](#) require a provider to clock in and clock out when physically present at the location where services are provided.³

The act permits the Department to deny, suspend, defer, or recoup payment for any claim that is not supported by a validated EVV record. Before doing so, the Department must provide affected providers with notice, training, technical assistance, and compliance education concerning claim validation requirements. Additionally, the act permits the Department to establish performance benchmarks or minimum compliance thresholds related to EVV utilization, matching accuracy, manual entry rates, modified visit rates, late visit entry rates, and unmatched claim rates. The act specifies that none of the provisions described above prohibit 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 EVV.⁴

The act requires the Medicaid Director to adopt rules regarding EVV that establish (1) claim validation procedures, (2) standards for verified EVV records, (3) good-cause exemptions, (4) corrective action processes, (5) procedures for technical assistance and provider remediation, (6) phased implementation schedules by provider type or service category, and (7) standards for denying, suspending, deferring, or recouping payment for claims not supported by validated EVV records.⁵

High risk providers

In addition to the EVV requirements described above, the Department must establish additional requirements under which high risk in-home care service providers are required to verify data regarding the services they provide. The Department must establish criteria under which an in-home care service provider is considered a high risk provider, which at a minimum must include:

- Repeated mismatches in check-in data;
- Data that indicates impossible travel times;
- 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;
- Unusual outliers in billing data;

³ R.C. 5164.42(B).

⁴ R.C. 5164.42(C), (D), and (F).

⁵ R.C. 5164.42(E).

- Other data indicators that demonstrate a high risk of fraud.

As a condition of receiving payment for services, a high risk in-home care service provider must satisfy all requirements established by the Department, including the use of fingerprint scanning, facial or vocal recognition, a secure personal identification number, or other approved verification method. The act prohibits the Department from selling or otherwise distributing any data transmitted or stored as part of a high risk provider's use of enhanced EVV requirements. The Department is prohibited from selling or otherwise distributing any data transmitted or stored as part of a provider's use of EVV and from using stored data for any purpose other than to verify Medicaid payment claims and to reduce fraud within the Medicaid Program.⁶

EVV for nonemergency medical transportation services

The act requires the Department to develop, procure, certify, or approve a process or system to obtain GPS coordinates to verify nonemergency medical transportation services provided under the Medicaid Program. Under the act, "nonemergency medical transportation" means transportation for which immediate response is not needed for the provision of medical treatment. "Nonemergency medical transportation" does not include transportation conducted by an emergency medical service organization or nonemergency medical service organization that is licensed by the State Board of Emergency Medical, Fire, and Transportation Services.⁷ The act permits the Department to (1) establish an internal electronic verification system, (2) contract with one or more vendors to establish a system, or (3) integrate with existing electronic verification systems it utilizes.⁸

Any electronic verification system developed, procured, certified, or approved by the Department under the act must be used to ensure payment integrity with the Medicaid Program, ensure compliance with all state and federal requirements, and serve as a fraud prevention measure within the Medicaid Program. The act prohibits data transmitted or stored by an electronic verification system from being used to conduct unrelated surveillance of Medicaid providers or for enforcement purposes unrelated to the Medicaid Program. All data transmitted or stored by the system must be encrypted, subject to role-based access controls and audit logs, and comply with all state and federal requirements concerning the protection of patient information. Additionally, the Department must integrate any electronic verification system with the Department's existing claims and encounters database and system. The act also requires the Department to coordinate with Medicaid managed care organizations (MCOs) and seek any necessary federal approval to coordinate with electronic verification systems in the Medicare Program.⁹

⁶ R.C. 5164.421.

⁷ R.C. 5164.40(C); R.C. 4766.01, not in the act.

⁸ R.C. 5164.401(A).

⁹ R.C. 5164.401(C) and (D).

System functioning

The electronic verification system must do all of the following:¹⁰

- Utilize a ride dispatch system similar to other private transportation services;
- Utilize GPS-based verification, which includes real-time satellite location data that can be used to confirm the physical presence of a person or device in a specified location, to track a provider's arrival at a pickup location, initiation of a transport, arrival at a drop-off location, and completion of a transport;
- Record timestamps, route data, and total distance traveled during a transport;
- Be capable of transmitting data directly to the Department as a condition of payment.

Implementation timelines

The act requires the Department to develop technical standards and an implementation plan not later than April 6, 2027. A copy of the plan must be submitted to the General Assembly. Not later than October 6, 2027, the Department must establish a pilot program under which certain Medicaid providers will be required to utilize the act's electronic verification system. Beginning not later than April 6, 2028, all nonemergency medical transportation service providers must utilize the electronic verification system.¹¹

In establishing and requiring use of an electronic verification system, the Department must ensure that Medicaid recipients are not denied medically necessary services solely due to a provider's failure to utilize the required system. The Department also must ensure that any transition periods that result from the implementation of the electronic verification system do not impact continuity of care for Medicaid recipients. The Department must provide training and technical support to providers to ensure compliance with the electronic verification system requirements.¹²

System use and exemption

Upon full implementation of the electronic verification system, no nonemergency medical transportation service provider may receive Medicaid payment for services rendered to a Medicaid recipient unless the provider submits all necessary data through the system. The Department must pay a claim for services submitted through the system if (1) all required GPS-based verification and timestamp data are present and (2) no unresolved discrepancies about the claim exist.¹³

The act requires the Department to establish a process by which nonemergency medical transportation service providers can seek an exemption from utilizing the electronic verification

¹⁰ R.C. 5164.401(B); see also R.C. 5164.40(B) and 5164.42(A)(2).

¹¹ R.C. 5164.401(E).

¹² R.C. 5164.401(F).

¹³ R.C. 5164.402(A).

system for (1) equipment failure or network unavailability, including rural connectivity issues, (2) emergencies, or (3) concerns for the safety of a Medicaid recipient. Before granting an exemption, a provider must submit written documentation to the Department detailing why an exemption should be granted. The Department must routinely monitor the number of exemptions requested by a provider.¹⁴

Fraud-detection and cross-reference tools

The act requires the Department to develop and implement automated fraud-detection tools to assist with identifying fraud using the electronic verification system. The fraud-detection tools must be capable of flagging irregular patterns of activity by Medicaid providers that must use the system. Irregular patterns include (1) the seeking and approval of repeated exemptions from the use of the electronic verification system, (2) anomalous and irregular route patterns taken by nonemergency medical transportation service providers, and (3) discrepancies between location data and submitted claims.¹⁵

The Department must conduct periodic audits and investigations concerning data collected through the electronic verification system and fraud-detection tools. The Department may suspend a Medicaid provider agreement for failure to comply with an audit or investigation. Additionally, if an audit or investigation results in a credible allegation of fraud, the act requires the Department to handle that allegation in accordance with continuing law regarding Medicaid fraud and to refer the credible allegation to the Attorney General for investigation.¹⁶

Not later than October 6, 2031, the Department must develop and implement a system by which data received from a provider through the electronic verification system can be cross-referenced with claims for Medicaid payment submitted to the Department by other Medicaid providers. The cross-reference system must be capable of verifying the following information:

- The Medicaid recipient who received nonemergency medical transportation services was transported for the purpose of receiving a Medicaid service;
- The Medicaid recipient who received nonemergency medical transportation services was transported to a Medicaid provider with an active and valid Medicaid provider agreement at the time of transport;
- The records are received within an allowable timeframe and reflect an encounter, claim, or billing activity for a service described above.

The Department must establish an allowable timeframe under which claims for Medicaid payment for transportation services may be cross-referenced and matched against claims for other Medicaid services. The allowable timeframe must account for documented exceptions that

¹⁴ R.C. 5164.402(B) and (C).

¹⁵ R.C. 5164.404(A).

¹⁶ R.C. 5164.36 and 5164.404(B) and (C).

created delays, including provider cancellations, appointment rescheduling, emergency diversions, delayed billing, and administrative errors.¹⁷

Rulemaking

The Department must adopt rules to implement the act's provisions related to the electronic verification of nonemergency medical transportation services. The rules must address technical standards for electronic verification systems including GPS intervals and criteria for certification of electronic verification systems. Additionally, the rules must specify the procedures by which a provider may seek an exemption from electronic verification requirements, the protocols by which the Department will conduct audits and enforcement of electronic verification requirements, and any other standards and procedures that are necessary to implement the requirements described above.¹⁸

EVV dashboard

The act requires the Department to maintain a statewide EVV dashboard, which must be updated at least quarterly. The dashboard must include (1) statewide utilization rates of EVV, (2) rates of successful matching between EVV records and submitted claims for Medicaid payment, (3) provider compliance trends, (4) the percentage of claims that are supported by verified EVV documentation, (5) aggregate statistics regarding manually adjusted EVV entries, and (6) any other metrics that the Department determines appropriate for monitoring compliance, fraud prevention, and program integrity.¹⁹

The Department must make aggregate statewide data available on the Department's website and use information collected and maintained on the dashboard and website to identify providers that may require technical assistance, additional training, corrective action, or program integrity review. The act also permits the Department to (1) provide provider-specific compliance information through a secure provider portal or dashboard and (2) adopt rules to implement the dashboard.²⁰

Nonconsensual tracking exception

Continuing law generally prohibits a person from knowingly installing a tracking device or tracking application on another person's property without the other person's consent or causing a tracking device or tracking application to track the position or movement of another person or another person's property without the other person's consent. The act exempts from this prohibition the use of location verification technology by the Department, a Medicaid provider, a provider's employee or contractor, or an EVV vendor when the technology is used solely to comply with EVV requirements to (1) verify the beginning or ending of a Medicaid-covered service, (2) validate a claim for Medicaid payment, or (3) support the integrity of the Medicaid

¹⁷ R.C. 5164.403(A) and (B).

¹⁸ R.C. 5164.406.

¹⁹ R.C. 5162.17(B).

²⁰ R.C. 5162.17(C) to (E).

Program including through an audit, investigation, payment, or recovery activity. The exception does not apply if the location verification technology is used for continuous tracking outside of the delivery of Medicaid-covered services.²¹

Medicaid provider enrollment

In-person review and site inspection

Continuing law unchanged by the act requires that each person or government entity seeking to provide services to a Medicaid recipient as a Medicaid provider must enter into a provider agreement with the Department.²² The act imposes several requirements on a person or government entity seeking to become a Medicaid provider.

Before entering into a provider agreement with a Medicaid provider seeking initial enrollment as a Medicaid HCBS provider, the act requires the Department to conduct an in-person review of the individual or a site inspection of the entity seeking enrollment. Thereafter, the Department must conduct subsequent in-person reviews or site inspections every three years. The act additionally requires the Department to deny, refuse to revalidate, suspend, or terminate a provider agreement if the Department determines that an individual or entity seeking enrollment as an HCBS provider is principally located at the same address as more than six other active HCBS providers or is principally located at the same address as another HCBS provider when the address contains less than 1,000 square feet of space. The Department must make a referral to the Auditor of State whenever the Department determines that a single address is the principal place of business for more than six HCBS providers.²³

The act also requires the Department to investigate if it determines that an individual or entity seeking initial enrollment as a provider shares the same address or telephone number of a current provider. If necessary, the act requires the Department to deny the provider agreement.²⁴

Disclaimer form and onboarding

The act requires the Department, in coordination with the Attorney General, to establish a disclaimer form that provides an affirmative and explicit explanation of the penalties for Medicaid fraud. The Department must provide each person or government entity seeking to participate in the Medicaid Program as a provider with a copy of the disclaimer form. The act prohibits the Department from entering into a provider agreement with a person or government entity until they have signed and returned the disclaimer form to the Department, acknowledging that they have received and reviewed the form.²⁵ In addition, the act requires the Department to establish a standardized onboarding process for all providers that provides a link to the

²¹ R.C. 2903.216(B)(1) and (D)(10).

²² R.C. 5164.30, not in the act.

²³ R.C. 5164.302.

²⁴ R.C. 5164.331.

²⁵ R.C. 5164.303.

relevant administrative rules that describe the provider agreement requirements for participation in the Medicaid Program.²⁶

Ownership disclosures

As a condition of entering into a provider agreement with the Department or revalidating an existing provider agreement, the act requires each person or government entity to disclose to the Department the identity of each person with at least a 5% direct or indirect ownership interest in the person or entity. The Department must verify all ownership disclosures against (1) the exclusion list maintained by the U.S. Department of Health and Human Services Office of Inspector General, (2) prior Medicaid sanctions imposed by another state, and (3) any prior convictions for fraud that a person may have. The act requires the Department to enter into all necessary agreements with Medicaid MCOs to enable parallel verification by MCOs. The agreements must ensure confidentiality and privacy of all information and data shared in accordance with state and federal law. The act further permits the Department to implement best practices from other states as necessary to implement the requirements described above.²⁷

Suspicious increase in claims

Under the act, the Department must impose a temporary suspension of Medicaid payments and investigate if it determines there is a suspicious increase in the number of claims for payment submitted by a provider in the first 60 days of the provider entering into a provider agreement. The act additionally requires the Department to flag and investigate any time it determines that the number of claims for payment submitted by a provider in a month increases by more than 100% without a corresponding increase in the number of Medicaid enrollees receiving services from the provider.²⁸

Medicaid provider agreement denial, suspension, or termination

Continuing law authorizes the Medicaid Director to (1) deny, refuse to revalidate, suspend, or terminate a provider agreement or (2) exclude an individual, provider of services or goods, or other entity from participation in the Medicaid Program if the Director determines that the action is in the best interests of Medicaid recipients or the state. The act additionally permits the Director to take either of the following actions:²⁹

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

²⁶ R.C. 5164.304.

²⁷ R.C. 5164.305.

²⁸ R.C. 5164.332.

²⁹ R.C. 5164.33(A)(1).

- Deny an application for a provider agreement or refuse to revalidate a provider agreement where the applicant is an owner of, or individual who resides with an owner of, a current or former Medicaid provider whose provider agreement was terminated or suspended by the Department.

The act requires the Director to suspend the provider agreement of any provider that has not submitted a claim for payment to the Department for one year. Additionally, the act provides that whenever the U.S. Centers for Medicare and Medicaid Services imposes a temporary moratorium on new providers or new provider types for the Medicare Program, the Director must issue a similar moratorium and deny all pending applications for provider agreements, including any applications that were pending before the issuance of the moratorium. The act requires the Director to comply with all federal requirements when issuing such a moratorium.³⁰

To the extent permitted under state and federal law, the act requires the Department to share information concerning the Director's decision to deny, refuse to revalidate, suspend, or terminate a Medicaid provider agreement with any other state board or commission responsible for regulating a component of the health care industry. Additionally, the Director may adopt rules to implement the requirements described above.³¹

Medicaid provider revalidation and credentialing

The act specifies that each Medicaid provider agreement expires not later than three years after its effective date, or sooner if determined necessary by the Director. Prior law specified that provider agreements expired five years after their effective date and did not authorize an earlier timeframe if determined necessary by the Director.³²

In addition to holding a valid provider agreement, some Medicaid providers also must go through a credentialing process to demonstrate that the provider holds appropriate licensure. The act requires specified providers and facilities to provide certain information to the Department or the Department's credentialing designee every 24 months as a condition of continued participation in the Medicaid Program. The Department may require a provider or facility to submit the information sooner than every 24 months if required by federal law or if the Director determines that a shorter timeframe is necessary. The act permits the Department to request additional clarifying information at any time during the credentialing or recredentialing process.³³

Providers subject to this requirement include (1) physicians, (2) psychologists, (3) physician assistants, (4) dentists, (5) optometrists, (6) pharmacists, (7) chiropractors, (8) acupuncturists, (9) clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners, (10) licensed independent social workers, licensed independent marriage and family therapists, and licensed professional clinical counselors, (11) licensed independent

³⁰ R.C. 5164.33(A)(2) and (3); see also 42 Code of Federal Regulations (C.F.R.) 424.570 and 455.470.

³¹ R.C. 5164.33(E) and (F).

³² R.C. 5164.32(A).

³³ R.C. 5164.292(A), (D), and (E).

chemical dependency counselors, (12) certified Ohio behavior analysts, (13) audiologists and speech-language pathologists, (14) occupational therapists and physical therapists, and (15) dietitians. These professionals must provide the Department or the Department's credentialing designee with the following information:³⁴

- Not later than 180 days before the credentialing date, access to the standard credentialing application form used by the Council for Affordable Quality Healthcare;
- Active provider licensing information and if applicable, board certification;
- Educational background;
- If applicable, clinical privileges;
- Medical malpractice insurance;
- If applicable, U.S. Drug Enforcement Administration certification;
- National Practitioner Data Bank information regarding malpractice and clinical privilege actions;
- Sanctions or limitations on licensure;
- If applicable, eligibility for Medicare or Medicaid.

The act further subjects specified facilities to credentialing requirements. These facilities include (1) nursing facilities, (2) hospitals, (3) hospice care programs, (4) home health agencies, (5) ambulatory surgical facilities, (6) community mental health services providers and community addiction services providers, (7) freestanding dialysis centers and freestanding radiation therapy centers, and (8) Class 1, 2, and 3 residential facilities licensed by the Department of Behavioral Health. They must provide the Department or the Department's credentialing designee with the following information as part of the credentialing process:³⁵

- The Department of Insurance Standardized Credentialing Form Part B;
- Active provider licensing information;
- Certification through an accrediting body or a site visit completed by a state designated agency;
- If applicable, eligibility for participation in Medicare or Medicaid;
- Verification of good standing with applicable state and federal bodies;
- Active malpractice insurance.

³⁴ R.C. 5164.292(B).

³⁵ R.C. 5164.292(C).

Medicaid payments

Alternative payer evaluation

Before issuing any payment for Medicaid services, the act requires that the Department electronically evaluate all claims to determine whether an alternative primary insurance coverage source exists that is responsible for payment of the claim. For purposes of the act, an alternative primary insurance coverage source is an insurance coverage source that is not the Medicaid Program.³⁶ When conducting its evaluation, the Department must use automated algorithmic analysis and insurance discovery engines that are capable of identifying alternative primary insurance coverage sources that may be associated with a Medicaid recipient. If an alternative primary insurance coverage source is identified, the act requires that the submitted claim be redirected to the identified alternative source before any Medicaid payment is made. The act prohibits the Department or a Medicaid MCO from issuing payment for a claim unless the evaluation described above has been conducted. The act requires the Department to adopt rules to implement the evaluation requirements, including standards for approved discovery engines, timelines for claims processing, and reporting requirements.³⁷

Collection of overpayment

Continuing law generally permits the Department to recover a Medicaid payment made to a provider to which the provider was not entitled by giving notice of the overpayment within the five-year period immediately following the end of the state fiscal year in which the overpayment was made. The act requires the Department to recover overpayments when an audit determines and verifies an impossible claim submitted by a provider. An impossible claim includes submitting a claim for in-home care services on a date the recipient was in the hospital or to recipients located at different addresses at the same time.³⁸

Medicaid eligibility

The act provides that no individual is eligible to participate in the Medicaid Program in Ohio unless they are eligible to participate in the Medicaid Program based on federal law concerning lawful residency. Federal law provides that, beginning October 1, 2026, federal Medicaid payments will not be made for medical assistance provided to an individual who is not a resident of a state or territory of the United States and is not (1) a citizen or national of the United States, (2) an alien lawfully admitted for permanent residence, (3) an alien granted the status of a Cuban and Haitian entrant, or (4) an individual lawfully residing in the United States in accordance with the Compact of Free Association.³⁹

³⁶ R.C. 5162.19(A).

³⁷ R.C. 5162.19(C) to (F).

³⁸ R.C. 5164.57(A)(1) and (E).

³⁹ R.C. 5163.05; 42 U.S.C. 1396b(v)(5).

Family caregiver oversight

The act requires the Department to establish oversight mechanisms for services provided by a family caregiver under a Medicaid HCBS waiver. The oversight may include (1) quarterly audits, (2) enhanced check-in reviews, (3) annual recertification as a Medicaid provider, (4) independent case manager verification, (5) caps on the hours of compensated care absent documented medical necessity, (6) forensic review triggers, and (7) background check monitoring in accordance with continuing law. In addition to the oversight mechanisms described above, the act permits the Department to require a family caregiver who is considered high risk or who has repeatedly violated established requirements concerning family caregivers to provide services through a waiver agency rather than as an independent provider.⁴⁰

Prior authorization for Medicaid services

Personal care services

Under the act, the Department must generally require prior authorization for personal care services provided under the Medicaid Program when the services that are requested exceed the amount or scope of services described in a written plan of care or individual service plan. For purposes of this requirement, “personal care services” means any Medicaid service that assists a recipient who is not an inpatient in a hospital or a resident or a nursing facility or intermediate care facility for individuals with intellectual disabilities with activities of daily living, instrumental activities of daily living, supervision, homemaker tasks, attendant care, personal support services, or substantially similar in-home support services that are not medical services. The requirement does not apply to personal care services provided under a Medicaid waiver administered by the Department of Developmental Disabilities.⁴¹

The act requires an independent provider or waiver agency employee to submit a signed and dated request for prior authorization for personal care services. An independent provider must submit a request directly to the Department while a waiver agency employee must submit the request to the waiver agency, which will submit the request to the Department. As part of the request, the independent provider or waiver agency must submit supporting documentation that provides evidence that the requested services are medically necessary and whether the services are urgent care services.⁴²

The Department must notify the independent provider or waiver agency within ten business days of receiving a prior authorization request whether additional information is needed to make a determination. If so, the provider or agency must submit that information to the Department within five business days of receiving notification. Within ten business days of receiving all information, the Department must make a prior authorization determination;

⁴⁰ R.C. 5164.41(B) and (C).

⁴¹ R.C. 5164.13(A)(2), (B), and (I).

⁴² R.C. 5164.13(C).

however, if the request is for urgent care services, the Department must review it and make a determination within 48 hours.⁴³

When making a determination concerning a prior authorization request for personal care services, the act requires the Department to determine whether the services requested are medically necessary. The act requires the Department to determine that the services are medically necessary if the services (1) are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes, (2) are of an appropriate type, amount, duration, scope, and intensity, (3) are the most efficient, effective, and lowest cost alternative that, when combined with other services, ensure the health and welfare of the individual receiving the services, and (4) protect the individual from substantial harm expected to occur if the requested services are not authorized.⁴⁴

After reviewing all information submitted, the Department must approve the request, deny the request, or approve the request in part. The Department must provide written notice of its determination to the independent provider or waiver agency and update the prior authorization status to reflect its determination. If the Department denies a request, the affected individual, independent provider, or waiver agency may appeal the Department's decision. The act requires the Department to adopt rules to implement the procedures described above.⁴⁵

Therapeutic behavioral services

The act requires the Department to impose a prior authorization requirement on all therapeutic behavioral services provided under the Medicaid Program.⁴⁶

Medicaid fraud

Credible allegations of fraud

Federal regulations require state Medicaid agencies to suspend payments to a Medicaid provider on the identification of a credible allegation of fraud. Continuing law relies on the federal definition of "credible allegation of fraud," which includes any allegation that has been verified by the state from any source.⁴⁷ The act expands the definition to include falsified or fake check-ins, forged paperwork, double billing for Medicaid services, identity misuse, impossible travel patterns, claims that overlap with a hospital stay that are not provided in accordance with an authorized individual service plan, and coordinated billing rings.⁴⁸

Subject to federal requirements, whenever the Attorney General or Auditor of State submits a credible allegation of fraud with evidence to the Department, the act requires the Department to (1) suspend Medicaid payments to the provider in whole, in part, or as applied to

⁴³ R.C. 5164.13(D).

⁴⁴ R.C. 5164.13(E).

⁴⁵ R.C. 5164.13(F), (G), (H), and (J).

⁴⁶ R.C. 5164.12.

⁴⁷ 42 C.F.R. 455.2 and 455.23.

⁴⁸ R.C. 5164.36(A)(1).

targeted payments, and (2) require prepayment review of claims. If the Department suspends Medicaid payments based on the submission of a credible allegation of fraud by the Attorney General or Auditor, the Medicaid provider or owner (if the provider is not an institution) is entitled to a hearing and independent administrative review of the suspension. Payments remain suspended until the completion of the administrative review. The act requires the Department to adopt rules establishing expedited appeal procedures for purposes of the administrative review.⁴⁹

Criminal penalties

The act modifies the criminal penalties associated with the crime of Medicaid fraud. Under prior law, Medicaid fraud was established as a first degree misdemeanor and depending on the value of the property, services, or funds obtained, could rise to a third degree felony. The act establishes Medicaid fraud as a fifth degree felony and requires a court to impose a fine of \$1,000. Additional Medicaid fraud penalties are specified as follows:⁵⁰

- If the value of the property, services, or funds obtained is more than \$1,000 but less than \$7,500, Medicaid fraud is a fourth degree felony and a court must impose a fine of \$5,000;
- If the value is at least \$7,500 but less than \$75,000, Medicaid fraud is a third degree felony and a court must impose a fine of \$25,000;
- If the value is at least \$75,000 but less than \$150,000, Medicaid fraud is a third degree felony and there is a presumption of a prison term, and a court must impose a fine of \$75,000;
- If the value of the property, services, or funds obtained is at least \$150,000 but less than \$750,000, Medicaid fraud is a second degree felony and there is a presumption of a prison term, and a court must impose a fine of \$150,000;
- If the value of the property, services, or funds obtained is at least \$750,000, Medicaid fraud is a first degree felony and there is a presumption of a prison term, and a court must impose a fine of \$150,000.

Corrupt activity

The act adds the offense of Medicaid fraud to the list of offenses that constitute “corrupt activity” under Ohio’s Corrupt Activities Law, under specified circumstances.⁵¹

A person who engages in a “pattern of corrupt activity” may be subject to criminal penalties and fines, property forfeiture, a civil proceeding from a person seeking relief, and a corrupt activity lien. Under continuing law, “corrupt activity” means engaging in, attempting to engage in, conspiring to engage in, or soliciting, coercing, or intimidating another person to engage in: (1) any of a list of offenses specified in the law, with some of the offenses being

⁴⁹ R.C. 5164.36(B)(3), (B)(4)(e) and (I), and (D)(2).

⁵⁰ R.C. 2913.40(E).

⁵¹ R.C. 2923.31(I)(2)(c).

included only when they occur in limited, specified circumstances, (2) any conduct constituting an offense in another state that is substantially similar to any offense included under clause (1), if the defendant was convicted of the conduct in the other state, or (3) “racketeering activity” under federal law, animal or ecological terrorism, or certain organized retail theft conduct.⁵²

The act expands the list of specified offenses to also include the offense of Medicaid fraud when the proceeds of the violation, the payments made in the violation, the amount of a claim for payment or for any other benefit that is false or deceptive and that is involved in the violation, or the value of the contraband or other property illegally possessed, sold, or purchased in the violation exceeds \$1,000.⁵³

Medicaid fraud employment protections

The act prohibits an employer from discharging, demoting, reassigning, or taking any punitive action against an employee who, based on reasonable belief, submitted a good faith report that an instance of fraud occurred in the Medicaid Program. The act further permits an employee who alleges their employer has taken an action described above to commence an action in any court of competent jurisdiction for reinstatement with back pay, if the action is based on discharge, or for equitable relief, and reasonable attorney’s fees.⁵⁴

Use of automated review tools

The act specifies that if the Department utilizes automated review tools when implementing its provisions, the Department must ensure that (1) no action is taken automatically without human review that results from the automated review tool’s determination or decision, and (2) the appropriate Department employee responsible for overseeing the determination or decision has reviewed the findings of the automated review tool to confirm that the tool made the correct determination or decision. For purposes of this requirement, the act defines an “automated review tool” to include artificial intelligence, automated fraud detection tools, automated algorithmic analysis, or any other electronic automated review tool, system, or service.⁵⁵

Medicaid MCOs

Payment integrity actions

The act permits each Medicaid MCO to implement reasonable and timely payment integrity actions on the identification of credible indicators of fraud, waste, or abuse. These actions may include payment suspension and prepayment review and denial.⁵⁶

⁵² R.C. 2923.31(I); R.C. 2923.32, 2923.34, and 2923.36, not in the act.

⁵³ R.C. 2923.31(I)(2)(c).

⁵⁴ R.C. 5164.43(B) and (C).

⁵⁵ R.C. 5162.90 and 5164.11.

⁵⁶ R.C. 5167.23(B).

The act prohibits a Medicaid MCO from initiating prepayment review for a Medicaid provider without first obtaining approval from the Department. If initiated, the act permits a prepayment review to remain in effect for longer than six months without being renewed. The act further provides that a Medicaid MCO may place a provider the MCO determines to be a suspected high-risk provider on claims payment suspension during any open investigation or stand-down period. The Medicaid MCO must notify and obtain approval from the Department or the Attorney General before implementing claims payment suspension.⁵⁷

If a Medicaid MCO places a provider on prepayment review or claims payment suspension as described above, the MCO must give the affected provider written notice and an opportunity to participate in the Medicaid MCO's established grievance process. Upon completion of any grievance process, an affected provider may appeal the decision to the Department.⁵⁸

If a Medicaid MCO initiates payment integrity actions, it must complete all applicable deconfliction procedures required by the Department. The act defines "deconfliction" as the systematic coordination between a Medicaid MCO and multiple state and federal oversight agencies to (1) share investigative data, (2) eliminate overlapping inquiries, and (3) streamline the prosecution of fraudulent Medicaid providers. An MCO may take a payment integrity action before deconfliction is complete when doing so is necessary to prevent continued improper payments and to mitigate a program integrity risk. The act additionally requires an MCO to maintain documented evidence of credible indicators of fraud, waste, and abuse that are the basis of an action described above and ensure that all actions taken are consistent with state and federal law.⁵⁹

Reporting fraud, waste, and abuse

The act requires each Medicaid MCO to report to the Department credible evidence of fraud, waste, or abuse, or materially inconsistent billing. The Department must refer potential fraud to the Attorney General in a timely manner for investigation.⁶⁰

Enrollment benchmarks

Until April 6, 2028, the act imposes requirements concerning the enrollment of Medicaid recipients into managed care and distribution of enrollees among the Medicaid MCO plans. During this period, the Department must ensure that each Medicaid MCO plan enrolls at least 10% of the total number of participants participating in managed care.⁶¹

⁵⁷ R.C. 5167.23(C)(1) and (2).

⁵⁸ R.C. 5167.23(C)(3).

⁵⁹ R.C. 5167.23(A), (D), and (E).

⁶⁰ R.C. 5167.18.

⁶¹ R.C. 5167.03(E).

Reports

EVV utilization and compliance

The act requires the Department of Medicaid to submit an annual report to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the Auditor of State regarding EVV utilization and compliance for the immediately preceding calendar year. The report must be submitted not later than March 1 annually. At a minimum, the report must include all of the following information:

- Provider utilization and compliance rates;
- The number and percentage of claims or service visits with complete EVV data;
- The number and percentage of claims or service visits with missing, incomplete, manually entered, modified, or unmatched EVV data;
- The number of claims denied or paid due to EVV compliance status;
- Compliance trends by provider type and geographic region;
- Enforcement or corrective actions taken by the Department;
- Any recommendations to improve EVV utilization, compliance, payment integrity, and fraud prevention.

Not later than 30 days after submitting the report, the Department must make it publicly available on the Department's website, but the Department must redact any information that is confidential under state or federal law or would otherwise compromise an ongoing audit, investigation, or enforcement action. The act further specifies that nothing described above is to be construed to limit the authority of the Auditor of State under continuing law.⁶²

Nonemergency medical transportation electronic verification

In addition to the report above that applies to EVV generally, the act requires the Department to submit an annual report to the General Assembly detailing the electronic verification system for nonemergency medical transportation services. The report must include:⁶³

- The verified number of service claims submitted through the electronic verification system;
- The number of claims denied or recouped;
- The number of cases of fraud referred to the Attorney General's Medicaid Fraud Control Unit as a result of electronic verification systems;
- The number of provider sanctions issued from electronic verification system data;

⁶² R.C. 5162.139.

⁶³ R.C. 5164.405.

- The total amount of cost savings to the Medicaid Program achieved from electronic verification systems;
- Any impacts to Medicaid recipient access to services from the system;
- Any additional information or data the Department considers relevant.

Medicaid encounter data system and risk matrix

The act requires the Department, not later than March 31, 2027, to prepare and submit a report to the General Assembly regarding the creation of a Medicaid encounter data system and a risk matrix that may be used to connect individuals with national provider identifier records associated with providers. The report must examine the operation of a potential Medicaid encounter data system and risk matrix, including the scope of work required by the Department to operationalize them.⁶⁴

Medicaid integrity

The act requires the Department to annually prepare and submit a report to the chairperson and ranking member of the committees of the House of Representatives and Senate that have jurisdiction over Medicaid that details the Department's efforts to ensure integrity within the Medicaid Program.⁶⁵

Billing codes

The act requires the Department to prepare and submit an annual report to the General Assembly that details any Medicaid billing codes that represent an increase or decrease of greater than 50% in the utilization rate or total expenditures for a particular service from the previous state fiscal year. As part of the report, the Department also must provide data concerning any identified billing code or utilization rate or expenditure data for an identified service for the five years preceding the report.⁶⁶

Cost estimate

Not later than November 5, 2026, the Department of Medicaid must submit a report to the General Assembly with a cost estimate to implement the act's requirements. The report must include a comparison of state funds and expected matching federal funds necessary to develop, procure, certify, or approve an EVV system and the expected cost savings for the Medicaid Program that will result from implementing the system.⁶⁷

General Assembly review of Medicaid waivers

The act requires the standing committees of the House and Senate that primarily consider legislation governing Medicaid to jointly meet annually and conduct a review of one-quarter of

⁶⁴ Section 4.

⁶⁵ R.C. 5162.138.

⁶⁶ R.C. 5162.1311.

⁶⁷ Section 3.

Ohio's Medicaid waivers. The review must focus on each waiver's purpose and evaluate each waiver's success at achieving its desired purpose. The act requires the standing committees to review all of the Medicaid waivers before conducting a subsequent review of any waiver.⁶⁸

All-payer claims database

The act requires the Superintendent of Insurance to establish and administer an all-payer claims database by October 6, 2027. Each payer, which includes a health plan issuer, a Medicaid MCO, the Medicaid Program, and the Medicare Program, must submit its claims to the Superintendent for inclusion in the database, but only to the extent permitted by federal law. With respect to health plan issuers, the requirement is delayed until January 1, 2028. When submitting claims, a payer must do so in the format and according to the schedule prescribed by the Superintendent in rule.⁶⁹

In addition to establishing and administering the database, the act requires the Superintendent to include in it any claim received from a payer. The Superintendent must make the database's claims information available to any person or government entity and may require a person to obtain a subscription with the Department of Insurance to access included information in accordance with Ohio's Public Records Law.⁷⁰

The Superintendent must adopt rules establishing standards and procedures for the following:⁷¹

- Submitting claims for inclusion in the database, including the prescribed format and schedule;
- Maintaining the privacy and security of personal and health information contained in claims;
- Making information in the database available;
- Imposing penalties when claims are not submitted.

The Superintendent may adopt any other rule considered necessary to implement the act's requirements. Rules must be adopted in accordance with Ohio's Administrative Procedure Act. The act exempts its rulemaking provisions from existing law establishing limits on the number of regulatory restrictions a state agency may have in effect.⁷²

⁶⁸ R.C. 103.413.

⁶⁹ R.C. 3901.93(A)(2), (3), and (4) and (B)(1) and (2); see also R.C. 3922.01(P), not in the act.

⁷⁰ R.C. 3901.93(B)(3) and (4); R.C. 149.43, not in the act.

⁷¹ R.C. 3901.93(C).

⁷² R.C. 3901.93(D); R.C. 121.95 to 121.953, not in the act.

Auditor of State

Subpoena authority

The act authorizes the Auditor of State to issue subpoenas compelling the production of books, records, accounts, documents, electronically stored information, testimony, or other information that is relevant to any audit, examination, special audit, investigation, or review within the authority of the Auditor of State. The act further requires that the Attorney General, on the request of the Auditor, bring an action in a court of competent jurisdiction to enforce compliance with any subpoena issued.⁷³

State employee fraud reporting

Continuing law requires that all state officials and employees of a state agency must report alleged fraud, theft in office, or the misuse or misappropriation of public money by a state official or employee. Under prior law, these reports were required to be made to the Inspector General, except in the case of employees of the General Assembly, a court, or statewide elected officials. The act instead requires that all state officials and employees make these reports to the Auditor of State's fraud reporting system; however, it permits an official or employee of the Auditor to report to the Inspector General. The act specifies that these provisions do not prohibit either the Auditor or Inspector General from referring a report to another office when appropriate.⁷⁴

Attorney General investigations

Continuing law authorizes the Attorney General to conduct investigations concerning improper activity related to the Medicaid Program or the regulation of long-term care facilities. In carrying out this authority, the act permits the Attorney General to administer oaths, subpoena witnesses, adduce evidence, and subpoena the production of any book, document, or other relevant matter. If the Attorney General subpoenas the production of relevant matter located outside Ohio, the act permits the Attorney General to designate a representative to inspect the matter on the Attorney General's behalf. That representative may be an official of the state where the matter is located. Additionally, the act authorizes the Attorney General to carry out similar requests received from officials of other states. Any person who is subpoenaed as described above must make the relevant matter available at a convenient location.⁷⁵

The act further provides that any person subpoenaed as a witness to produce relevant matter may file a petition in Franklin County, the county where the person lives, or the county where the person's principal place of business is located to (1) extend for good cause the date on which the subpoena is to be returned or (2) modify or quash the subpoena. The person may file

⁷³ R.C. 117.10(F).

⁷⁴ R.C. 4113.52(A)(1)(a).

⁷⁵ R.C. 109.85(A) and (B).

the petition at any time before the date specified for the return of the subpoena or not later than 20 days after the service of the subpoena, whichever is earlier.⁷⁶

The act requires any person who is subpoenaed to comply with the terms of the subpoena unless a court orders otherwise. If a person fails without lawful excuse to obey a subpoena, the Attorney General may apply to the court for an order that (1) compels the requested discovery, (2) finds the person in contempt of court, and (3) grants other relief that may be required until the person obeys the subpoena. If the court finds that the person's failure to comply with a subpoena was in bad faith or for the purpose of delay, it may order the person to pay reasonable expenses incurred by the Attorney General in obtaining the order. These expenses may include attorney's fees and sanctions under the Rules of Civil Procedure.⁷⁷

Designation

The act designates the provisions described above as the "Medicaid Program Integrity and Fraud Prevention Act."⁷⁸

Enhanced Cybersecurity for SNAP Act

The Supplemental Nutrition Assistance Program (SNAP) assists low-income households with purchasing food. Households participating in SNAP receive monthly benefit allotments that are provided through an electronic benefit transfer (EBT) card, which can be used to purchase food in a similar manner to a debit card. In Ohio, the EBT card is known as the Ohio Direction Card.⁷⁹

Beginning October 6, 2026, ODJFS must begin the transition to chip-enabled EBT cards. It must ensure that all newly issued EBT cards are chip-enabled and must replace existing cards with chip-enabled cards under ODJFS's ordinary timeframe for replacing cards. Additionally, the act requires the Director to ensure that the ODJFS website contains a mechanism that allows SNAP participants to report fraudulent transactions.⁸⁰

The act designates these SNAP-related provisions as the "Enhanced Cybersecurity for SNAP Act."⁸¹

⁷⁶ R.C. 109.85(C).

⁷⁷ R.C. 109.85(D) and (E).

⁷⁸ Section 5.

⁷⁹ Ohio Department of Job and Family Services, [What is the Ohio Direction Card](#).

⁸⁰ R.C. 5101.542(D) and 5101.5411.

⁸¹ Section 5.

HISTORY

Action	Date
Introduced	11-04-25
Reported, S. Finance	05-20-26
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