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Substitute Bill Comparative Synopsis

Sub. H.B. 795

136th General Assembly

House Medicaid

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This table summarizes how the latest substitute version of the bill differs from the immediately preceding version. It addresses only the topics on which the two versions differ substantively. It does not list topics on which the two bills are substantively the same.

Topic	Previous Version (As Introduced)	Latest Version (I_136_3280)
Electronic verification of in-home personal care services	Requires the Department of Medicaid to develop, procure, certify, or approve one or more systems from the electronic verification of in-home personal care services (R.C. 5164.40 to 5164.406).	Instead requires that the electronic verification system be for in-home care services, which is defined to include: <ul style="list-style-type: none">▪ Personal care services;▪ Home health services covered as part of the home health services benefit;▪ Services provided under a Medicaid home- and community-based services waiver component;

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	<p>Requires that an electronic verification system developed, procured, certified, or approved under the bill be capable of performing specified functions (R.C. 5164.401(B)(1) and (2)).</p> <p>No provision.</p> <p>No provision.</p> <p>No provision.</p>	<ul style="list-style-type: none"> ▪ Any other services that are provided to a Medicaid recipient in either a residential or community setting. (R.C. 5164.40(E), 5164.401 to 5164.407.) <p>Additionally 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 being provided (R.C. 5164.401(B)(3)).</p> <p>Requires the Department to establish a verification system under which high risk in-home care service providers are required to verify data regarding the services provided (R.C. 5164.404(A)).</p> <p>Requires the Department to establish criteria for classifying high risk providers that includes (1) repeated mismatches in check-in data, (2) data that indicates impossible travel times, (3) claims data that overlaps with a Medicaid recipient's stay in a hospital, (4) unusual outliers in billing data, and (5) other data indicators that demonstrate a high risk for fraud (R.C. 5164.404(B)).</p> <p>As part of the verification system, requires high risk providers to utilize fingerprint scanning, facial recognition, vocal</p>

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	No provision.	<p>recognition, a secure personal identification number, or other approved verification method as a condition of receiving payment for services provided under the Medicaid program (R.C. 5164.404(C)).</p> <p>Prohibits the Department from selling or otherwise distributing data collected or transmitted through a verification system (R.C. 5164.404(D)).</p>
Electronic visit verification	No provision.	<p>Requires the Department of Medicaid to require each claim for a service subject to electronic visit verification requirements under state and federal law be supported by a validated electronic visit verification record as a condition of payment (R.C. 5164.42(B)).</p> <p>Requires the Department to establish standards and procedures for matching claims to electronic visit verification records and the data elements necessary to validate that a 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 service, (4) the location of service delivery, (5) the individual providing the service, and (6) the time the service began and ended (R.C. 5164.42(B)).</p>

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	No provision.	Permits the Department to establish performance benchmarks or minimum compliance thresholds related to (1) electronic visit verification utilization, (2) matching accuracy, (3) manual entry rates, (4) modified visit rates, (5) late visit entry rates, and (6) unmatched claim rates (R.C. 5164.42(D)).
	No provision.	Permits the Department to deny, suspend, defer, or recoup payment for a claim that is not supported by a validated electronic visit verification record after the Department has provided an affected provider with notice, training, technical assistance, and compliance education (R.C. 5164.42(C)).
	No provision.	Specifies that nothing in the provisions described above prohibits the Department, Auditor of State, Attorney General, or 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 (R.C. 5164.42(F)).
	No provision.	Authorizes the Medicaid Director to adopt rules to implement the requirements described above, including (1) claim validation procedures, (2) standards for verified electronic visit verification records,

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	<p>No provision.</p> <p>No provision.</p>	<p>technical assistance, additional training, corrective action, or program integrity review (R.C. 5162.17(C) and (D)).</p> <p>Exempts the use of location verification technology from the continuing law prohibition against installing a tracking device or tracking application on another person's property without consent when used by the Department, a Medicaid provider or the provider's employee or contractor, or electronic visit verification vendor when used solely to comply with electronic visit verification requirements (R.C. 2903.216(D)(10)).</p> <p>By March 1 of each year, requires the Medicaid Director to submit a report to the Governor, the Speaker of the House of Representatives, Senate President, and Auditor of State regarding electronic visit verification utilization and compliance and make the report publicly available on the Department's website 30 days after submitting the report (R.C. 5162.139).</p>
Medicaid provider enrollment	No provision.	Requires the Department of Medicaid to conduct an in-person review of an individual or site inspection of an entity before enrolling the provider in the Medicaid program as a

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	No provision.	home- and community-based services provider (R.C. 5164.302(A)).
	No provision.	Thereafter, requires the Department to conduct subsequent in-person reviews or site inspections every three years (R.C. 5164.302(A)).
	No provision.	
	No provision.	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 a provider of home- and community-based services under the Medicaid program is principally located at the same address as two other existing home- and community-based services Medicaid providers or is principally located at the same address as another home- and community-based services Medicaid provider when the address contains less than one thousand square feet of space (R.C. 5164.302(B)).
	No provision.	
	No provision.	Requires the Department to work with the Auditor of State whenever it is determined that a single address is the principal place of business for more than two home- and community-based services Medicaid providers (R.C. 5164.302(C)).

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	No provision.	Requires the Department to conduct an investigation if it determines that an individual or entity seeking initial enrollment as a provider shares the same address, business signage, or telephone number (R.C. 5164.331).
	No provision.	Requires the Department to impose a temporary suspension of payment and conduct an investigation if the Department determines there is a suspicious increase in the number of claims for payment submitted by a provider in the first 60 days of the provider entering into a provider agreement with the Department (R.C. 5164.332(A)).
	No provision.	Requires the Department to flag and investigate any time the Department determines that the number of claims for payment submitted by a provider in a month increases by more than 100% without a corresponding increase in the number of Medicaid enrollees receiving services from the provider (R.C. 5164.332(B)).
Family caregiver oversight	No provision.	Requires the Department to establish oversight mechanisms concerning services provided by a family caregiver under a home- and community-based services Medicaid waiver component (R.C. 5164.41(B)).

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	No provision.	Permits the Department to require a family caregiver who the Department considers to be high risk or a repeat violator of the Department's family caregiver requirements to provide services through a waiver agency rather than as an independent provider (R.C. 5164.41(C)).
Provider revalidation and credentialing	<p>No provision.</p> <p>No provision.</p> <p>No provision.</p>	<p>Requires the Department to require specified Medicaid providers and facilities to provide the Department or Department's credentialing designee with specified information every 24 months (R.C. 5164.292(A) to (C)).</p> <p>Authorizes the Department to require a provider or facility to provide information sooner than every 24 months if required under federal law or if the Medicaid Director determines that a shorter timeframe is necessary (R.C. 5164.292(D)).</p> <p>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 (rather than five years under current law) (R.C. 5164.32).</p>
Provider agreement denial or termination	No provision.	Requires the Medicaid Director to deny, refuse to revalidate, suspend, or terminate

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	<p>No provision.</p> <p>No provision.</p>	<p>the Medicaid provider agreement of any provider that has not submitted a claim for payment to the Department for a period of one year (R.C. 5164.33(A)(2)).</p> <p>Requires the Medicaid Director to issue a moratorium and deny all pending applications for provider agreements when a moratorium against new providers in the Medicaid program is issued under federal law (R.C. 5164.33(A)(3)).</p> <p>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 board or commission responsible for regulating a component of the health care industry (R.C. 5164.33(E)).</p>
Medicaid fraud	No provision.	<p>Modifies the existing law penalties for Medicaid fraud as follows:</p> <ul style="list-style-type: none"> ▪ Establishes Medicaid fraud as a fifth degree felony (rather than a first degree misdemeanor); ▪ Enhances the penalty level as follows if the value of the property, services,

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	No provision.	<p>or funds meets certain dollar amounts:</p> <ul style="list-style-type: none"> ▫ For amounts greater than \$1,000 and less than \$5,000, a fourth degree felony; ▫ For amounts greater than \$5,000 and less than \$25,000, a third degree felony; ▫ For amounts greater than \$25,000 and less than \$75,000, a third degree felony with a presumption for a prison term; ▫ For amounts greater than \$75,000 and less than \$150,000, a second degree felony, and if a court imposes a prison term, it must impose a mandatory prison term for a second degree felony under continuing law; ▫ For amounts greater than \$150,000, a first degree felony, and if a court imposes a prison term, it must impose a mandatory prison term for a first degree felony under continuing law. <p>(R.C. 2913.40(E)(1) and 2929.01.)</p> <p>Additionally permits a court to require a person who commits Medicaid fraud to pay</p>

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	No provision.	restitution in an amount not to exceed 200% of the value of the property, services, or funds obtained and that restitution amounts must be paid to the Medicaid Program Integrity Fund (R.C. 2913.40(E)(2)).
	No provision.	Expands the definition of "credible allegation of fraud" for purposes of the Medicaid program enforcement to include (1) falsified or fake check-ins, (2) forged paperwork, (3) double billing for Medicaid services, (4) identity misuse, (5) impossible travel patterns, (6) hospital-overlap claims, and (7) coordinated billing rings (R.C. 5164.36(A)(1)).
	No provision.	Upon a credible allegation of fraud submitted to the Department by the Attorney General, requires the Department to suspend the provider agreement and Medicaid payments of a provider either in whole or in part and requires the Department to adhere to any recommendation issued by the Attorney General (R.C. 5164.36(B)(3)).
	No provision.	Specifies that suspension of a provider agreement or payment described above may be in whole, in part, targeted to specified payments to a provider, or require pre-payment review (R.C. 5164.36).

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	No provision.	If a Medicaid provider agreement or payment is suspended as described above, entitles the provider or owner to a hearing and independent administrative review of the suspension not later than ten business days after the suspension takes effect and specifies that a suspension remains in effect while the administrative review occurs (R.C. 5164.36(B)(4)(e) and (D)(2)).
Medicaid Program Integrity Fund	<p>No provision.</p> <p>No provision.</p> <p>No provision.</p>	<p>Establishes the Medicaid Program Integrity Fund within the state treasury and specifies that the fund consists of all monies recovered as a result of Medicaid fraud including restitution, civil settlements, forfeitures, and any other fraud-related recoveries (R.C. 109.852).</p> <p>Authorizes the Attorney General to use money from the fund for fraud enforcement, fraud analytics, whistleblower administration, verification oversight, and program integrity operations (R.C. 109.852).</p> <p>Declares that it is the intent of the General Assembly to create the fund as a mechanism for providing funding for Medicaid fraud investigation that does not require general revenue funds (R.C. 109.852(B)).</p>

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Medicaid fraud employment protections	No provision. No provision.	Prohibits an employer from retaliating against an employee because the employee made a good faith report that, based on a reasonable belief, Medicaid fraud has occurred (R.C. 5164.43(B)). Authorizes an employee alleging an employer has violated the bill's retaliation prohibition to sue the employer for reinstatement with back pay, or for equitable relief, together with reasonable attorney's fees (R.C. 5164.43(C)).
Collection of overpayment	No provision.	Requires the Department to recover all overpayments to a provider when an audit determines and verifies an impossible claim submitted by a provider (R.C. 5164.57(E)).
Alternative payment evaluation	No provision. No provision.	Prior to the issuance of any payment on a claim for services provided under the Medicaid program, requires the Department to electronically evaluate all claims using automated algorithmic analysis and insurance discovery engines to determine whether an alternative primary coverage source exists (R.C. 5162.19(A) and (B)). If an alternative primary insurance coverage source is identified, requires the claim for payment to be redirected to the identified

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Therapeutic behavioral services	No provision.	<p>coverage source prior to any Medicaid payment being issued (R.C. 5162.19(D)).</p> <p>Requires the Department to impose a prior authorization requirement on all therapeutic behavioral services that are provided under the Medicaid program (R.C. 5164.12).</p>
General Assembly review of Medicaid waivers	No provision.	<p>Requires the standing committees of the House and Senate that primarily consider Medicaid legislation to meet jointly on an annual basis to conduct a review of ¼ of the Medicaid waiver components within the Medicaid program (R.C. 103.413).</p> <p>Requires the committees to conduct a review of all Medicaid waiver components before conducting a subsequent review of any waiver component (R.C. 103.413).</p>
Billing codes annual report	No provision.	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% for a particular service from the previous year and include data from the preceding five years concerning the billing code or service (R.C. 5162.1311).
Risk matrix	No provision.	Requires the Department to contract with a vendor to establish a risk matrix to connect individuals with the National Provider

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	No provision.	<p>Identifier records associated with providers (R.C. 5162.18).</p> <p>Requires the matrix to include identity proofing, financial distress among providers, and information concerning a provider's ties to a foreign organization (R.C. 5162.18).</p>
Medicaid Encounter Data System	<p>No provision.</p> <p>No provision.</p>	<p>Requires the Department of Medicaid to establish and maintain a database of Medicaid encounter data submitted by Medicaid managed care organizations (MCOs)(R.C. 5162.85 and 5162.86).</p> <p>For each Medicaid managed care plan, requires the plan's Medicaid MCO to submit certain information to the Department on a quarterly basis, including its (1) total number of services rendered, (2) total spending on medical claims, nonclaims expenditures, and nonbenefit services, (3) total spending on pass-through payments and state directed payments by a Medicaid provider, (4) total spending, including funds from state and federal sources, (5) total number and share of enrollees receiving care in an emergency room, (6) total claims and spending on services delivered in an emergency room, (7) total spending on services delivered by a subcontractor, provider or Medicaid managed care organization's related party, by service type, (8) total spending on</p>

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	<p>No provision.</p> <p>No provision.</p>	<p>prescription drugs for each National Drug Code Identifier, and (9) total number and share of enrollees who did not file any claims (R.C. 5162.86(A)).</p> <p>Requires each Medicaid MCO to submit to the Department complete copies of all data, reports, and disclosures that the MCO submits to the federal Centers for Medicare and Medicaid Services (R.C. 5162.86(B)).</p> <p>Establishes requirements on the Department regarding future contract terms with MCOs, to prepare reports of MCO submissions, and to make submissions available on the Department's website (R.C. 5162.86(B) to (E)).</p>
Medicaid participant audits, improper payments, and conflicts of interest	<p>No provision.</p> <p>No provision.</p>	<p>Requires certain participants in the Medicaid program (referred to as risk contractors and subcontractors) to (1) have audits completed by independent auditors, (2) identify, report on, and repay improper payments, and (3) develop corrective action plans to address improper payments (R.C. 5162.87, 5162.88, and 5162.89).</p> <p>Requires the Department of Medicaid to publish audits, reports of improper payments, and corrective action plans (R.C. 5162.87, 5162.88, and 5162.89).</p>

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	No provision.	Prohibits conflicts of interest for actuarial firms providing services to Medicaid program participants (R.C. 5162.89).
All-payer claims database	<p>No provision.</p> <p>No provision.</p> <p>No provision.</p>	<p>Requires 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 (R.C. 3901.93(B)).</p> <p>Delays until January 1, 2028, the requirement that a payer that is a health plan issuer submit claims to the Superintendent for inclusion in the database (R.C. 3901.93(B)(2)).</p> <p>Authorizes the Superintendent to make the database's claims information available to persons and government entities only through a subscription with the Department of Insurance, except that claims information must be made available to the General Assembly and state departments for free and without subscriptions (R.C. 3901.93(B)(4)).</p>

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	No provision.	Directs the Superintendent to adopt rules to implement the bill'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 (R.C. 3901.93(C)).
Auditor of State subpoena authority	No provision. No provision.	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 (R.C. 117.10(F)). Requires the Attorney General, upon the request of the Auditor of State, to bring an action in a court of competent jurisdiction to enforce compliance with a subpoena (R.C. 117.10(F)).
State employee fraud reporting	No provision.	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 (R.C. 4113.52(A)(1)(a)).

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	No provision.	Permits an official or employee of the Auditor of State to report to the Inspector General alleged fraud, theft in office, or the misuse or misappropriation of public money (R.C. 4113.52(A)(1)(a)).
Auditor award for reporting fraud	No provision.	<p>Allows the Auditor of State to issue an award for reporting fraud of up to \$10,000 if all of the following apply:</p> <ul style="list-style-type: none"> ▪ The person reports the fraud through the Auditor of State’s fraud reporting system; ▪ A public office or public official is found liable for the fraud in a civil action or criminal action as a result of the person reporting fraud; ▪ The person who reports the fraud is not found liable for the fraud in a civil or criminal action. <p>(R.C. 117.103 and 117.104.)</p>
Forensic audit and compliance framework	No provision.	Requires the Auditor of State to establish an independent forensic audit and compliance framework for monitoring the Medicaid program, including monitoring Medicaid providers considered to be at high risk of committing fraud within the Medicaid program (R.C. 117.61(A)).

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	No provision.	Permits the Auditor to contract with outside forensic auditors and compliance professionals as necessary to operate the framework (R.C. 117.61(B)).
	No provision.	Prohibits any standing committee of the House of Representatives or Senate from holding a hearing on legislation concerning the integrity of the Medicaid program unless a forensic audit has been conducted (R.C. 117.61(C)).
	No provision.	Requires the Department of Medicaid to annually prepare and submit a report to the chairpersons and ranking members of the committees of the House and Senate with jurisdiction over Medicaid detailing the Department's efforts to ensure integrity within the Medicaid program (R.C. 5162.138).
Unclaimed funds	No provision.	Requires the Medicaid Director, by February 1 of each year, to provide the Director of Commerce with a list of all Medicaid providers who have had a provider agreement suspended or terminated due to fraudulent activity (R.C. 5164.54(A)).
	No provision.	Requires the Director of Commerce, by March 1 of every year, to provide the Medicaid Director with a list of any individual identified by the Medicaid Director who has

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	No provision.	unclaimed funds delivered or reported to the state (R.C. 5164.54(B)).
	No provision.	Requires the Department of Medicaid to file a claim to recover unclaimed funds from the Director of Commerce on behalf of an individual identified by the Department (R.C. 5164.54(C)).
	No provision.	Requires the Director of Commerce to pay a claim to the Department of Medicaid for any amount owed by an individual to the Department and requires the Department to adjust any amounts owed by an individual based on amounts received in unclaimed funds (R.C. 5164.54(C)).
	No provision.	Establishes a similar process for the Attorney General (in collaboration with the Auditor of State) for individuals against whom a finding for recovery or improper payments has been issued for actions related to the Medicaid program and the Director of Job and Family Services for individuals who have had a provider agreement suspended or terminated due to fraudulent activity (R.C. 109.851 and 5101.88).

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Inspector General as “peace officer”	No provision.	Adds the Inspector General and a deputy Inspector General to the definition of “peace officer” while either is engaged in the scope of the official’s duties (R.C. 109.71, 109.77, 121.483, and 2935.01).
Publicly funded child care (PFCC) provider contracts	No provision.	Extends the disciplinary authority of the Department of Children and Youth (DCY) regarding PFCC providers by allowing DCY to also suspend or terminate the provider’s contract (R.C. 5104.32(D)).
	No provision.	Establishes an additional ground upon which DCY can take action against a PFCC provider – if evidence demonstrates that the provider acted with intent to commit fraud against the PFCC program (R.C. 5104.32(D)(3)).
	No provision.	Defines fraud against the PFCC program to mean an intentional act or omission to deceive for purposes of obtaining or retaining payments under the PFCC care program that a PFCC provider is not entitled to obtain or retain (R.C. 5104.32(D)(3)).

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	No provision.	Requires the DCY Director to revoke the license of a child care center, child day camp, licensed preschool or school child program, licensed type B home, or type A home, and a county department of job and family services to revoke the certificate of a certified in-home aide, if the center, camp, program, home, or in-home aide had its PFCC provider contract terminated for acting with intent to commit fraud against the PFCC program and, in the case of DCY-licensed providers, specifies that they are then forever ineligible for licensure (R.C. 3301.58, 5104.03, 5104.12, and 5104.22).
Supplemental Nutrition Assistance Program (SNAP) broad based categorical eligibility	No provision. No provision.	Unless required under federal law, prohibits the gross income limits for an eligible SNAP household from exceeding the standards established under federal law (R.C. 5101.5411(B)). Unless required by federal law, specifies that a household is not categorically eligible for SNAP if any members of the household receive or are authorized to receive any noncash, in-kind, or other similar benefit (R.C. 5101.5411(C)).

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Bill designation	Designates the bill's provisions as the "Safeguarding Healthcare Integrity through Electronic Location Data (SHIELD) Act" (Section 3).	Instead designates the bill's provisions as the "Ohio Medicaid Program Integrity and Fraud Prevention Act" (Section 4).