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136th General Assembly
Regular Session
2025-2026

Sub. H. B. No. 795

To amend sections 109.85, 117.10, 2903.216, 1
2913.40, 2923.31, 4113.52, 5164.32, 5164.33, 2
5164.34, 5164.342, 5164.36, 5164.57, and 5167.18 3
and to enact sections 103.413, 3901.93, 4
5162.138, 5162.139, 5162.1311, 5162.17, 5162.18, 5
5162.19, 5163.05, 5164.12, 5164.13, 5164.292, 6
5164.302, 5164.303, 5164.304, 5164.305, 7
5164.331, 5164.332, 5164.40, 5164.401, 5164.402, 8
5164.403, 5164.404, 5164.405, 5164.406, 5164.41, 9
5164.42, 5164.421, 5164.43, and 5167.23 of the 10
Revised Code regarding program integrity for 11
certain components of the Medicaid program, 12
regarding the authority of the Attorney General 13
and Auditor of State, and to name this act the 14
Ohio Medicaid Program Integrity and Fraud 15
Prevention Act. 16

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

Section 1. That sections 109.85, 117.10, 2903.216, 17
2913.40, 2923.31, 4113.52, 5164.32, 5164.33, 5164.34, 5164.342, 18
5164.36, 5164.57, and 5167.18 be amended and sections 103.413, 19



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3901.93, 5162.138, 5162.139, 5162.1311, 5162.17, 5162.18, 20
5162.19, 5163.05, 5164.12, 5164.13, 5164.292, 5164.302, 21
5164.303, 5164.304, 5164.305, 5164.331, 5164.332, 5164.40, 22
5164.401, 5164.402, 5164.403, 5164.404, 5164.405, 5164.406, 23
5164.41, 5164.42, 5164.421, 5164.43, and 5167.23 of the Revised 24
Code be enacted to read as follows: 25

Sec. 103.413. Annually, the standing committees of the 26
house of representatives and the senate that primarily consider 27
legislation governing the medicaid program shall meet jointly 28
and conduct a review of one-quarter of the medicaid waiver 29
components as defined in section 5166.01 of the Revised Code 30
operating within the medicaid program. The review shall focus on 31
the waiver's purpose and evaluate the waiver's success at 32
achieving the desired purpose. The standing committees shall 33
review all medicaid waiver components within the medicaid 34
program before conducting a subsequent review of any medicaid 35
waiver component. 36

Sec. 109.85. (A) Upon the written request of the governor, 37
the general assembly, the auditor of state, the medicaid 38
director, the director of health, or the director of budget and 39
management, or upon the attorney general's becoming aware of 40
criminal or improper activity related to Chapter 3721. of the 41
Revised Code and the medicaid program, the attorney general 42
shall investigate any criminal or civil violation of law related 43
to Chapter 3721. of the Revised Code or the medicaid program. In 44
any investigation conducted pursuant to this section the 45
attorney general may administer oaths, subpoena witnesses, 46
adduce evidence, and subpoena the production of any book, 47
document, record, or other relevant matter. 48

~~(B)~~ (B) (1) If the attorney general under division (A) of 49

this section subpoenas the production of any relevant matter 50
that is located outside this state, the attorney general may 51
designate a representative, including an official of the state 52
in which that relevant matter is located, to inspect the 53
relevant matter on the attorney general's behalf. The attorney 54
general may carry out similar requests received from officials 55
of other states. 56

(2) Any person who is subpoenaed to produce relevant 57
matter pursuant to division (A) of this section shall make that 58
relevant matter available at a convenient location within this 59
state or the state of the representative designated under 60
division (B) (1) of this section. 61

(C) Any person who is subpoenaed as a witness or to 62
produce relevant matter pursuant to division (A) of this section 63
may file in the court of common pleas of Franklin county, the 64
county in this state in which the person resides, or the county 65
in this state in which the person's principal place of business 66
is located a petition to extend for good cause shown the date on 67
which the subpoena is to be returned or to modify or quash for 68
good cause shown that subpoena. The person may file the petition 69
at any time prior to the date specified for the return of the 70
subpoena or within twenty days after the service of the 71
subpoena, whichever is earlier. 72

(D) Any person who is subpoenaed as a witness or to 73
produce relevant matter pursuant to division (A) of this section 74
shall comply with the terms of the subpoena unless the court 75
orders otherwise prior to the date specified for the return of 76
the subpoena or, if applicable, that date as extended. If a 77
person fails without lawful excuse to obey a subpoena, the 78
attorney general may apply to the same court of common pleas as 79

designated in division (C) of this section for an order that 80
does one or more of the following: 81

(1) Compels the requested discovery; 82

(2) Adjudges the person in contempt of court; 83

(3) Grants other relief that may be required until the 84
person obeys the subpoena. 85

(E) If the court finds that a person's failure to comply 86
with a subpoena issued under this section was in bad faith or 87
for the purpose of delay, it may order the person to pay to the 88
attorney general the reasonable expenses incurred in obtaining 89
the order, including attorney's fees, and may invoke the 90
sanctions provided by Rule 37 of the Rules of Civil Procedure. 91

(F) When it appears to the attorney general, as a result 92
of an investigation under division (A) of this section, that 93
there is cause to prosecute for the commission of a crime or to 94
pursue a civil remedy, the attorney general may refer the 95
evidence to the prosecuting attorney having jurisdiction of the 96
matter, or to a regular grand jury drawn and impaneled pursuant 97
to sections 2939.01 to 2939.24 of the Revised Code, or to a 98
special grand jury drawn and impaneled pursuant to section 99
2939.17 of the Revised Code, or the attorney general may 100
initiate and prosecute any necessary criminal or civil actions 101
in any court or tribunal of competent jurisdiction in this 102
state. When proceeding under this section, the attorney general, 103
and any assistant or special counsel designated by the attorney 104
general for that purpose, have all rights, privileges, and 105
powers of prosecuting attorneys. The attorney general shall have 106
exclusive supervision and control of all investigations and 107
prosecutions initiated by the attorney general under this 108

section. The forfeiture provisions of Chapter 2981. of the 109
Revised Code apply in relation to any such criminal action 110
initiated and prosecuted by the attorney general. 111

~~(C)~~(G) Nothing in this section shall prevent a county 112
prosecuting attorney from investigating and prosecuting criminal 113
activity related to Chapter 3721. of the Revised Code and the 114
medicaid program. The forfeiture provisions of Chapter 2981. of 115
the Revised Code apply in relation to any prosecution of 116
criminal activity related to the medicaid program undertaken by 117
the prosecuting attorney. 118

Sec. 117.10. (A) The auditor of state shall audit all 119
public offices as provided in this chapter. The auditor of state 120
also may audit the specific funds or accounts of private 121
institutions, associations, boards, and corporations into which 122
has been placed or deposited public money from a public office 123
and may require of them annual reports in such form as the 124
auditor of state prescribes. The auditor of state may audit some 125
or all of the other funds or accounts of a private institution, 126
association, board, or corporation that has received public 127
money from a public office only if one or more of the following 128
applies: 129

(1) The audit is specifically required or authorized by 130
the Revised Code; 131

(2) The private institution, association, board, or 132
corporation requests that the auditor of state audit some or all 133
of its other funds or accounts; 134

(3) All of the revenue of the private institution, 135
association, board, or corporation is composed of public money; 136

(4) The private institution, association, board, or 137

corporation failed to separately and independently account for 138
the public money in its possession, in violation of section 139
117.431 of the Revised Code; 140

(5) The auditor of state has a reasonable belief that the 141
private institution, association, board, or corporation 142
illegally expended, converted, misappropriated, or otherwise 143
cannot account for the public money it received from a public 144
office and that it is necessary to audit its other funds or 145
accounts to make that determination. 146

(B) If the auditor of state performs or contracts for the 147
performance of an audit, including a special audit, of the 148
public employees retirement system, school employees retirement 149
system, state teachers retirement system, state highway patrol 150
retirement system, or Ohio police and fire pension fund, the 151
auditor of state shall make a timely report of the results of 152
the audit to the Ohio retirement study council. 153

(C) The auditor of state may audit the accounts of any 154
medicaid provider, as defined in section 5164.01 of the Revised 155
Code. 156

(D) If a public office has been audited by an agency of 157
the United States government, the auditor of state may, if 158
satisfied that the federal audit has been conducted according to 159
principles and procedures not contrary to those of the auditor 160
of state, use and adopt the federal audit and report in lieu of 161
an audit by the auditor of state's own office. 162

(E) Within thirty days after the creation or dissolution 163
or the winding up of the affairs of any public office, that 164
public office shall notify the auditor of state in writing that 165
this action has occurred. 166

(F) The auditor of state may issue subpoenas compelling 167
the production of books, records, accounts, documents, 168
electronically-stored information, testimony, or other 169
information relevant to any audit, examination, special audit, 170
investigation, or review within the authority of the auditor of 171
state under this chapter. Upon request of the auditor of state, 172
the attorney general shall bring an action in a court of 173
competent jurisdiction to enforce compliance with any subpoena 174
issued pursuant to this section. 175

(G) Nothing in this section precludes the auditor of state 176
from issuing to a private institution, association, board, or 177
corporation a subpoena and compulsory process for the attendance 178
of witnesses or the production of records under section 117.18 179
of the Revised Code if the subpoena and compulsory process is in 180
furtherance of an audit the auditor of state is authorized by 181
law to perform. 182

Sec. 2903.216. (A) As used in this section: 183

(1) "Business entity" means any form of corporation, 184
partnership, association, cooperative, joint venture, business 185
trust, or sole proprietorship that conducts business in this 186
state. 187

(2) "Business of private investigation" and "private 188
investigator" have the same meanings as in section 4749.01 of 189
the Revised Code. 190

(3) "Disabled adult" and "elderly person" have the same 191
meanings as in section 2913.01 of the Revised Code. 192

(4) "Electronic monitoring" and "electronic monitoring 193
device" have the same meanings as in section 2929.01 of the 194
Revised Code. 195

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

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

(7) "Ohio protection order" means a protection order filed or issued or a consent agreement approved pursuant to section 2919.26 or 3113.31 of the Revised Code, a protection order filed or issued pursuant to section 2151.34, 2903.213, or 2903.214 of the Revised Code, or a no contact order issued as any of the following:

(a) As part of a person's sentence under a community control sanction imposed under section 2929.16, 2929.17, 2929.26, or 2929.27 of the Revised Code;

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

(c) As a post-release control sanction imposed as a condition of a person's post-release control under section 2967.28 of the Revised Code;

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

(e) As a term or condition of the intervention plan of a person granted intervention in lieu of conviction under section 2951.041 of the Revised Code.

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

(9) "Tracking application" means any software program that permits a person to remotely determine or track the position or

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| movement of another person or another person's property. | 224 |
| (10) "Tracking device" means an electronic or mechanical | 225 |
| device that permits a person to remotely determine or track the | 226 |
| position or movement of another person or another person's | 227 |
| property, including an electronic monitoring device. | 228 |
| (B) Except as otherwise provided in division (D) of this | 229 |
| section, no person shall knowingly do either of the following: | 230 |
| (1) Install a tracking device or tracking application on | 231 |
| another person's property without the other person's consent or | 232 |
| cause a tracking device or tracking application to track the | 233 |
| position or movement of another person or another person's | 234 |
| property without the other person's consent; | 235 |
| (2) If the person installed a tracking device or tracking | 236 |
| application on another's property with the other person's | 237 |
| consent and the other person subsequently revokes that consent, | 238 |
| fail to remove or ensure the removal of the device or | 239 |
| application after the other person revokes the consent. | 240 |
| (C) (1) For purposes of this section, if a person has given | 241 |
| consent for another to install a tracking device or tracking | 242 |
| application on the consenting person's property, it is presumed | 243 |
| that the consenting person has revoked that consent if any of | 244 |
| the following applies: | 245 |
| (a) The consenting person and the person to whom consent | 246 |
| was given are lawfully married and one of them files a complaint | 247 |
| for divorce or a petition for dissolution of marriage from the | 248 |
| other. Not later than seventy-two hours after being served with | 249 |
| a complaint for divorce or a petition for dissolution of | 250 |
| marriage, the person to whom consent was given shall lawfully | 251 |
| uninstall or discontinue use of the tracking device or tracking | 252 |

application. If the person to whom consent was given cannot 253
lawfully uninstall or discontinue use of the tracking device or 254
tracking application, the person to whom consent was given shall 255
notify the court in which the complaint for divorce or the 256
petition for dissolution of marriage was filed in writing. 257

(b) The consenting person or the person to whom consent 258
was given files an Ohio protection order against the other 259
person or an Ohio protection order is issued against the other 260
person, and the person to be protected under the order is the 261
consenting person. Not later than seventy-two hours after being 262
served with the Ohio protection order, the person to whom 263
consent was given shall lawfully uninstall or discontinue use of 264
the tracking device or tracking application. If the person to 265
whom consent was given cannot lawfully uninstall or discontinue 266
use of the tracking device or tracking application, the person 267
to whom consent was given shall notify the court that issued the 268
Ohio protection order in writing that the person to whom consent 269
was given has installed or is using a tracking device or 270
tracking application on the previously consenting person's 271
person or the person's property and cannot uninstall or 272
discontinue its use without violating the Ohio protection order. 273

(2) Revocation of consent under this division is effective 274
upon the service of the petition or motion or an Ohio protection 275
order. 276

(D) This section does not apply to any of the following: 277

(1) A law enforcement officer, or any law enforcement 278
agency, that installs a tracking device or tracking application 279
on another person's property or causes a tracking device or 280
tracking application to track the position or movement of 281
another person or another person's property as part of a 282

criminal investigation, or a probation officer, parole officer, 283
or employee of the department of rehabilitation and correction, 284
a halfway house, or a community-based correctional facility when 285
engaged in the lawful performance of the officer's or employee's 286
official duties; 287

(2) A parent or legal guardian of a minor child who 288
installs or uses a tracking device or tracking application to 289
track the minor child if any of the following applies: 290

(a) The parents or legal guardians of the child are 291
lawfully married to each other and are not separated or 292
otherwise living apart, and either of those parents or legal 293
guardians consents to the installation of the tracking device or 294
tracking application; 295

(b) The parent or legal guardian of the child is the sole 296
surviving parent or legal guardian of the child; 297

(c) The parent or legal guardian of the child has sole 298
custody of the child; 299

(d) The parents or legal guardians of the child are 300
divorced, separated, or otherwise living apart and neither 301
parent has sole custody of the child, and both consent to the 302
installation of the tracking device or tracking application; 303

(e) The parents or legal guardians of the child are 304
divorced, separated, or otherwise living apart, neither parent 305
has sole custody of the child, and either only one parent 306
consents to the installation of the tracking device or tracking 307
application or one parent revokes consent, if the consenting 308
parent only uses the tracking device or tracking application 309
during that parent's parenting or custodial time and disables or 310
removes the tracking device or application during the 311

nonconsenting parent's parenting or custodial time. 312

(3) A caregiver of an elderly person or disabled adult, if 313
the elderly person's or disabled adult's treating physician 314
certifies that the installation of a tracking device or tracking 315
application onto the elderly person's or disabled adult's 316
property is necessary to ensure the safety of the elderly person 317
or disabled adult; 318

(4) A person acting in good faith on behalf of a business 319
entity for a legitimate business purpose, provided that this 320
division does not apply to a private investigator engaged in the 321
business of private investigation on behalf of another person; 322

(5) (a) A private investigator or other person licensed 323
under section 4749.03 of the Revised Code, who is acting in the 324
normal course of the investigator's business of private 325
investigation on behalf of another person and who has the 326
consent of the owner of the property upon which the tracking 327
device or tracking application is installed, for the purpose of 328
obtaining information with reference to any of the following: 329

(i) Criminal offenses committed, threatened, or suspected 330
against the United States, a territory of the United States, a 331
state, or any person or legal entity; 332

(ii) Locating an individual known to be a fugitive from 333
justice; 334

(iii) Locating lost or stolen property or other assets 335
that have been awarded by the court; 336

(iv) Investigating claims related to workers' 337
compensation. 338

(b) This division does not apply if the person on whose 339

behalf the private investigator is working is the subject of an 340
Ohio protection order or a protection order issued by a court of 341
another state or if the private investigator knows or reasonably 342
should know that the person on whose behalf the private 343
investigator is working seeks the investigator's services to aid 344
in the commission of a crime. 345

(6) An owner or lessee of a motor vehicle who installs, or 346
directs the installation of, a tracking device or tracking 347
application on the vehicle during the period of ownership or 348
lease, if any of the following applies: 349

(a) The tracking device or tracking application is removed 350
before the vehicle's title is transferred or the vehicle's lease 351
expires; 352

(b) The new owner of the vehicle, in the case of a sale, 353
or the lessor of the vehicle, in the case of an expired lease, 354
consents in writing to the non-removal of the tracking device or 355
tracking application; 356

(c) The owner of the vehicle at the time of the 357
installation of the tracking device or tracking application was 358
the original manufacturer of the vehicle. 359

(7) A person who installs a tracking device or application 360
on property in which the person has an ownership or contractual 361
interest, unless the person is the subject of a protective order 362
and the property is likely to be used by the person who obtained 363
the protective order; 364

(8) A person or business entity that installs a tracking 365
device or tracking application on any fixed wing aircraft or 366
rotorcraft operated or managed by the person or business entity 367
pursuant to 14 C.F.R. part 91 or part 135 to track the position 368

or movement of the fixed wing aircraft or rotorcraft; 369

(9) A surety bail bond agent, or any employee or 370
contractor of a surety bail bond agent, that installs a tracking 371
device or tracking application on another person's property or 372
causes a tracking device or tracking application to track the 373
position or movement of another person or another person's 374
property as part of the surety bail bond agent's, employee's, or 375
contractor's official responsibilities or duties; 376

(10) The use of location verification technology by the 377
department of medicaid, a medicaid provider, a provider's 378
employee or contractor, or an electronic visit verification 379
vendor when the technology is used solely to comply with 380
electronic visit verification requirements under state or 381
federal law including all of the following, provided that 382
verification technology is not used for continuous tracking 383
outside of the delivery of medicaid-covered services: 384

(a) Verification of the beginning or ending of a medicaid- 385
covered service; 386

(b) Validating a claim for medicaid payment; 387

(c) Support for integrity of the medicaid program 388
including audit, investigation, payment, or recovery activities. 389

(E) For purposes of division (D) (1) of this section, a 390
probation officer, parole officer, or employee of the department 391
of rehabilitation and correction, a halfway house, or a 392
community-based correctional facility is engaged in the lawful 393
performance of the officer's or employee's duties if both of the 394
following apply: 395

(1) The court or the department of rehabilitation and 396
correction imposes electronic monitoring on a person. 397

(2) The officer or employee installs or uses an electronic 398
monitoring device on that person in accordance with the court's 399
or department's imposition of electronic monitoring of that 400
person. 401

(F) Whoever violates this section is guilty of illegal use 402
of a tracking device or application. 403

(1) Except as otherwise provided in division (F)(2) of 404
this section, illegal use of a tracking device or application is 405
a misdemeanor of the first degree. 406

(2) Illegal use of a tracking device or application is a 407
felony of the fourth degree if any of the following applies: 408

(a) The offender previously has been convicted of or 409
pleaded guilty to a violation of this section or section 410
2903.211 of the Revised Code. 411

(b) At the time of the commission of the offense, the 412
offender was the subject of a protection order issued under 413
section 2903.213 or 2903.214 of the Revised Code, regardless of 414
whether the person to be protected under the order is the victim 415
of the offense or another person. 416

(c) Prior to committing the offense, the offender had been 417
determined to represent a substantial risk of physical harm to 418
others as manifested by evidence of then-recent homicidal or 419
other violent behavior, evidence of then-recent threats that 420
placed another in reasonable fear of violent behavior and 421
serious physical harm, or other evidence of then-present 422
dangerousness. 423

(d) The offender has a history of violence toward the 424
victim or a history of other violent acts towards the victim. 425

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| Sec. 2913.40. (A) As used in this section: | 426 |
| (1) "Statement or representation" means any oral, written, electronic, electronic impulse, or magnetic communication that is used to identify an item of goods or a service for which reimbursement may be made under the medicaid program or that states income and expense and is or may be used to determine a rate of reimbursement under the medicaid program. | 427 428 429 430 431 432 |
| (2) "Provider" means any person who has signed a provider agreement with the department of medicaid to provide goods or services pursuant to the medicaid program or any person who has signed an agreement with a party to such a provider agreement under which the person agrees to provide goods or services that are reimbursable under the medicaid program. | 433 434 435 436 437 438 |
| (3) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code. | 439 440 |
| (4) "Recipient" means any individual who receives goods or services from a provider under the medicaid program. | 441 442 |
| (5) "Records" means any medical, professional, financial, or business records relating to the treatment or care of any recipient, to goods or services provided to any recipient, or to rates paid for goods or services provided to any recipient and any records that are required by the rules of the medicaid director to be kept for the medicaid program. | 443 444 445 446 447 448 |
| <u>(6)</u> | 449 |
| <u>"Presumption that a prison term shall be imposed" means a presumption, as described in division (D) of section 2929.13 of the Revised Code, that a prison term is a necessary sanction for a felony in order to comply with the purposes and principles of sentencing under section 2929.11 of the Revised Code.</u> | 450 451 452 453 454 |

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

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

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

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

(D) No person, having submitted a claim for or provided goods or services under the medicaid program, shall do either of the following for a period of at least six years after a reimbursement pursuant to that claim, or a reimbursement for those goods or services, is received under the medicaid program:

(1) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of

all goods or services for which the claim was submitted, or for 484
which reimbursement was received, by the person; 485

(2) Knowingly alter, falsify, destroy, conceal, or remove 486
any records that are necessary to disclose fully all income and 487
expenditures upon which rates of reimbursements were based for 488
the person. 489

(E) Whoever violates this section is guilty of medicaid 490
fraud. Except as otherwise provided in this division, medicaid 491
fraud is a ~~misdemeanor of the first~~ felony of the fifth degree 492
and, notwithstanding section 2929.18 of the Revised Code, the 493
court shall impose as the fine for the offense a fine of one 494
thousand dollars. ~~If~~ 495

(1) If the value of property, services, or funds obtained 496
in violation of this section is one thousand dollars or more and 497
is less than seven thousand five hundred dollars, medicaid fraud 498
is a felony of the ~~fifth~~ fourth degree and, notwithstanding 499
section 2929.18 of the Revised Code, the court shall impose as 500
the fine for the offense a fine of five thousand dollars. ~~If~~ 501

(2) If the value of property, services, or funds obtained 502
in violation of this section is seven thousand five hundred 503
dollars or more and is less than ~~one hundred fifty~~ seventy-five 504
thousand dollars, medicaid fraud is a felony of the ~~fourth~~ third 505
degree and, notwithstanding section 2929.18 of the Revised Code, 506
the court shall impose as the fine for the offense a fine of 507
twenty-five thousand dollars. ~~If~~ 508

(3) If the value of the property, services, or funds 509
obtained in violation of this section is ~~one hundred fifty~~ 510
~~seventy-five~~ thousand dollars or more and is less than one 511
hundred fifty thousand dollars, medicaid fraud is a felony of 512

the third degree and there is a presumption for a prison term. 513
Notwithstanding section 2929.18 of the Revised Code, the court 514
shall impose as the fine for the offense a fine of seventy-five 515
thousand dollars. 516

(4) If the value of the property, services, or funds 517
obtained in violation of this section is one hundred fifty 518
thousand dollars or more and is less than seven hundred fifty 519
thousand dollars, medicaid fraud is a felony of the second 520
degree and there is a presumption of a prison term. 521
Notwithstanding section 2929.18 of the Revised Code, the court 522
shall impose as the fine for the offense a fine of one hundred 523
fifty thousand dollars. 524

(5) If the value of the property or services stolen is 525
seven hundred fifty thousand dollars or more, medicaid fraud is 526
a felony of the first degree and there is a presumption of a 527
prison term. Notwithstanding section 2929.18 of the Revised 528
Code, the court shall impose as the fine for the offense a fine 529
of one hundred fifty thousand dollars. 530

(F) Upon application of the governmental agency, office, 531
or other entity that conducted the investigation and prosecution 532
in a case under this section, the court shall order any person 533
who is convicted of a violation of this section for receiving 534
any reimbursement for furnishing goods or services under the 535
medicaid program to which the person is not entitled to pay to 536
the applicant its cost of investigating and prosecuting the 537
case. The costs of investigation and prosecution that a 538
defendant is ordered to pay pursuant to this division shall be 539
in addition to any other penalties for the receipt of that 540
reimbursement that are provided in this section, section 5164.35 541
of the Revised Code, or any other provision of law. 542

(G) The provisions of this section are not intended to be 543
exclusive remedies and do not preclude the use of any other 544
criminal or civil remedy for any act that is in violation of 545
this section. 546

Sec. 2923.31. As used in sections 2923.31 to 2923.36 of 547
the Revised Code: 548

(A) "Beneficial interest" means any of the following: 549

(1) The interest of a person as a beneficiary under a 550
trust in which the trustee holds title to personal or real 551
property; 552

(2) The interest of a person as a beneficiary under any 553
other trust arrangement under which any other person holds title 554
to personal or real property for the benefit of such person; 555

(3) The interest of a person under any other form of 556
express fiduciary arrangement under which any other person holds 557
title to personal or real property for the benefit of such 558
person. 559

"Beneficial interest" does not include the interest of a 560
stockholder in a corporation or the interest of a partner in 561
either a general or limited partnership. 562

(B) "Costs of investigation and prosecution" and "costs of 563
investigation and litigation" mean all of the costs incurred by 564
the state or a county or municipal corporation under sections 565
2923.31 to 2923.36 of the Revised Code in the prosecution and 566
investigation of any criminal action or in the litigation and 567
investigation of any civil action, and includes, but is not 568
limited to, the costs of resources and personnel. 569

(C) "Enterprise" includes any individual, sole 570

proprietorship, partnership, limited partnership, corporation, 571
trust, union, government agency, or other legal entity, or any 572
organization, association, or group of persons associated in 573
fact although not a legal entity. "Enterprise" includes illicit 574
as well as licit enterprises. 575

(D) "Innocent person" includes any bona fide purchaser of 576
property that is allegedly involved in a violation of section 577
2923.32 of the Revised Code, including any person who 578
establishes a valid claim to or interest in the property in 579
accordance with division (E) of section 2981.04 of the Revised 580
Code, and any victim of an alleged violation of that section or 581
of any underlying offense involved in an alleged violation of 582
that section. 583

(E) "Pattern of corrupt activity" means two or more 584
incidents of corrupt activity, whether or not there has been a 585
prior conviction, that are related to the affairs of the same 586
enterprise, are not isolated, and are not so closely related to 587
each other and connected in time and place that they constitute 588
a single event. 589

At least one of the incidents forming the pattern shall 590
occur on or after January 1, 1986. Unless any incident was an 591
aggravated murder or murder, the last of the incidents forming 592
the pattern shall occur within six years after the commission of 593
any prior incident forming the pattern, excluding any period of 594
imprisonment served by any person engaging in the corrupt 595
activity. 596

For the purposes of the criminal penalties that may be 597
imposed pursuant to section 2923.32 of the Revised Code, at 598
least one of the incidents forming the pattern shall constitute 599
a felony under the laws of this state in existence at the time 600

it was committed or, if committed in violation of the laws of 601
the United States or of any other state, shall constitute a 602
felony under the law of the United States or the other state and 603
would be a criminal offense under the law of this state if 604
committed in this state. 605

(F) "Pecuniary value" means money, a negotiable 606
instrument, a commercial interest, or anything of value, as 607
defined in section 1.03 of the Revised Code, or any other 608
property or service that has a value in excess of one hundred 609
dollars. 610

(G) "Person" means any person, as defined in section 1.59 611
of the Revised Code, and any governmental officer, employee, or 612
entity. 613

(H) "Personal property" means any personal property, any 614
interest in personal property, or any right, including, but not 615
limited to, bank accounts, debts, corporate stocks, patents, or 616
copyrights. Personal property and any beneficial interest in 617
personal property are deemed to be located where the trustee of 618
the property, the personal property, or the instrument 619
evidencing the right is located. 620

(I) "Corrupt activity" means engaging in, attempting to 621
engage in, conspiring to engage in, or soliciting, coercing, or 622
intimidating another person to engage in any of the following: 623

(1) Conduct defined as "racketeering activity" under the 624
"Organized Crime Control Act of 1970," 84 Stat. 941, 18 U.S.C. 625
1961(1)(B), (1)(C), (1)(D), and (1)(E), as amended; 626

(2) Conduct constituting any of the following: 627

(a) A violation of section 1315.55, 1322.07, 2903.01, 628
2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2905.01, 2905.02, 629

2905.11, 2905.22, 2905.32 as specified in division (I) (2) (g) of 630
this section, 2907.321, 2907.322, 2907.323, 2909.02, 2909.03, 631
2909.22, 2909.23, 2909.24, 2909.26, 2909.27, 2909.28, 2909.29, 632
2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2911.31, 2913.05, 633
2913.06, 2913.30, 2921.02, 2921.03, 2921.04, 2921.11, 2921.12, 634
2921.32, 2921.41, 2921.42, 2921.43, 2923.12, or 2923.17; 635
division (F) (1) (a), (b), or (c) of section 1315.53; division (A) 636
(1) or (2) of section 1707.042; division (B), (C) (4), (D), (E), 637
or (F) of section 1707.44; division (A) (1) or (2) of section 638
2923.20; division (E) or (G) of section 3772.99; division (J) (1) 639
of section 4712.02; section 4719.02, 4719.05, or 4719.06; 640
division (C), (D), or (E) of section 4719.07; section 4719.08; 641
or division (A) of section 4719.09 of the Revised Code. 642

(b) Any violation of section 3769.11, 3769.15, 3769.16, or 643
3769.19 of the Revised Code as it existed prior to July 1, 1996, 644
any violation of section 2915.02 of the Revised Code that occurs 645
on or after July 1, 1996, and that, had it occurred prior to 646
that date, would have been a violation of section 3769.11 of the 647
Revised Code as it existed prior to that date, or any violation 648
of section 2915.05 of the Revised Code that occurs on or after 649
July 1, 1996, and that, had it occurred prior to that date, 650
would have been a violation of section 3769.15, 3769.16, or 651
3769.19 of the Revised Code as it existed prior to that date. 652

(c) Any violation of section 2907.21, 2907.22, 2907.31, 653
2913.02, 2913.11, 2913.21, 2913.31, 2913.32, 2913.34, 2913.40, 654
2913.42, 2913.47, 2913.51, 2915.03, 2925.03, 2925.04, 2925.05, 655
or 2925.37 of the Revised Code, any violation of section 2925.11 656
of the Revised Code that is a felony of the first, second, 657
third, or fourth degree and that occurs on or after July 1, 658
1996, any violation of section 2915.02 of the Revised Code that 659
occurred prior to July 1, 1996, any violation of section 2915.02 660

of the Revised Code that occurs on or after July 1, 1996, and 661
that, had it occurred prior to that date, would not have been a 662
violation of section 3769.11 of the Revised Code as it existed 663
prior to that date, any violation of section 2915.06 of the 664
Revised Code as it existed prior to July 1, 1996, or any 665
violation of division (B) of section 2915.05 of the Revised Code 666
as it exists on and after July 1, 1996, when the proceeds of the 667
violation, the payments made in the violation, the amount of a 668
claim for payment or for any other benefit that is false or 669
deceptive and that is involved in the violation, or the value of 670
the contraband or other property illegally possessed, sold, or 671
purchased in the violation exceeds one thousand dollars, or any 672
combination of violations described in division (I) (2) (c) of 673
this section when the total proceeds of the combination of 674
violations, payments made in the combination of violations, 675
amount of the claims for payment or for other benefits that is 676
false or deceptive and that is involved in the combination of 677
violations, or value of the contraband or other property 678
illegally possessed, sold, or purchased in the combination of 679
violations exceeds one thousand dollars; 680

(d) Any violation of section 5743.112 of the Revised Code 681
when the amount of unpaid tax exceeds one hundred dollars; 682

(e) Any violation or combination of violations of section 683
2907.32 of the Revised Code involving any material or 684
performance containing a display of bestiality or of sexual 685
conduct, as defined in section 2907.01 of the Revised Code, that 686
is explicit and depicted with clearly visible penetration of the 687
genitals or clearly visible penetration by the penis of any 688
orifice when the total proceeds of the violation or combination 689
of violations, the payments made in the violation or combination 690
of violations, or the value of the contraband or other property 691

illegally possessed, sold, or purchased in the violation or 692
combination of violations exceeds one thousand dollars; 693

(f) Any combination of violations described in division 694
(I) (2) (c) of this section and violations of section 2907.32 of 695
the Revised Code involving any material or performance 696
containing a display of bestiality or of sexual conduct, as 697
defined in section 2907.01 of the Revised Code, that is explicit 698
and depicted with clearly visible penetration of the genitals or 699
clearly visible penetration by the penis of any orifice when the 700
total proceeds of the combination of violations, payments made 701
in the combination of violations, amount of the claims for 702
payment or for other benefits that is false or deceptive and 703
that is involved in the combination of violations, or value of 704
the contraband or other property illegally possessed, sold, or 705
purchased in the combination of violations exceeds one thousand 706
dollars; 707

(g) Any violation of section 2905.32 of the Revised Code 708
to the extent the violation is not based solely on the same 709
conduct that constitutes corrupt activity pursuant to division 710
(I) (2) (c) of this section due to the conduct being in violation 711
of section 2907.21 of the Revised Code. 712

(3) Conduct constituting a violation of any law of any 713
state other than this state that is substantially similar to the 714
conduct described in division (I) (2) of this section, provided 715
the defendant was convicted of the conduct in a criminal 716
proceeding in the other state; 717

(4) Animal or ecological terrorism; 718

(5) (a) Conduct constituting any of the following: 719

(i) Organized retail theft; 720

(ii) Conduct that constitutes one or more violations of 721
any law of any state other than this state, that is 722
substantially similar to organized retail theft, and that if 723
committed in this state would be organized retail theft, if the 724
defendant was convicted of or pleaded guilty to the conduct in a 725
criminal proceeding in the other state. 726

(b) By enacting division (I) (5) (a) of this section, it is 727
the intent of the general assembly to add organized retail theft 728
and the conduct described in division (I) (5) (a) (ii) of this 729
section as conduct constituting corrupt activity. The enactment 730
of division (I) (5) (a) of this section and the addition by 731
division (I) (5) (a) of this section of organized retail theft and 732
the conduct described in division (I) (5) (a) (ii) of this section 733
as conduct constituting corrupt activity does not limit or 734
preclude, and shall not be construed as limiting or precluding, 735
any prosecution for a violation of section 2923.32 of the 736
Revised Code that is based on one or more violations of section 737
2913.02 or 2913.51 of the Revised Code, one or more similar 738
offenses under the laws of this state or any other state, or any 739
combination of any of those violations or similar offenses, even 740
though the conduct constituting the basis for those violations 741
or offenses could be construed as also constituting organized 742
retail theft or conduct of the type described in division (I) (5) 743
(a) (ii) of this section. 744

(J) "Real property" means any real property or any 745
interest in real property, including, but not limited to, any 746
lease of, or mortgage upon, real property. Real property and any 747
beneficial interest in it is deemed to be located where the real 748
property is located. 749

(K) "Trustee" means any of the following: 750

(1) Any person acting as trustee under a trust in which 751
the trustee holds title to personal or real property; 752

(2) Any person who holds title to personal or real 753
property for which any other person has a beneficial interest; 754

(3) Any successor trustee. 755

"Trustee" does not include an assignee or trustee for an 756
insolvent debtor or an executor, administrator, administrator 757
with the will annexed, testamentary trustee, guardian, or 758
committee, appointed by, under the control of, or accountable to 759
a court. 760

(L) "Unlawful debt" means any money or other thing of 761
value constituting principal or interest of a debt that is 762
legally unenforceable in this state in whole or in part because 763
the debt was incurred or contracted in violation of any federal 764
or state law relating to the business of gambling activity or 765
relating to the business of lending money at an usurious rate 766
unless the creditor proves, by a preponderance of the evidence, 767
that the usurious rate was not intentionally set and that it 768
resulted from a good faith error by the creditor, 769
notwithstanding the maintenance of procedures that were adopted 770
by the creditor to avoid an error of that nature. 771

(M) "Animal activity" means any activity that involves the 772
use of animals or animal parts, including, but not limited to, 773
hunting, fishing, trapping, traveling, camping, the production, 774
preparation, or processing of food or food products, clothing or 775
garment manufacturing, medical research, other research, 776
entertainment, recreation, agriculture, biotechnology, or 777
service activity that involves the use of animals or animal 778
parts. 779

(N) "Animal facility" means a vehicle, building, 780
structure, nature preserve, or other premises in which an animal 781
is lawfully kept, handled, housed, exhibited, bred, or offered 782
for sale, including, but not limited to, a zoo, rodeo, circus, 783
amusement park, hunting preserve, or premises in which a horse 784
or dog event is held. 785

(O) "Animal or ecological terrorism" means the commission 786
of any felony that involves causing or creating a substantial 787
risk of physical harm to any property of another, the use of a 788
deadly weapon or dangerous ordnance, or purposely, knowingly, or 789
recklessly causing serious physical harm to property and that 790
involves an intent to obstruct, impede, or deter any person from 791
participating in a lawful animal activity, from mining, 792
forestry, harvesting, gathering, or processing natural 793
resources, or from being lawfully present in or on an animal 794
facility or research facility. 795

(P) "Research facility" means a place, laboratory, 796
institution, medical care facility, government facility, or 797
public or private educational institution in which a scientific 798
test, experiment, or investigation involving the use of animals 799
or other living organisms is lawfully carried out, conducted, or 800
attempted. 801

(Q) "Organized retail theft" means the theft of retail 802
property with a retail value of one thousand dollars or more 803
from one or more retail establishments with the intent to sell, 804
deliver, or transfer that property to a retail property fence. 805

(R) "Retail property" means any tangible personal property 806
displayed, held, stored, or offered for sale in or by a retail 807
establishment. 808

(S) "Retail property fence" means a person who possesses, 809
procures, receives, or conceals retail property that was 810
represented to the person as being stolen or that the person 811
knows or believes to be stolen. 812

(T) "Retail value" means the full retail value of the 813
retail property. In determining whether the retail value of 814
retail property equals or exceeds one thousand dollars, the 815
value of all retail property stolen from the retail 816
establishment or retail establishments by the same person or 817
persons within any one-hundred-eighty-day period shall be 818
aggregated. 819

Sec. 3901.93. (A) As used in this section: 820

(1) "Department" has the same meaning as in section 121.01 821
of the Revised Code. 822

(2) "Health plan issuer" has the same meaning as in 823
section 3922.01 of the Revised Code. 824

(3) "Medicaid managed care organization" has the same 825
meaning as in section 5167.01 of the Revised Code. 826

(4) "Payer" includes a health plan issuer, a medicaid 827
managed care organization, the medicaid program, and the 828
medicare program. 829

(B) (1) Not later than one year after the effective date of 830
this section, the superintendent of insurance shall establish 831
and administer an all-payer claims database. 832

(2) To the extent permitted by federal law and except as 833
otherwise provided in this division, each payer shall submit its 834
claims to the superintendent for inclusion in the database. Such 835
claims shall be submitted in the format and according to the 836

schedule prescribed by the superintendent in rule. 837

In the case of a payer that is a health plan issuer, the 838
requirement to submit claims begins January 1, 2028. 839

(3) The superintendent shall include in the database each 840
claim the superintendent receives. 841

(4) The superintendent shall make claims information 842
included in the database available to any person or government 843
entity. The superintendent may require a person to obtain a 844
subscription with the department of insurance to access 845
information included in the database in accordance with section 846
149.43 of the Revised Code. 847

(C) The superintendent shall adopt rules to implement this 848
section, including rules establishing standards and procedures 849
for the following: 850

(1) Submitting claims for inclusion in the database, 851
including the prescribed format and schedule; 852

(2) Maintaining the privacy and security of personal and 853
health information contained in claims; 854

(3) Making available to persons or government entities 855
claims information from the database; 856

(4) Imposing penalties when claims are not submitted. 857

The superintendent may adopt any other rules the 858
superintendent considers necessary to implement this section. 859
All rules shall be adopted in accordance with Chapter 119. of 860
the Revised Code. 861

(D) Notwithstanding any provision of section 121.95 of the 862
Revised Code to the contrary, a regulatory restriction contained 863

in a rule adopted under division (C) of this section is not 864
subject to sections 121.95 to 121.953 of the Revised Code. 865

Sec. 4113.52. (A) (1) (a) All state officials and employees 866
employed by or appointed to a state agency as defined in 867
division (D) of section 121.41 of the Revised Code shall report 868
alleged fraud, theft in office, or the misuse or 869
misappropriation of public money by a state official or employee 870
~~to the inspector general. All other state employees and elected~~ 871
~~officials shall report fraud, theft in office, or the misuse or~~ 872
~~misappropriation of public money to the auditor of state's~~ 873
fraud-reporting system under section 117.103 of the Revised 874
Code. An official or employee of the auditor of state may report 875
alleged fraud, theft in office, or the misuse or 876
misappropriation of public money to the inspector general. 877
Nothing in this division prohibits the auditor of state or the 878
inspector general from referring a report to the other office 879
when appropriate. 880

(b) A person is required to make a report under division 881
(A) (1) (c) of this section if the person meets any of the 882
following: 883

(i) The person is elected to local public office. 884

(ii) The person is appointed to or within a local public 885
office. 886

(iii) The person has a fiduciary duty to a local public 887
office. 888

(iv) The person holds a supervisory position within a 889
local public office. 890

(v) The person is employed in the department or office 891
responsible for processing any revenue or expenses of the local 892

public office. 893

(c) If a person identified in division (A) (1) (b) of this 894
section, during the person's term of office or in the course of 895
the person's employment, becomes aware of fraud, theft in 896
office, or the misuse or misappropriation of public money, the 897
person shall timely notify the auditor of state via the auditor 898
of state's fraud-reporting system under section 117.103 of the 899
Revised Code or via other means. 900

(d) A person who serves as legal counsel, or who is 901
employed as legal counsel, for a local public office or a state 902
official or employee employed by or appointed to a state agency 903
is not required to make a report under division (A) (1) (a) or (c) 904
of this section concerning any communication received from a 905
client in an attorney-client relationship. 906

(e) Divisions (A) (1) (a), (b), and (c) of this section do 907
not apply to a prosecuting attorney, director of law, village 908
solicitor, or similar chief legal officer of a municipal 909
corporation, or to any employee of the prosecuting attorney, 910
director of law, village solicitor, or similar chief legal 911
officer of a municipal corporation. 912

(f) If a person becomes aware in the course of the 913
person's employment of a violation of any state or federal 914
statute or any ordinance or regulation of a political 915
subdivision that the person's employer has authority to correct, 916
and the person reasonably believes that the violation is a 917
criminal offense that is likely to cause an imminent risk of 918
physical harm to persons or a hazard to public health or safety, 919
a felony, or an improper solicitation for a contribution, the 920
person orally shall notify the person's supervisor or other 921
responsible officer of the person's employer of the violation 922

and subsequently shall file with that supervisor or officer a 923
written report that provides sufficient detail to identify and 924
describe the violation. If the employer does not correct the 925
violation or make a reasonable and good faith effort to correct 926
the violation within twenty-four hours after the oral 927
notification or the receipt of the report, whichever is earlier, 928
the person may file a written report that provides sufficient 929
detail to identify and describe the violation with the 930
prosecuting authority of the county or municipal corporation 931
where the violation occurred, with a peace officer, with the 932
inspector general if the violation is within the inspector 933
general's jurisdiction, with the auditor of state's fraud- 934
reporting system under section 117.103 of the Revised Code if 935
applicable, or with any other appropriate public official or 936
agency that has regulatory authority over the employer and the 937
industry, trade, or business in which the employer is engaged. 938

(g) If a person makes a report under division (A) (1) (f) of 939
this section, the employer, within twenty-four hours after the 940
oral notification was made or the report was received or by the 941
close of business on the next regular business day following the 942
day on which the oral notification was made or the report was 943
received, whichever is later, shall notify the person, in 944
writing, of any effort of the employer to correct the alleged 945
violation or hazard or of the absence of the alleged violation 946
or hazard. 947

(2) If a person becomes aware in the course of the 948
person's employment of a violation of Chapter 3704., 3734., 949
6109., or 6111. of the Revised Code that is a criminal offense, 950
the person directly may notify, either orally or in writing, any 951
appropriate public official or agency that has regulatory 952
authority over the employer and the industry, trade, or business 953

in which the employer is engaged. 954

(3) If a person becomes aware in the course of the 955
person's employment of a violation by a fellow employee of any 956
state or federal statute, any ordinance or regulation of a 957
political subdivision, or any work rule or company policy of the 958
person's employer and the person reasonably believes that the 959
violation is a criminal offense that is likely to cause an 960
imminent risk of physical harm to persons or a hazard to public 961
health or safety, a felony, or an improper solicitation for a 962
contribution, the person orally shall notify the person's 963
supervisor or other responsible officer of the person's employer 964
of the violation and subsequently shall file with that 965
supervisor or officer a written report that provides sufficient 966
detail to identify and describe the violation. 967

(4) The reporting requirements under division (A) of this 968
section are not intended to infringe, and should not be 969
interpreted as infringing on, the constitutional right against 970
self-incrimination. 971

(B) Except as otherwise provided in division (C) of this 972
section, no employer shall take any disciplinary or retaliatory 973
action against ~~an~~ a person for making any report authorized by 974
division (A) (1) or (2) of this section, or as a result of the 975
person's having made any inquiry or taken any other action to 976
ensure the accuracy of any information reported under either 977
such division. No employer shall take any disciplinary or 978
retaliatory action against a person for making any report 979
authorized by division (A) (3) of this section if the person made 980
a reasonable and good faith effort to determine the accuracy of 981
any information so reported, or as a result of the person's 982
having made any inquiry or taken any other action to ensure the 983

accuracy of any information reported under that division. For 984
purposes of this division, disciplinary or retaliatory action by 985
the employer includes, without limitation, doing any of the 986
following: 987

- (1) Removing or suspending the person from employment; 988
- (2) Withholding from the person salary increases or 989
employee benefits to which the person is otherwise entitled; 990
- (3) Transferring or reassigning the person; 991
- (4) Denying the person a promotion that otherwise would 992
have been received; 993
- (5) Reducing the person in pay or position. 994

(C) A person shall make a reasonable and good faith effort 995
to determine the accuracy of any information reported under 996
division (A) (1) or (2) of this section. If the person who makes 997
a report under either division fails to make such an effort, the 998
person may be subject to disciplinary action by the person's 999
employer, including suspension or removal, for reporting 1000
information without a reasonable basis to do so under division 1001
(A) (1) or (2) of this section. 1002

(D) If an employer takes any disciplinary or retaliatory 1003
action against ~~an~~a person as a result of the person's having 1004
filed a report under division (A) of this section, the person 1005
may bring a civil action for appropriate injunctive relief or 1006
for the remedies set forth in division (E) of this section, or 1007
both, within one hundred eighty days after the date the 1008
disciplinary or retaliatory action was taken, in a court of 1009
common pleas in accordance with the Rules of Civil Procedure. A 1010
civil action under this division is not available to a person as 1011
a remedy for any disciplinary or retaliatory action taken by an 1012

appointing authority against the person as a result of the 1013
person's having filed a report under division (A) of section 1014
124.341 of the Revised Code. 1015

(E) The court, in rendering a judgment for the person in 1016
an action brought pursuant to division (D) of this section, may 1017
order, as it determines appropriate, reinstatement of the person 1018
to the same position that the person held at the time of the 1019
disciplinary or retaliatory action and at the same site of 1020
employment or to a comparable position at that site, the payment 1021
of back wages, full reinstatement of fringe benefits and 1022
seniority rights, or any combination of these remedies. The 1023
court also may award the prevailing party all or a portion of 1024
the costs of litigation and, if the person who brought the 1025
action prevails in the action, may award the prevailing person 1026
reasonable attorney's fees, witness fees, and fees for experts 1027
who testify at trial, in an amount the court determines 1028
appropriate. If the court determines that an employer 1029
deliberately has violated division (B) of this section, the 1030
court, in making an award of back pay, may include interest at 1031
the rate specified in section 1343.03 of the Revised Code. 1032

(F) Any report filed with the inspector general under this 1033
section shall be filed as a complaint in accordance with section 1034
121.46 of the Revised Code. 1035

(G) As used in this section: 1036

(1) "Contribution" has the same meaning as in section 1037
3517.01 of the Revised Code. 1038

(2) "Improper solicitation for a contribution" means a 1039
solicitation for a contribution that satisfies all of the 1040
following: 1041

(a) The solicitation violates division (B), (C), or (D) of 1042
section 3517.092 of the Revised Code; 1043

(b) The solicitation is made in person by a public 1044
official or by an employee who has a supervisory role within the 1045
public office; 1046

(c) The public official or employee knowingly made the 1047
solicitation, and the solicitation violates division (B), (C), 1048
or (D) of section 3517.092 of the Revised Code; 1049

(d) The employee reporting the solicitation is an employee 1050
of the same public office as the public official or the employee 1051
with the supervisory role who is making the solicitation. 1052

(3) "Misappropriation of public money" means knowingly 1053
using public money or public property for an unauthorized, 1054
improper, or unlawful purpose to serve a private or personal 1055
benefit or interest. 1056

(4) "Misuse of public money" means knowingly using public 1057
money or public property in a manner not authorized by law. 1058

(5) "Public office" has the same meaning as in section 1059
117.01 of the Revised Code. 1060

(H) Nothing in this section shall be construed to limit 1061
the authority of an auditor to make inquiries or interview state 1062
or local government employees or officials or otherwise perform 1063
audit procedures related to fraud during the course of an audit 1064
or attestation engagement. 1065

Sec. 5162.138. The department of medicaid shall annually 1066
prepare and submit a report to the chairpersons and ranking 1067
members of the committees of the house of representatives and 1068
senate with jurisdiction over medicaid detailing the 1069

department's efforts to ensure integrity within the medicaid 1070
program. 1071

Sec. 5162.139. (A) As used in this section, "electronic 1072
visit verification" or "EVV" has the same meaning as in section 1073
1903(1) of the "Social Security Act," 42 U.S.C. 1903(1). 1074

(B) Not later than the first day of March annually, the 1075
medicaid director shall submit a report to the governor, the 1076
speaker of the house of representatives, the president of the 1077
senate, and the auditor of state regarding electronic visit 1078
verification utilization and compliance for the immediately 1079
preceding calendar year. The report shall, at a minimum, include 1080
all of the following: 1081

(1) Provider utilization rates; 1082

(2) Provider compliance rates; 1083

(3) The number and percentage of claims or service visits 1084
with complete EVV data; 1085

(4) The number and percentage of claims or service visits 1086
with missing, incomplete, manually entered, modified, late, or 1087
unmatched EVV data; 1088

(5) The number of claims denied or paid due to EVV 1089
compliance status; 1090

(6) Compliance trends by provider type and geographic 1091
region; 1092

(7) Enforcement or corrective actions taken by the 1093
department; 1094

(8) Any recommendations to improve EVV utilization, 1095
compliance, payment integrity, and fraud prevention. 1096

(C) The department of medicaid shall make the report 1097
publicly available on the department's internet web site not 1098
later than thirty days after submitting the report in accordance 1099
with division (B) of this section, except that the department 1100
shall redact any information that is confidential under state or 1101
federal law or would otherwise compromise an ongoing audit, 1102
investigation, or enforcement action. 1103

(D) Nothing in this section shall be construed to limit 1104
the authority of the auditor of state under Chapter 117. of the 1105
Revised Code. 1106

Sec. 5162.1311. The department of medicaid shall prepare 1107
and submit an annual report to the general assembly in 1108
accordance with section 101.68 of the Revised Code that details 1109
any billing code that represents an increase or decrease of 1110
greater than fifty per cent in the utilization rate or total 1111
expenditures for a particular service from the previous state 1112
fiscal year. As part of the report, the department shall also 1113
provide data concerning any identified billing code or 1114
utilization rate or expenditure data for an identified service 1115
from the five years preceding the report. 1116

Sec. 5162.17. (A) As used in this section: 1117

(1) "Electronic visit verification" or "EVV" has the same 1118
meaning as in section 1903(1) of the "Social Security Act," 42 1119
U.S.C. 1396b(1). 1120

(2) "Provider" means a medicaid provider required by state 1121
or federal law to utilize an electronic visit verification 1122
system as a condition of payment for services provided under the 1123
medicaid program. 1124

(B) The department of medicaid shall maintain a statewide 1125

electronic visit verification performance dashboard. The 1126
dashboard shall include all of the following information, 1127
updated not less than quarterly: 1128

(1) Statewide utilization rates of electronic visit 1129
verification; 1130

(2) Rates of successful matching between EVV records and 1131
submitted claims for medicaid payment; 1132

(3) Provider compliance trends; 1133

(4) The percentage of claims that are supported by 1134
verified EVV documentation; 1135

(5) Aggregate statistics regarding manually adjusted EVV 1136
entries; 1137

(6) Any other metrics the department determines 1138
appropriate for monitoring compliance, fraud prevention, and 1139
program integrity. 1140

(C) The department shall make aggregate statewide data 1141
available to the public on the department's internet web site. 1142

(D) The department shall use information collected and 1143
maintained under this section to identify providers that may 1144
require technical assistance, additional training, corrective 1145
action, or program integrity review. The department may provide 1146
provider-specific compliance information through a secure 1147
provider portal or dashboard. 1148

(E) The medicaid director may adopt rules under section 1149
5162.02 of the Revised Code to implement this section. 1150

Sec. 5162.18. The department of medicaid shall contract 1151
with a vendor to establish a risk matrix. The matrix shall be 1152

used to connect individuals with national provider identifier 1153
records associated with providers. The matrix shall include 1154
identity proofing, financial distress among providers, and 1155
information concerning a provider's ties to a foreign 1156
organization. 1157

Sec. 5162.19. (A) As used in this section, "alternative 1158
primary insurance coverage source" means an insurance coverage 1159
source that is not coverage under the medicaid program, 1160
including coverage under the medicare program or coverage under 1161
a health benefit plan as defined in section 3922.01 of the 1162
Revised Code. 1163

(B) Prior to the issuance of any payment on a claim for 1164
services provided under either the fee-for-service component of 1165
the medicaid program or the care management system established 1166
under Chapter 5167. of the Revised Code, the department of 1167
medicaid shall require that all claims be electronically 1168
evaluated to determine whether an alternative primary insurance 1169
coverage source exists that is responsible for payment of the 1170
claim. 1171

(C) An evaluation conducted under division (B) of this 1172
section shall use automated algorithmic analysis and insurance 1173
discovery engines capable of identifying alternative primary 1174
insurance coverage sources associated with the medicaid 1175
recipient prior to any payment being issued. 1176

(D) Neither the department nor a medicaid managed care 1177
organization shall issue payment for a claim that has not been 1178
subjected to an evaluation under this section. 1179

(E) If an alternative primary insurance coverage source is 1180
identified, the claim shall be redirected to the identified 1181

alternative primary insurance coverage source prior to any 1182
medicaid payment for the claim, consistent with all medicaid 1183
payer-of-last-resort requirements under state and federal law. 1184

(F) The department shall adopt rules in accordance with 1185
Chapter 119. of the Revised Code as necessary to implement the 1186
requirements of this section, including standards for approved 1187
insurance discovery engines, claims processing timelines, and 1188
reporting requirements. 1189

Sec. 5163.05. No individual is eligible to participate in 1190
the medicaid program in this state unless that individual is 1191
eligible to participate in the medicaid program under section 1192
1903(v) (5) of the "Social Security Act," 42 U.S.C. 1396b(v) (5) . 1193

Sec. 5164.12. The department of medicaid shall impose a 1194
prior authorization requirement on all therapeutic behavioral 1195
services that are provided under the medicaid program. 1196

Sec. 5164.13. (A) As used in this section: 1197

(1) "Independent provider" has the same meaning as in 1198
section 5164.341 of the Revised Code. 1199

(2) "Personal care services" means any service reimbursed 1200
under the medicaid program that assists a recipient who is not 1201
an inpatient in a hospital or a resident of a nursing facility 1202
or ICF/IID with activities of daily living, instrumental 1203
activities of daily living, supervision, homemaker tasks, 1204
attendant care, personal support services, or substantially 1205
similar in-home support services that are not medical services. 1206

(3) "Prior authorization" means advance written approval 1207
issued by the department of medicaid, a medicaid managed care 1208
organization, or other entity contracted to perform utilization 1209
review functions before medicaid payment may be made. 1210

(4) "Waiver agency" has the same meaning as in section 1211
5164.342 of the Revised Code. 1212

(B) Subject to division (I) of this section, the 1213
department of medicaid shall require prior authorization for 1214
personal care services provided under the medicaid program in 1215
accordance with the requirements of this section. 1216

(C) (1) To initiate a request for prior authorization under 1217
this section, an independent provider shall submit a signed and 1218
dated request to the department. An employee of a waiver agency 1219
shall submit a signed and dated request to the waiver agency, 1220
and the waiver agency shall submit the request to the 1221
department. 1222

(2) Included in a request, the independent provider waiver 1223
agency employee shall submit supporting documentation that 1224
provides evidence that the requested services are medically 1225
necessary in accordance with the standards established under 1226
division (E) of this section. 1227

(D) (1) Within ten business days of receiving a request 1228
under division (C) of this section, the department shall notify 1229
the independent provider or waiver agency if additional 1230
information is needed to make a determination. The independent 1231
provider or waiver agency shall submit the additional 1232
information to the department within five business days of 1233
receiving notification from the department. 1234

(2) The department shall review the request and make a 1235
determination within ten business days of receiving all 1236
necessary information. 1237

(E) When reviewing a request submitted under division (C) 1238
of this section, the department shall determine whether the 1239

services for which prior authorization is requested are 1240
medically necessary. The department shall determine services to 1241
be medically necessary if the services satisfy the following: 1242

(1) The services are appropriate for the individual's 1243
health and welfare needs, living arrangement, circumstances, and 1244
expected outcomes. 1245

(2) The services are of an appropriate type, amount, 1246
duration, scope, and intensity. 1247

(3) The services are the most efficient, effective, and 1248
lowest cost alternative that, when combined with other services, 1249
ensure the health and welfare of the individual receiving the 1250
services. 1251

(4) The services protect the individual from substantial 1252
harm expected to occur if the requested services are not 1253
authorized. 1254

(F) After conducting a review of a request received under 1255
this section, the department shall do one of the following: 1256

(1) Approve the request if the department finds that the 1257
services for which prior authorization is requested meet the 1258
criteria established under division (E) of this section; 1259

(2) Deny the request; 1260

(3) Approve the request in part if some of the criteria 1261
set forth in division (E) of this section are satisfied. 1262

(G) When the department makes a determination regarding a 1263
request for prior authorization, the department shall provide 1264
written notification to the independent provider or waiver 1265
agency either setting forth the reason for denial or indicating 1266
that prior authorization has been approved. The department shall 1267

update the prior authorization status to reflect its 1268
determination. 1269

(H) If a request for prior authorization is denied, an 1270
individual, independent provider, or waiver agency may appeal 1271
the denial in accordance with procedures established by the 1272
medicaid director under rules adopted under division (J) of this 1273
section. 1274

(I) This section does not apply to personal care services 1275
provided under a medicaid waiver component administered by the 1276
department of developmental disabilities. 1277

(J) The medicaid director shall adopt rules in accordance 1278
with Chapter 119. of the Revised Code as necessary to implement 1279
this section. 1280

Sec. 5164.292. (A) The department of medicaid shall 1281
require the providers and facilities described in this section 1282
to provide the department or the department's credentialing 1283
designee with the information described in divisions (B) and (C) 1284
of this section every twenty-four months, or sooner if required 1285
under division (D) of this section, as a condition of continued 1286
participation in the medicaid program. 1287

(B) (1) Each of the following providers shall provide the 1288
department or the department's credentialing designee with the 1289
information described in division (B) (2) of this section as 1290
required by this section: 1291

(a) Physicians licensed under Chapter 4731. of the Revised 1292
Code to practice medicine and surgery, osteopathic medicine and 1293
surgery, or podiatric medicine and surgery; 1294

(b) Psychologists licensed under Chapter 4732. of the 1295
Revised Code; 1296

| | |
|---|------|
| <u>(c) Physician assistants licensed under Chapter 4730. of</u> | 1297 |
| <u>the Revised Code;</u> | 1298 |
| <u>(d) Dentists licensed under Chapter 4715. of the Revised</u> | 1299 |
| <u>Code;</u> | 1300 |
| <u>(e) Optometrists licensed under Chapter 4725. of the</u> | 1301 |
| <u>Revised Code;</u> | 1302 |
| <u>(f) Pharmacists licensed under Chapter 4729. of the</u> | 1303 |
| <u>Revised Code;</u> | 1304 |
| <u>(g) Chiropractors licensed under Chapter 4734. of the</u> | 1305 |
| <u>Revised Code;</u> | 1306 |
| <u>(h) Acupuncturists licensed under Chapter 4762. of the</u> | 1307 |
| <u>Revised Code;</u> | 1308 |
| <u>(i) Clinical nurse specialists, certified nurse-midwives,</u> | 1309 |
| <u>or certified nurse practitioners licensed under Chapter 4723. of</u> | 1310 |
| <u>the Revised Code;</u> | 1311 |
| <u>(j) Licensed independent social workers, licensed</u> | 1312 |
| <u>independent marriage and family therapists, or licensed</u> | 1313 |
| <u>professional clinical counselors licensed under Chapter 4757. of</u> | 1314 |
| <u>the Revised Code;</u> | 1315 |
| <u>(k) Licensed independent chemical dependency counselors</u> | 1316 |
| <u>licensed under Chapter 4758. of the Revised Code;</u> | 1317 |
| <u>(l) Certified Ohio behavior analysts licensed under</u> | 1318 |
| <u>Chapter 4783. of the Revised Code;</u> | 1319 |
| <u>(m) Audiologists and speech-language pathologists licensed</u> | 1320 |
| <u>under Chapter 4753. of the Revised Code;</u> | 1321 |
| <u>(n) Occupational therapists and physical therapists</u> | 1322 |
| <u>licensed under Chapter 4755. of the Revised Code;</u> | 1323 |

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| <u>(o) Dietitians licensed under Chapter 4759. of the Revised Code.</u> | 1324 |
| | 1325 |
| <u>(2) Providers described in division (B) (1) of this section shall provide the department or department's credentialing designee with all of the following about the provider in accordance with this section:</u> | 1326 |
| | 1327 |
| | 1328 |
| | 1329 |
| <u>(a) Access to the standard provider credentialing application form used by the council for affordable quality healthcare in accordance with section 3963.05 of the Revised Code within one hundred eighty days prior to credentialing date;</u> | 1330 |
| | 1331 |
| | 1332 |
| | 1333 |
| <u>(b) Active provider licensing information;</u> | 1334 |
| <u>(c) Board certification, if applicable;</u> | 1335 |
| <u>(d) Educational background;</u> | 1336 |
| <u>(e) Clinical privileges, if applicable;</u> | 1337 |
| <u>(f) Medical malpractice insurance;</u> | 1338 |
| <u>(g) Drug enforcement administration certification, if applicable;</u> | 1339 |
| | 1340 |
| <u>(h) National practitioner data bank information regarding malpractice and clinical privilege actions;</u> | 1341 |
| | 1342 |
| <u>(i) Sanctions or limitations on licensure;</u> | 1343 |
| <u>(j) Eligibility for participation in medicare and medicaid, if applicable.</u> | 1344 |
| | 1345 |
| <u>(C) (1) Each of the following facilities shall provide the department or the department's credentialing designee with the information described in division (C) (2) of this section as required by this section:</u> | 1346 |
| | 1347 |
| | 1348 |
| | 1349 |

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|--|------------------------------|
| <u>(a) Nursing facilities as defined in Chapter 5165. of the Revised Code;</u> | 1350 1351 |
| <u>(b) Hospitals as defined in Chapter 3727. of the Revised Code;</u> | 1352 1353 |
| <u>(c) Hospice care programs licensed under Chapter 3712. of the Revised Code;</u> | 1354 1355 |
| <u>(d) Home health agencies licensed by the department of health under Chapter 3740. of the Revised Code;</u> | 1356 1357 |
| <u>(e) Ambulatory surgical facilities as defined in section 3702.30 of the Revised Code;</u> | 1358 1359 |
| <u>(f) Community mental health services providers and community addiction services providers as defined in Chapter 5119. of the Revised Code;</u> | 1360 1361 1362 |
| <u>(g) Freestanding dialysis centers and freestanding radiation therapy centers licensed by the department of health under Chapter 3702. of the Revised Code;</u> | 1363 1364 1365 |
| <u>(h) Residential facilities as defined in Chapter 5119. of the Revised Code.</u> | 1366 1367 |
| <u>(2) Facilities described in division (C)(1) of this section shall provide the department or department's credentialing designee with all of the following about the facility in accordance with this section:</u> | 1368 1369 1370 1371 |
| <u>(a) The standardized credentialing form part B maintained by the department of insurance;</u> | 1372 1373 |
| <u>(b) Active provider licensing information;</u> | 1374 |
| <u>(c) Certification through an accrediting body or a site visit completed by a state designated agency;</u> | 1375 1376 |

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|---|------|
| <u>(d) Eligibility for participation in medicare and</u> | 1377 |
| <u>medicaid, if applicable;</u> | 1378 |
| <u>(e) Verification of good standing with applicable state</u> | 1379 |
| <u>and federal bodies;</u> | 1380 |
| <u>(f) Active malpractice insurance.</u> | 1381 |
| <u>(D) The department of medicaid shall require a provider or</u> | 1382 |
| <u>facility to provide the information described in this section to</u> | 1383 |
| <u>the department or the department's credentialing designee sooner</u> | 1384 |
| <u>than every twenty-four months if required under federal law or</u> | 1385 |
| <u>if the medicaid director determines that a shorter time frame is</u> | 1386 |
| <u>necessary.</u> | 1387 |
| <u>(E) Nothing in this section prohibits the department from</u> | 1388 |
| <u>requesting additional clarifying information at any time during</u> | 1389 |
| <u>the credentialing or recredentialing process from a provider or</u> | 1390 |
| <u>facility.</u> | 1391 |
| <u>Sec. 5164.302.</u> (A) <u>Before entering into a provider</u> | 1392 |
| <u>agreement with a medicaid provider that seeks initial enrollment</u> | 1393 |
| <u>as a provider of home and community-based services under the</u> | 1394 |
| <u>medicaid program, the department of medicaid shall conduct an</u> | 1395 |
| <u>in-person review of the individual or site inspection of the</u> | 1396 |
| <u>entity seeking enrollment as a provider. The department shall</u> | 1397 |
| <u>thereafter conduct a subsequent in-person review or site</u> | 1398 |
| <u>inspection every three years.</u> | 1399 |
| <u>(B) The department shall deny, refuse to revalidate,</u> | 1400 |
| <u>suspend, or terminate a provider agreement if the department</u> | 1401 |
| <u>determines that an individual or entity seeking enrollment as a</u> | 1402 |
| <u>provider of home and community-based services under the medicaid</u> | 1403 |
| <u>program is principally located at the same address as more than</u> | 1404 |
| <u>six other active home and community-based services medicaid</u> | 1405 |

providers or is principally located at the same address as 1406
another home and community-based services medicaid provider when 1407
the address contains less than one thousand square feet of 1408
space. 1409

(C) The department of medicaid shall make a referral to 1410
the auditor of state whenever it is determined that a single 1411
address is the principal place of business for more than six 1412
home and community-based services medicaid providers. 1413

Sec. 5164.303. (A) The department of medicaid shall 1414
coordinate with the attorney general to create a disclaimer form 1415
that provides an affirmative and explicit explanation of the 1416
penalties specified in section 2913.40 of the Revised Code for 1417
medicaid fraud. 1418

(B) The department shall provide a copy of the disclaimer 1419
form to each person or government entity seeking to participate 1420
in the medicaid program as a provider. The department shall not 1421
enter into a provider agreement with a person or government 1422
entity until the person or government entity has signed and 1423
returned the disclaimer form to the department, acknowledging 1424
that the person or government entity has received and reviewed 1425
the form. 1426

Sec. 5164.304. The department of medicaid shall establish 1427
a standardized onboarding process for all providers with a valid 1428
provider agreement with the department. The onboarding process 1429
shall provide instruction regarding and an explanation of all 1430
relevant state and federal laws governing the medicaid program, 1431
including the relevant requirements for home care and personal 1432
care service providers established by the department of 1433
medicaid, the department of developmental disabilities, and the 1434
department of aging. 1435

Sec. 5164.305. (A) As a condition of entering into a 1436
provider agreement with the department of medicaid or 1437
revalidating an existing provider agreement, each person or 1438
government entity seeking to enroll in the medicaid program as a 1439
provider or to revalidate an existing provider agreement shall 1440
disclose to the department the identity of each person with at 1441
least a five per cent direct or indirect ownership interest in 1442
the person or entity. 1443

(B) The department shall verify all ownership disclosures 1444
under division (A) of this section against the exclusion list 1445
maintained by the United States department of health and human 1446
services office of inspector general, prior medicaid sanctions 1447
imposed by another state, and any prior convictions for fraud 1448
that a person may have. 1449

(C) The department shall enter into all agreements 1450
necessary to share information and data obtained under this 1451
section with medicaid managed care organizations to enable 1452
parallel verification by medicaid managed care organizations. An 1453
agreement entered into between the department and a medicaid 1454
managed care organization under this section shall ensure 1455
confidentiality and privacy of the information and data in 1456
accordance with state and federal law. 1457

(D) In implementing this section, the department may 1458
implement best practices from other states' medicaid programs. 1459

Sec. 5164.32. (A) Each medicaid provider agreement shall 1460
expire not later than ~~five~~three years from its effective date 1461
or sooner if determined necessary by the medicaid director. ~~If a~~ 1462
provider agreement entered into before the effective date of 1463
this amendment does not have a time limit, the department of 1464
medicaid shall convert the agreement to a provider agreement 1465

~~with a time limit.~~ 1466

(B) The medicaid director shall adopt rules under section 1467
5164.02 of the Revised Code as necessary to implement this 1468
section. The rules shall be consistent with subpart E of 42 1469
C.F.R. Part 455 and include a process for revalidating medicaid 1470
providers' continued enrollments as providers. All of the 1471
following apply to the revalidation process: 1472

(1) The department shall refuse to revalidate a provider's 1473
provider agreement when the provider fails to file a complete 1474
application for revalidation within the time and in the manner 1475
required under the revalidation process. 1476

(2) If a provider files a complete application for 1477
revalidation within the time and in the manner required under 1478
the revalidation process, but the provider agreement expires 1479
before the department acts on the application or before the 1480
effective date of the department's decision on the application, 1481
the provider, subject to division (B)(3) of this section, may 1482
continue operating under the terms of the expired provider 1483
agreement until the effective date of the department's decision. 1484

(3) If a provider continues operating under the terms of 1485
an expired provider agreement pursuant to division (B)(2) of 1486
this section and the department denies the provider's 1487
application for revalidation, medicaid payments shall not be 1488
made for services or items the provider provides during the 1489
period beginning on the date the provider agreement expired and 1490
ending on the effective date of a subsequent provider agreement, 1491
if any, the department enters into with the provider. 1492

Sec. 5164.33. ~~(A)~~(A) (1) The medicaid director may do the 1493
following for any reason permitted or required by federal law 1494

and when the director determines that the action is in the best 1495
interests of medicaid recipients or the state: 1496

~~(1)~~(a) Deny, refuse to revalidate, suspend, or terminate a 1497
provider agreement; 1498

~~(2)~~(b) Exclude an individual, provider of services or 1499
goods, or other entity from participation in the medicaid 1500
program; 1501

(c) Place a provider or entity at a high risk of fraud on 1502
heightened scrutiny when suspension, termination, or exclusion 1503
of the provider will result in access to care issues for 1504
medicaid recipients. Heightened scrutiny shall include close 1505
monitoring of billing and claims, increased compliance through 1506
corrective action plans, and the potential for termination or 1507
exclusion if violations occur. 1508

(d) Deny an application for a provider agreement or refuse 1509
to revalidate a provider agreement, including applications or 1510
revalidations where the applicant is an owner of, or individual 1511
that resides with an owner of, a current or former medicaid 1512
provider whose provider agreement was terminated or suspended by 1513
the department. 1514

(2) The medicaid director shall suspend a provider 1515
agreement of any provider who has not submitted a claim for 1516
payment to the department for a period of one year. 1517

(3) Whenever a temporary moratorium on the enrollment of 1518
new providers or provider types is issued pursuant to 42 C.F.R. 1519
424.570, the medicaid director shall issue a similar moratorium 1520
and deny all pending applications for provider agreements, 1521
including applications that were pending prior to the issuance 1522
of the temporary moratorium and were still awaiting approval 1523

when the moratorium was issued. In issuing a moratorium under 1524
this section, the director shall comply with the requirements 1525
specified in 42 C.F.R. 455.470. 1526

(B) No individual, provider, or entity excluded from 1527
participation in the medicaid program under this section shall 1528
do any of the following: 1529

(1) Own, or provide services to, any other medicaid 1530
provider or risk contractor; 1531

(2) Arrange for, render, or order services for medicaid 1532
recipients during the period of exclusion; 1533

(3) During the period of exclusion, receive direct 1534
payments under the medicaid program or indirect payments of 1535
medicaid funds in the form of salary, shared fees, contracts, 1536
kickbacks, or rebates from or through any other medicaid 1537
provider or risk contractor. 1538

(C) An individual, provider, or entity excluded from 1539
participation in the medicaid program under this section may 1540
request a reconsideration of the exclusion. The director shall 1541
adopt rules under section 5164.02 of the Revised Code governing 1542
the process for requesting a reconsideration. 1543

(D) Nothing in this section limits the applicability of 1544
section 5164.38 of the Revised Code to a medicaid provider. 1545

(E) To the extent permitted under state or federal law, 1546
the department of medicaid shall share information concerning 1547
the director's decision to deny, refuse to revalidate, suspend, 1548
or terminate a provider agreement under this section with any 1549
other state board or commission responsible for regulating a 1550
component of the health care industry. 1551

(F) The medicaid director may adopt rules under section 5164.02 of the Revised Code as necessary to implement this section. 1552
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Sec. 5164.331. The department of medicaid shall conduct an investigation if the department determines that an individual or entity seeking initial enrollment as a provider shares the same address or telephone number as a current provider. If an investigation conducted by the department determines it necessary, the department shall take the actions described in section 5164.302 of the Revised Code with regard to the individual or entity seeking initial enrollment as a provider. 1555
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Sec. 5164.332. (A) The department of medicaid shall impose a temporary suspension of medicaid payments and conduct an investigation if the department determines there is a suspicious increase in the number of claims for payment submitted by a provider in the first sixty days of the provider entering into a provider agreement with the department. 1563
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(B) The department shall flag and investigate any time the department determines that the number of claims for payment submitted by a provider in a month increases by more than one hundred per cent without a corresponding increase in the number of medicaid enrollees receiving services from the provider. 1569
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Sec. 5164.34. (A) As used in this section: 1574

(1) "Criminal records check" has the same meaning as in section 109.572 of the Revised Code. 1575
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(2) "Disqualifying offense" means any of the offenses listed or described in divisions (A) (3) (a) to (e) of section 109.572 of the Revised Code. 1577
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1579

(3) "Owner" means a person who has an ownership interest 1580

in a medicaid provider in an amount designated in rules 1581
authorized by this section. 1582

(4) "Person subject to the criminal records check 1583
requirement" means the following: 1584

(a) A medicaid provider who is notified under division (E) 1585
(1) of this section that the provider is subject to a criminal 1586
records check; 1587

(b) An owner or prospective owner, officer or prospective 1588
officer, or board member or prospective board member of a 1589
medicaid provider if, pursuant to division (E)(1)(a) of this 1590
section, the owner or prospective owner, officer or prospective 1591
officer, or board member or prospective board member is 1592
specified in information given to the provider under division 1593
(E)(1) of this section; 1594

(c) An employee or prospective employee of a medicaid 1595
provider if both of the following apply: 1596

(i) The employee or prospective employee is specified, 1597
pursuant to division (E)(1)(b) of this section, in information 1598
given to the provider under division (E)(1) of this section. 1599

(ii) The provider is not prohibited by division (D)(3)(b) 1600
of this section from employing the employee or prospective 1601
employee. 1602

(5) "Responsible entity" means the following: 1603

(a) With respect to a criminal records check required 1604
under this section for a medicaid provider, the department of 1605
medicaid or the department's designee; 1606

(b) With respect to a criminal records check required 1607
under this section for an owner or prospective owner, officer or 1608

prospective officer, board member or prospective board member, 1609
or employee or prospective employee of a medicaid provider, the 1610
provider. 1611

(B) This section does not apply to any of the following: 1612

(1) An individual who is subject to a criminal records 1613
check under section 3712.09, 3721.121, 5123.081, or 5123.169 of 1614
the Revised Code; 1615

(2) An individual who is subject to a database review or 1616
criminal records check under section 173.38, 173.381, 3740.11, 1617
or 5164.342 of the Revised Code; 1618

(3) An individual who is an applicant or independent 1619
provider, both as defined in section 5164.341 of the Revised 1620
Code. 1621

(C) The department of medicaid may do any of the 1622
following: 1623

(1) Require that any medicaid provider submit to a 1624
criminal records check as a condition of obtaining or 1625
maintaining a provider agreement; 1626

(2) Require that any medicaid provider require an owner or 1627
prospective owner, officer or prospective officer, or board 1628
member or prospective board member of the provider submit to a 1629
criminal records check as a condition of being an owner, 1630
officer, or board member of the provider; 1631

(3) Require that any medicaid provider do the following: 1632

(a) If so required by rules authorized by this section, 1633
determine pursuant to a database review conducted under division 1634

(F) (1) (a) of this section whether any employee or prospective 1635
employee of the provider is included in a database; 1636

(b) Unless the provider is prohibited by division (D) (3) 1637
(b) of this section from employing the employee or prospective 1638
employee, require the employee or prospective employee to submit 1639
to a criminal records check as a condition of being an employee 1640
of the provider. 1641

(D) (1) The department or the department's designee shall 1642
deny or terminate a medicaid provider's provider agreement if 1643
the provider is a person subject to the criminal records check 1644
requirement and either of the following applies: 1645

(a) The provider fails to obtain the criminal records 1646
check after being given the information specified in division 1647
(G) (1) of this section. 1648

(b) Except as provided in rules authorized by this 1649
section, the provider is found by the criminal records check to 1650
have been convicted of or have pleaded guilty to a disqualifying 1651
offense, regardless of the date of the conviction or the date of 1652
entry of the guilty plea. 1653

(2) No medicaid provider shall permit a person to be an 1654
owner, officer, or board member of the provider if the person is 1655
a person subject to the criminal records check requirement and 1656
either of the following applies: 1657

(a) The person fails to obtain the criminal records check 1658
after being given the information specified in division (G) (1) 1659
of this section. 1660

(b) Except as provided in rules authorized by this 1661
section, the person is found by the criminal records check to 1662
have been convicted of or have pleaded guilty to a disqualifying 1663
offense, regardless of the date of the conviction or the date of 1664
entry of the guilty plea. 1665

(3) Except as provided in division (I) of this section, no
medicaid provider shall employ a person if any of the following
apply:

(a) The person has been excluded from being a medicaid
provider, a medicare provider, or provider for any other federal
health care program.

(b) If the person is subject to a database review
conducted under division (F)(1)(a) of this section, the person
is found by the database review to be included in a database and
the rules authorized by this section regarding the database
review prohibit the provider from employing a person included in
the database.

(c) If the person is a person subject to the criminal
records check requirement, either of the following applies:

(i) The person fails to obtain the criminal records check
after being given the information specified in division (G)(1)
of this section.

(ii) Except as provided in rules authorized by this
section, the person is found by the criminal records check to
have been convicted of or have pleaded guilty to a disqualifying
offense, regardless of the date of the conviction or the date of
entry of the guilty plea.

(E)(1) The department or the department's designee shall
inform each medicaid provider whether the provider is subject to
a criminal records check. For providers with valid provider
agreements, the information shall be given at times designated
in rules authorized by this section. For providers applying to
be medicaid providers, the information shall be given at the
time of initial application. When the information is given, the

department or the department's designee shall specify the 1695
following: 1696

(a) Which of the provider's owners or prospective owners, 1697
officers or prospective officers, or board members or 1698
prospective board members are subject to a criminal records 1699
check; 1700

(b) Which of the provider's employees or prospective 1701
employees are subject to division (C) (3) of this section. 1702

(2) At times designated in rules authorized by this 1703
section, a medicaid provider that is a person subject to the 1704
criminal records check requirement shall do the following: 1705

(a) Inform each person specified under division (E) (1) (a) 1706
of this section that the person is required to submit to a 1707
criminal records check as a condition of being an owner, 1708
officer, or board member of the provider; 1709

(b) Inform each person specified under division (E) (1) (b) 1710
of this section that the person is subject to division (C) (3) of 1711
this section. 1712

(F) (1) If a medicaid provider is a person subject to the 1713
criminal records check requirement, the department or the 1714
department's designee shall require the conduct of a criminal 1715
records check by the superintendent of the bureau of criminal 1716
identification and investigation. A medicaid provider shall 1717
require the conduct of a criminal records check by the 1718
superintendent with respect to each of the persons specified 1719
under division (E) (1) (a) of this section. With respect to each 1720
employee and prospective employee specified under division (E) 1721
(1) (b) of this section, a medicaid provider shall do the 1722
following: 1723

(a) If rules authorized by this section require the provider to conduct a database review to determine whether the employee or prospective employee is included in a database, conduct the database review in accordance with the rules;

(b) Unless the provider is prohibited by division (D)(3) of this section from employing the employee or prospective employee, require the conduct of a criminal records check of the employee or prospective employee by the superintendent.

(2) If a person subject to the criminal records check requirement does not present proof of having been a resident of this state for the five-year period immediately prior to the date the criminal records check is requested or provide evidence that within that five-year period the superintendent has requested information about the person from the federal bureau of investigation in a criminal records check, the responsible entity shall require the person to request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of the person. Even if the person presents proof of having been a resident of this state for the five-year period, the responsible entity may require that the person request that the superintendent obtain information from the federal bureau of investigation and include it in the criminal records check of the person.

(G) Criminal records checks required by this section shall be obtained as follows:

(1) The responsible entity shall provide each person subject to the criminal records check requirement information about accessing and completing the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the

standard impression sheet prescribed pursuant to division (C) (2) 1754
of that section. 1755

(2) The person subject to the criminal records check 1756
requirement shall submit the required form and one complete set 1757
of the person's fingerprint impressions directly to the 1758
superintendent for purposes of conducting the criminal records 1759
check using the applicable methods prescribed by division (C) of 1760
section 109.572 of the Revised Code. The person shall pay all 1761
fees associated with obtaining the criminal records check. 1762

(3) The superintendent shall conduct the criminal records 1763
check in accordance with section 109.572 of the Revised Code. 1764
The person subject to the criminal records check requirement 1765
shall instruct the superintendent to submit the report of the 1766
criminal records check directly to the responsible entity. If 1767
the department or the department's designee is not the 1768
responsible entity, the department or designee may require the 1769
responsible entity to submit the report to the department or 1770
designee. 1771

~~(H) (1) A medicaid provider may employ conditionally a 1772
person for whom a criminal records check is required by this 1773
section prior to obtaining the results of the criminal records 1774
check if both of the following apply: 1775~~

~~(a) The provider is not prohibited by division (D) (3) (b) 1776
of this section from employing the person. 1777~~

~~(b) The person submits a request for the criminal records 1778
check not later than five business days after the person begins 1779
conditional employment. 1780~~

~~(2) Except as provided in division (I) of this section, a 1781
medicaid provider that employs a person conditionally under 1782~~

~~division (H) (1) of this section shall terminate the person's
employment if either of the following apply:~~ 1783
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~~(a) The results of the criminal records check request are
not obtained within the period ending sixty days after the date
the request is made.~~ 1785
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~~(b) Regardless of when the results of the criminal records
check are obtained, the results indicate that the person has
been convicted of or has pleaded guilty to a disqualifying
offense, unless circumstances specified in rules authorized by
this section exist that permit the provider to employ the person
and the provider chooses to employ the person.~~ 1788
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~~(I)~~ As used in this division, "behavioral health services"
means alcohol and drug addiction services, mental health
services, or both. 1794
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A medicaid provider of behavioral health services may 1797
choose to employ a person who the provider would be prohibited 1798
by division (D) (3) of this section from employing ~~or would be~~ 1799
~~required by division (H) (2) of this section to terminate the~~ 1800
~~person's employment~~ if both of the following apply: 1801

(1) The person holds a valid health professional license 1802
issued under the Revised Code granting the person authority to 1803
provide behavioral health services, holds a valid peer recovery 1804
supporter certificate issued pursuant to rules adopted by the 1805
department of ~~mental behavioral health and addiction services,~~ 1806
or is in the process of obtaining such a license or certificate. 1807

(2) The provider does not submit any medicaid claims for 1808
any services the person provides. 1809

~~(J)~~ (I) The report of a criminal records check conducted 1810
pursuant to this section is not a public record for the purposes 1811

of section 149.43 of the Revised Code and shall not be made 1812
available to any person other than the following: 1813

(1) The person who is the subject of the criminal records 1814
check or the person's representative; 1815

(2) The medicaid director and the staff of the department 1816
who are involved in the administration of the medicaid program; 1817

(3) The department's designee; 1818

(4) The medicaid provider who required the person who is 1819
the subject of the criminal records check to submit to the 1820
criminal records check; 1821

(5) An individual receiving or deciding whether to 1822
receive, from the subject of the criminal records check, home 1823
and community-based services available under the medicaid state 1824
plan; 1825

(6) A court, hearing officer, or other necessary 1826
individual involved in a case or administrative hearing dealing 1827
with any of the following: 1828

(a) The denial, suspension, or termination of a provider 1829
agreement; 1830

(b) A person's denial of employment, termination of 1831
employment, or employment or unemployment benefits; 1832

(c) A civil or criminal action regarding the medicaid 1833
program. 1834

With respect to an administrative hearing dealing with the 1835
denial, suspension, or termination of a provider agreement, the 1836
report of a criminal records check may be introduced as evidence 1837
at the hearing and if admitted, becomes part of the hearing 1838

record. Any such report shall be admitted only under seal and 1839
shall maintain its status as not a public record. 1840

~~(K)~~(J) The medicaid director may adopt rules under section 1841
5164.02 of the Revised Code to implement this section. If the 1842
director adopts such rules, the rules shall designate the times 1843
at which a criminal records check must be conducted under this 1844
section. The rules may do any of the following: 1845

(1) Designate the categories of persons who are subject to 1846
a criminal records check under this section; 1847

(2) Specify circumstances under which the department or 1848
the department's designee may continue a provider agreement or 1849
issue a provider agreement when the medicaid provider is found 1850
by a criminal records check to have been convicted of or pleaded 1851
guilty to a disqualifying offense; 1852

(3) Specify circumstances under which a medicaid provider 1853
may permit a person to be an employee, owner, officer, or board 1854
member of the provider when the person is found by a criminal 1855
records check conducted pursuant to this section to have been 1856
convicted of or have pleaded guilty to a disqualifying offense; 1857

(4) Specify all of the following: 1858

(a) The circumstances under which a database review must 1859
be conducted under division (F)(1)(a) of this section to 1860
determine whether an employee or prospective employee of a 1861
medicaid provider is included in a database; 1862

(b) The procedures for conducting the database review; 1863

(c) The databases that are to be checked; 1864

(d) The circumstances under which, except as provided in 1865
division ~~(I)~~(H) of this section, a medicaid provider is 1866

prohibited from employing a person who is found by the database review to be included in a database. 1867
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Sec. 5164.342. (A) As used in this section: 1869

"Applicant" means a person who is under final consideration for employment with a waiver agency in a full-time, part-time, or temporary position that involves providing home and community-based services. 1870
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"Community-based long-term care provider" means a provider as defined in section 173.39 of the Revised Code. 1874
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"Community-based long-term care subcontractor" means a subcontractor as defined in section 173.38 of the Revised Code. 1876
1877

"Criminal records check" has the same meaning as in section 109.572 of the Revised Code. 1878
1879

"Disqualifying offense" means any of the offenses listed or described in divisions (A) (3) (a) to (e) of section 109.572 of the Revised Code. 1880
1881
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"Employee" means a person employed by a waiver agency in a full-time, part-time, or temporary position that involves providing home and community-based services. 1883
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"Waiver agency" means a person or government entity that provides home and community-based services under a home and community-based services medicaid waiver component administered by the department of medicaid, other than such a person or government entity that is certified under the medicare program. 1886
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"Waiver agency" does not mean an independent provider as defined in section 5164.341 of the Revised Code. 1891
1892

(B) This section does not apply to any individual who is subject to a database review or criminal records check under 1893
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section 3740.11 of the Revised Code. If a waiver agency also is 1895
a community-based long-term care provider or community-based 1896
long-term care subcontractor, the waiver agency may provide for 1897
any of its applicants and employees who are not subject to 1898
database reviews and criminal records checks under section 1899
173.38 of the Revised Code to undergo database reviews and 1900
criminal records checks in accordance with that section rather 1901
than this section. 1902

(C) No waiver agency shall employ an applicant or continue 1903
to employ an employee in a position that involves providing home 1904
and community-based services if any of the following apply: 1905

(1) A review of the databases listed in division (E) of 1906
this section reveals any of the following: 1907

(a) That the applicant or employee is included in one or 1908
more of the databases listed in divisions (E) (1) to (5) of this 1909
section; 1910

(b) That there is in the state nurse aide registry 1911
established under section 3721.32 of the Revised Code a 1912
statement detailing findings by the director of health that the 1913
applicant or employee abused, neglected, or exploited a long- 1914
term care facility or residential care facility resident or 1915
misappropriated property of such a resident; 1916

(c) That the applicant or employee is included in one or 1917
more of the databases, if any, specified in rules authorized by 1918
this section and the rules prohibit the waiver agency from 1919
employing an applicant or continuing to employ an employee 1920
included in such a database in a position that involves 1921
providing home and community-based services. 1922

(2) After the applicant or employee is given the 1923

information and notification required by divisions (F) (2) (a) and 1924
(b) of this section, the applicant or employee fails to do 1925
either of the following: 1926

(a) Access, complete, or forward to the superintendent of 1927
the bureau of criminal identification and investigation the form 1928
prescribed to division (C) (1) of section 109.572 of the Revised 1929
Code or the standard impression sheet prescribed pursuant to 1930
division (C) (2) of that section; 1931

(b) Instruct the superintendent to submit the completed 1932
report of the criminal records check required by this section 1933
directly to the chief administrator of the waiver agency. 1934

(3) Except as provided in rules authorized by this 1935
section, the applicant or employee is found by a criminal 1936
records check required by this section to have been convicted of 1937
or have pleaded guilty to a disqualifying offense, regardless of 1938
the date of the conviction or date of entry of the guilty plea. 1939

(D) At the time of each applicant's initial application 1940
for employment in a position that involves providing home and 1941
community-based services, the chief administrator of a waiver 1942
agency shall inform the applicant of both of the following: 1943

(1) That a review of the databases listed in division (E) 1944
of this section will be conducted to determine whether the 1945
waiver agency is prohibited by division (C) (1) of this section 1946
from employing the applicant in the position; 1947

(2) That, unless the database review reveals that the 1948
applicant may not be employed in the position, a criminal 1949
records check of the applicant will be conducted and the 1950
applicant is required to provide a set of the applicant's 1951
fingerprint impressions as part of the criminal records check. 1952

(E) As a condition of employing any applicant in a position that involves providing home and community-based services, the chief administrator of a waiver agency shall conduct a database review of the applicant in accordance with rules authorized by this section. If rules authorized by this section so require, the chief administrator of a waiver agency shall conduct a database review of an employee in accordance with the rules as a condition of continuing to employ the employee in a position that involves providing home and community-based services. A database review shall determine whether the applicant or employee is included in any of the following:

(1) The excluded parties list system that is maintained by the United States general services administration pursuant to subpart 9.4 of the federal acquisition regulation and available at the federal web site known as the system for award management;

(2) The list of excluded individuals and entities maintained by the office of inspector general in the United States department of health and human services pursuant to the "Social Security Act," sections 1128 and 1156, 42 U.S.C. 1320a-7 and 1320c-5;

(3) The registry of developmental disabilities employees established under section 5123.52 of the Revised Code;

(4) The internet-based sex offender and child-victim offender database established under division (A)(11) of section 2950.13 of the Revised Code;

(5) The internet-based database of inmates established under section 5120.66 of the Revised Code;

(6) The state nurse aide registry established under 1982
section 3721.32 of the Revised Code; 1983

(7) Any other database, if any, specified in rules 1984
authorized by this section. 1985

(F) (1) As a condition of employing any applicant in a 1986
position that involves providing home and community-based 1987
services, the chief administrator of a waiver agency shall 1988
require the applicant to request that the superintendent of the 1989
bureau of criminal identification and investigation conduct a 1990
criminal records check of the applicant. If rules authorized by 1991
this section so require, the chief administrator of a waiver 1992
agency shall require an employee to request that the 1993
superintendent conduct a criminal records check of the employee 1994
at times specified in the rules as a condition of continuing to 1995
employ the employee in a position that involves providing home 1996
and community-based services. However, a criminal records check 1997
is not required for an applicant or employee if the waiver 1998
agency is prohibited by division (C) (1) of this section from 1999
employing the applicant or continuing to employ the employee in 2000
a position that involves providing home and community-based 2001
services. If an applicant or employee for whom a criminal 2002
records check request is required by this section does not 2003
present proof of having been a resident of this state for the 2004
five-year period immediately prior to the date the criminal 2005
records check is requested or provide evidence that within that 2006
five-year period the superintendent has requested information 2007
about the applicant or employee from the federal bureau of 2008
investigation in a criminal records check, the chief 2009
administrator shall require the applicant or employee to request 2010
that the superintendent obtain information from the federal 2011
bureau of investigation as part of the criminal records check. 2012

Even if an applicant or employee for whom a criminal records 2013
check request is required by this section presents proof of 2014
having been a resident of this state for the five-year period, 2015
the chief administrator may require the applicant or employee to 2016
request that the superintendent include information from the 2017
federal bureau of investigation in the criminal records check. 2018

(2) The chief administrator shall provide the following to 2019
each applicant and employee for whom a criminal records check is 2020
required by this section: 2021

(a) Information about accessing, completing, and 2022
forwarding to the superintendent of the bureau of criminal 2023
identification and investigation the form prescribed pursuant to 2024
division (C)(1) of section 109.572 of the Revised Code and the 2025
standard impression sheet prescribed pursuant to division (C)(2) 2026
of that section; 2027

(b) Written notification that the applicant or employee is 2028
to instruct the superintendent to submit the completed report of 2029
the criminal records check directly to the chief administrator. 2030

(3) A waiver agency shall pay to the bureau of criminal 2031
identification and investigation the fee prescribed pursuant to 2032
division (C)(3) of section 109.572 of the Revised Code for any 2033
criminal records check required by this section. However, a 2034
waiver agency may require an applicant to pay to the bureau the 2035
fee for a criminal records check of the applicant. If the waiver 2036
agency pays the fee for an applicant, it may charge the 2037
applicant a fee not exceeding the amount the waiver agency pays 2038
to the bureau under this section if the waiver agency notifies 2039
the applicant at the time of initial application for employment 2040
of the amount of the fee and that, unless the fee is paid, the 2041
applicant will not be considered for employment. 2042

~~(G) (1) A waiver agency may employ conditionally an applicant for whom a criminal records check is required by this section prior to obtaining the results of the criminal records check if both of the following apply:~~ 2043
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~~(a) The waiver agency is not prohibited by division (C) (1) of this section from employing the applicant in a position that involves providing home and community-based services.~~ 2047
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~~(b) The chief administrator of the waiver agency requires the applicant to request a criminal records check regarding the applicant in accordance with division (F) (1) of this section not later than five business days after the applicant begins conditional employment.~~ 2050
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~~(2) A waiver agency that employs an applicant conditionally under division (C) (1) of this section shall terminate the applicant's employment if the results of the criminal records check, other than the results of any request for information from the federal bureau of investigation, are not obtained within the period ending sixty days after the date the request for the criminal records check is made. Regardless of when the results of the criminal records check are obtained, if the results indicate that the applicant has been convicted of or has pleaded guilty to a disqualifying offense, the waiver agency shall terminate the applicant's employment unless circumstances specified in rules authorized by this section exist that permit the waiver agency to employ the applicant and the waiver agency chooses to employ the applicant.~~ 2055
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~~(H) The report of any criminal records check conducted pursuant to a request made under this section is not a public record for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the~~ 2069
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| | |
|--|----------------------|
| following: | 2073 |
| (1) The applicant or employee who is the subject of the criminal records check or the representative of the applicant or employee; | 2074 2075 2076 |
| (2) The chief administrator of the waiver agency that requires the applicant or employee to request the criminal records check or the administrator's representative; | 2077 2078 2079 |
| (3) The medicaid director and the staff of the department who are involved in the administration of the medicaid program; | 2080 2081 |
| (4) The director of aging or the director's designee if the waiver agency also is a community-based long-term care provider or community-based long-term care subcontractor; | 2082 2083 2084 |
| (5) An individual receiving or deciding whether to receive home and community-based services from the subject of the criminal records check; | 2085 2086 2087 |
| (6) A court, hearing officer, or other necessary individual involved in a case or administrative hearing dealing with any of the following: | 2088 2089 2090 |
| (a) A denial of employment of the applicant or employee; | 2091 |
| (b) Employment or unemployment benefits of the applicant or employee; | 2092 2093 |
| (c) A civil or criminal action regarding the medicaid program; | 2094 2095 |
| (d) A denial, suspension, or termination of a provider agreement. | 2096 2097 |
| With respect to an administrative hearing dealing with a denial, suspension, or termination of a provider agreement, the | 2098 2099 |

report of a criminal records check may be introduced as evidence 2100
at the hearing and if admitted, becomes part of the hearing 2101
record. Any such report shall be admitted only under seal and 2102
shall maintain its status as not a public record. 2103

~~(I)~~ (H) The medicaid director shall adopt rules under 2104
section 5164.02 of the Revised Code to implement this section. 2105

(1) The rules may do the following: 2106

(a) Require employees to undergo database reviews and 2107
criminal records checks under this section; 2108

(b) If the rules require employees to undergo database 2109
reviews and criminal records checks under this section, exempt 2110
one or more classes of employees from the requirements; 2111

(c) For the purpose of division (E) (7) of this section, 2112
specify other databases that are to be checked as part of a 2113
database review conducted under this section. 2114

(2) The rules shall specify all of the following: 2115

(a) The procedures for conducting a database review under 2116
this section; 2117

(b) If the rules require employees to undergo database 2118
reviews and criminal records checks under this section, the 2119
times at which the database reviews and criminal records checks 2120
are to be conducted; 2121

(c) If the rules specify other databases to be checked as 2122
part of a database review, the circumstances under which a 2123
waiver agency is prohibited from employing an applicant or 2124
continuing to employ an employee who is found by the database 2125
review to be included in one or more of those databases; 2126

(d) The circumstances under which a waiver agency may 2127
employ an applicant or employee who is found by a criminal 2128
records check required by this section to have been convicted of 2129
or have pleaded guilty to a disqualifying offense. 2130

~~(J)~~(I) The amendments made by H.B. 487 of the 129th 2131
general assembly to this section do not preclude the department 2132
of medicaid from taking action against a person for failure to 2133
comply with former division (H) of this section as that division 2134
existed on the day preceding January 1, 2013. 2135

Sec. 5164.36. (A) As used in this section: 2136

(1) "Credible allegation of fraud" has the same meaning as 2137
in 42 C.F.R. 455.2, except that for purposes of this section any 2138
reference in that regulation to the "state" or the "state 2139
medicaid agency" means the department of medicaid. A "credible 2140
allegation of fraud" includes falsified or fake check-ins, 2141
forged paperwork, double billing for medicaid services, identity 2142
misuse, impossible travel patterns, claims that overlap with a 2143
hospital stay that are not provided in accordance with an 2144
authorized individual service plan, and coordinated billing 2145
rings. 2146

(2) "Disqualifying indictment" means an indictment of a 2147
medicaid provider or its officer, authorized agent, associate, 2148
manager, employee, or, if the provider is a noninstitutional 2149
provider, its owner, if either of the following applies: 2150

(a) The indictment charges the person with committing an 2151
act to which both of the following apply: 2152

(i) The act would be a felony or misdemeanor under the 2153
laws of this state or the jurisdiction within which the act 2154
occurred. 2155

(ii) The act relates to or results from furnishing or 2156
billing for medicaid services under the medicaid program or 2157
relates to or results from performing management or 2158
administrative services relating to furnishing medicaid services 2159
under the medicaid program. 2160

(b) The indictment charges the person with committing an 2161
act that would constitute a disqualifying offense. 2162

(3) "Disqualifying offense" means any of the offenses 2163
listed or described in divisions (A) (3) (a) to (e) of section 2164
109.572 of the Revised Code. 2165

(4) "Noninstitutional medicaid provider" means any person 2166
or entity with a provider agreement other than a hospital, 2167
nursing facility, or ICF/IID. 2168

(5) "Owner" means any person having at least five per cent 2169
ownership in a noninstitutional medicaid provider. 2170

(B) (1) Except as provided in division (C) of this section 2171
and in rules authorized by this section, the department of 2172
medicaid shall suspend the provider agreement held by a medicaid 2173
provider on determining either of the following: 2174

(a) There is a credible allegation of fraud against any of 2175
the following for which an investigation is pending under the 2176
medicaid program: 2177

(i) The medicaid provider; 2178

(ii) The medicaid provider's owner, officer, authorized 2179
agent, associate, manager, or employee. 2180

(b) A disqualifying indictment has been issued against any 2181
of the following: 2182

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| (i) The medicaid provider; | 2183 |
| (ii) The medicaid provider's officer, authorized agent, associate, manager, or employee; | 2184 2185 |
| (iii) If the medicaid provider is a noninstitutional provider, its owner. | 2186 2187 |
| (2) Subject to division (C) of this section, the department shall also suspend all medicaid payments to a medicaid provider for services rendered, regardless of the date that the services are rendered, when the department suspends the provider's provider agreement under this section. | 2188 2189 2190 2191 2192 |
| (3) <u>Except as otherwise provided in 42 C.F.R. 455.23, when the attorney general or auditor of state submits a credible allegation of fraud with evidence to the department, the department shall take the following actions:</u> | 2193 2194 2195 2196 |
| (a) <u>Suspend medicaid payments to the provider in whole, in part, or as applied to targeted payments;</u> | 2197 2198 |
| (b) <u>Require pre-payment review of the provider's claims.</u> | 2199 |
| (4) <u>The suspension of a provider agreement or medicaid payments shall continue in effect until the latest of the following occurs:</u> | 2200 2201 2202 |
| (a) If the suspension is the result of a credible allegation of fraud, the department or a prosecuting authority determines that there is insufficient evidence of fraud by the medicaid provider; | 2203 2204 2205 2206 |
| (b) Regardless of whether the suspension is the result of a credible allegation of fraud or a disqualifying indictment, the proceedings in any related criminal case are completed through dismissal of the indictment or through sentencing after | 2207 2208 2209 2210 |

conviction or entry of a guilty plea or through finding of not 2211
guilty or, if the department commences a process to terminate 2212
the suspended provider agreement, the termination process is 2213
concluded; 2214

(c) The medicaid provider pays in full all fines and debts 2215
due and owing to the department or makes arrangements 2216
satisfactory to the department to fulfill those obligations; 2217

(d) A civil action related to a credible allegation of 2218
fraud or disqualifying indictment is not pending against the 2219
medicaid provider; 2220

(e) If payments are suspended under division (B) (3) of 2221
this section, until the completion of the administrative review 2222
described in division (D) (2) of this section. 2223

~~(4)~~(5) (a) When a provider agreement is suspended under 2224
this section, none of the following shall take, during the 2225
period of the suspension, any of the actions specified in 2226
division ~~(B) (4) (b)~~ (B) (5) (b) of this section: 2227

(i) The medicaid provider; 2228

(ii) If the suspension is the result of an action taken by 2229
an officer, authorized agent, associate, manager, or employee of 2230
the medicaid provider, that person; 2231

(iii) If the medicaid provider is a noninstitutional 2232
provider and the suspension is the result of an action taken by 2233
the owner of the provider, the owner. 2234

(b) The following are the actions that persons specified 2235
in division ~~(B) (4) (a)~~ (B) (5) (a) of this section cannot take 2236
during the suspension of a provider agreement: 2237

(i) Own any other medicaid provider or risk contractor; 2238

(ii) Arrange, render, or order services on behalf of any other medicaid provider or risk contractor; 2239
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(iii) Arrange or order services for medicaid recipients or render services to medicaid recipients; 2241
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(iv) Receive direct payments under the medicaid program or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any other medicaid provider or risk contractor. 2243
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(C) The department shall not suspend a provider agreement or medicaid payments under division (B) of this section if either of the following is the case: 2247
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(1) The medicaid provider or, if the provider is a noninstitutional provider, the owner can demonstrate through the submission of written evidence that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the credible allegation of fraud or disqualifying indictment. 2250
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(2) The medicaid provider or, if the provider is a noninstitutional provider, the owner can demonstrate that good cause exists not to suspend the provider agreement or payments. 2256
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With respect to the evidence described in division (C) (1) of this section, the department shall grant, prior to suspension, the provider or owner an opportunity to submit the written evidence to the department. 2259
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With respect to a demonstration of good cause described in division (C) (2) of this section, the department shall specify in rules adopted under section 5164.02 of the Revised Code what constitutes good cause and the information, documents, or other evidence that must be submitted to the department as part of the 2263
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demonstration. 2268

~~(D)~~(D) (1) After suspending a provider agreement under 2269
division ~~(B)~~(B) (1) of this section, the department shall send 2270
notice of the suspension to the affected medicaid provider or, 2271
if the provider is a noninstitutional provider, the owner in 2272
accordance with the following time frames: 2273

~~(1)~~(a) Not later than five days after the suspension, 2274
unless a law enforcement agency makes a written request to 2275
temporarily delay the notice; 2276

~~(2)~~(b) If a law enforcement agency makes a written request 2277
to temporarily delay the notice, not later than thirty days 2278
after the suspension occurs subject to the conditions specified 2279
in division (E) of this section. 2280

(2) If medicaid payments are suspended in accordance with 2281
division (B) (3) of this section, the medicaid provider or, if 2282
the provider is a noninstitutional provider, the owner shall be 2283
entitled to a hearing and independent administrative review of 2284
the suspension. 2285

(E) A written request for a temporary delay described in 2286
division ~~(D)~~~~(2)~~(D) (1) (b) of this section may be renewed in 2287
writing by a law enforcement agency not more than two times 2288
except that under no circumstances shall the notice be issued 2289
more than ninety days after the suspension occurs. 2290

(F) The notice required by division (D) of this section 2291
shall do all of the following: 2292

(1) State that payments are being suspended in accordance 2293
with this section and 42 C.F.R. 455.23; 2294

(2) Set forth the general allegations related to the 2295

nature of the conduct leading to the suspension, except that it 2296
is not necessary to disclose any specific information concerning 2297
an ongoing investigation; 2298

(3) State that the suspension continues to be in effect 2299
until the latest of the circumstances specified in division ~~(B)~~ 2300
~~(3)~~ (B) (4) of this section occur; 2301

(4) Specify, if applicable, the type or types of medicaid 2302
claims or business units of the medicaid provider that are 2303
affected by the suspension; 2304

(5) Inform the medicaid provider or owner of the 2305
opportunity to submit to the department, not later than thirty 2306
days after receiving the notice, a request for reconsideration 2307
of the suspension in accordance with division (G) of this 2308
section. 2309

(G) (1) Pursuant to the procedure specified in division (G) 2310
(2) of this section, a medicaid provider subject to a suspension 2311
under this section or, if the provider is a noninstitutional 2312
provider, the owner may request a reconsideration of the 2313
suspension. The request shall be made not later than thirty days 2314
after receipt of a notice required by division ~~(D)~~ (D) (1) of this 2315
section. The reconsideration is not subject to an adjudication 2316
hearing pursuant to Chapter 119. of the Revised Code. 2317

(2) In requesting a reconsideration, the medicaid provider 2318
or owner shall submit written information and documents to the 2319
department. The information and documents may pertain to either 2320
of the following issues: 2321

(a) Whether the determination to suspend the provider 2322
agreement was based on a mistake of fact, other than the 2323
validity of an indictment in a related criminal case. 2324

(b) If there has been an indictment in a related criminal case, whether the indictment is a disqualifying indictment. 2325
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(H) The department shall review the information and documents submitted in a request made under division (G) of this section for reconsideration of a suspension. After the review, the suspension may be affirmed, reversed, or modified, in whole or in part. The department shall notify the affected provider or owner of the results of the review. 2327
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(I) Rules adopted under section 5164.02 of the Revised Code may specify circumstances under which the department would not suspend a provider agreement pursuant to this section. The department shall adopt rules establishing expedited appeal procedures for purposes of an administrative review conducted under division (D) (2) of this section. 2333
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Sec. 5164.40. As used in sections 5164.40 to 5164.406 of the Revised Code: 2339
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(A) "Breadcrumb location data" means data that provides a geographical position during a designated time period allowing the movements of a user to be tracked. 2341
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(B) "Electronic verification system" means an electronic system capable of recording and verifying data elements related to the delivery of health care services covered by the medicaid program. 2344
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(C) "GPS-based verification" has the same meaning as in section 5164.42 of the Revised Code. 2348
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(D) "Nonemergency medical transportation" means transportation for which immediate response is not needed for the provision of medical treatment and is provided to a medicaid recipient in accordance with 42 C.F.R. 431.53. "Nonemergency 2350
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medical transportation" does not include transportation 2354
conducted by an emergency medical service organization or 2355
nonemergency medical service organization as defined in section 2356
4766.01 of the Revised Code that is licensed by the state board 2357
of emergency medical, fire, and transportation services. 2358

Sec. 5164.401. (A) The department of medicaid shall 2359
develop, procure, certify, or approve a process or system to 2360
obtain global positioning system coordinates to verify 2361
nonemergency medical transportation services provided under the 2362
medicaid program to medicaid recipients. In developing, 2363
procuring, certifying, or approving a system under this section, 2364
the department may do any of the following: 2365

(1) Establish an internal electronic verification system; 2366

(2) Contract with one or more vendors to establish an 2367
electronic verification system; 2368

(3) Integrate with existing electronic verification 2369
systems utilized by the department. 2370

(B) A system or systems developed, procured, certified, or 2371
approved in accordance with this section shall do all of the 2372
following: 2373

(1) Utilize a ride dispatch system that is similar to 2374
other private transportation services; 2375

(2) Utilize GPS-based verification to track a provider's 2376
arrival at a pickup location, initiation of a transport, arrival 2377
at a drop-off location, and completion of a transport; 2378

(3) Record timestamps, route data, and total distance 2379
traveled during a transport; 2380

(4) Be capable of transmitting data directly to the 2381

department as a condition of payment. 2382

(C) (1) An electronic verification system developed, 2383
procured, certified, or approved in accordance with this section 2384
shall be used to ensure payment integrity within the medicaid 2385
program, compliance with state and federal requirements, and 2386
serve as a fraud prevention measure within the medicaid program. 2387
No data transmitted or stored by an electronic verification 2388
system shall be used to conduct unrelated surveillance of 2389
medicaid providers or for enforcement purposes unrelated to the 2390
medicaid program. 2391

(2) All data transmitted or stored by an electronic 2392
verification system shall be encrypted, be subject to role-based 2393
access controls and audit logs, and comply with all requirements 2394
under state and federal law regarding the protection of patient 2395
information. 2396

(D) The department shall integrate any electronic 2397
verification system developed, procured, certified, or approved 2398
under this section with the department's existing claims and 2399
encounters database and systems. If necessary, the department 2400
shall coordinate with medicaid managed care organizations and 2401
seek any necessary federal approval to facilitate coordination 2402
with electronic verification systems in the medicare program. 2403

(E) (1) Not later than six months after the effective date 2404
of this section, the department shall develop technical 2405
standards and a plan for implementing the requirement of this 2406
section and sections 5164.402 to 5164.406 of the Revised Code. 2407
The department shall submit a copy of the plan to the general 2408
assembly in accordance with section 101.68 of the Revised Code. 2409

(2) Not later than twelve months after the effective date 2410

of this section, the department shall establish a pilot program 2411
under which certain medicaid providers must utilize the 2412
electronic verification systems established under this section. 2413

(3) Beginning not later than eighteen months after the 2414
effective date of this section, the department shall require all 2415
nonemergency medical transportation service providers to utilize 2416
an electronic verification system established under division (B) 2417
of this section. 2418

(F) In establishing and requiring utilization of 2419
electronic visit verification systems under this section, the 2420
department shall ensure that medicaid recipients are not denied 2421
medically necessary services solely on the basis of a provider's 2422
failure to utilize a required system. The department shall 2423
further ensure that any transition periods that are the result 2424
of implementing the requirements of this section do not impact 2425
the continuity of care for medicaid recipients. The department 2426
shall provide training and technical support to providers to 2427
ensure compliance with this section. 2428

Sec. 5164.402. (A) Upon full implementation of the 2429
electronic verification systems developed, procured, certified, 2430
or approved in accordance with section 5164.401 of the Revised 2431
Code, no nonemergency medical transportation service provider 2432
shall be eligible to receive medicaid payment for transportation 2433
services provided to a medicaid recipient unless the provider 2434
submits all necessary data through an electronic verification 2435
system. The department of medicaid shall pay a claim for 2436
transportation services submitted through an electronic 2437
verification system if all of the following conditions are 2438
satisfied: 2439

(1) All required GPS-based verification and timestamp data 2440

are present. 2441

(2) The breadcrumb location data utilized by an electronic verification system is consistent with the billed services. 2442
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(3) No unresolved discrepancies about the claim exist. 2444

(B) The department shall establish a process by which a nonemergency medical transportation service provider may seek an exemption from utilizing an electronic verification system. The department may permit an exemption for any of the following reasons: 2445
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(1) Equipment failure or network unavailability, including rural connectivity issues; 2450
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(2) Emergencies; 2452

(3) Concerns for the safety of the medicaid recipient. 2453

(C) Before granting an exemption under division (B) of this section, the department shall require a nonemergency medical transportation service provider to submit written documentation detailing why an exemption should be granted. The department shall routinely monitor the number of exemptions requested by a provider. 2454
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Sec. 5164.403. (A) Not later than five years after the effective date of this section, the department of medicaid shall develop and implement a system by which global positioning system coordinates data received from a nonemergency medical transportation service provider may be cross-referenced with claims for medicaid payment submitted to the department by other medicaid providers. The system established in accordance with this section shall be capable of verifying all of the following: 2460
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(1) The medicaid recipient who received the nonemergency 2468

medical transportation services was transported for the purpose 2469
of receiving a medicaid service. 2470

(2) The medicaid recipient who received the nonemergency 2471
medical transportation services was transported to a medicaid 2472
provider with an active and valid provider agreement at the time 2473
of transport. 2474

(3) The records are received by the department within an 2475
allowable timeframe established under division (B) of this 2476
section and reflect an encounter, claim, or billing activity for 2477
a service described in division (A) (1) or (2) of this section. 2478

(B) The department shall establish an allowable timeframe 2479
under which claims for medicaid payment for transportation 2480
claims may be cross-referenced and matched against claims for 2481
other medicaid services. The allowable timeframe shall account 2482
for documented exceptions that create delays including provider 2483
cancellations, appointment rescheduling, emergency diversions, 2484
delayed billing, and administrative errors. 2485

Sec. 5164.404. (A) The department of medicaid shall 2486
develop and implement automated fraud-detection tools to assist 2487
with identifying fraud through the use of the electronic 2488
verification systems developed, procured, certified, or approved 2489
under section 5164.401 of the Revised Code. Any fraud-detection 2490
tools shall be capable of flagging irregular patterns of 2491
activity by medicaid providers that are required to utilize the 2492
electronic verification systems, including all of the following: 2493

(1) The seeking and approval of repeated exceptions under 2494
section 5164.402 of the Revised Code; 2495

(2) Anomalous or irregular patterns by nonemergency 2496
medical transportation service providers; 2497

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| <u>(3) Discrepancies between location data and submitted</u> | 2498 |
| <u>claims.</u> | 2499 |
| <u>(B) The department shall conduct periodic audits and</u> | 2500 |
| <u>investigations concerning data collected through use of the</u> | 2501 |
| <u>electronic verification systems under section 5164.401 of the</u> | 2502 |
| <u>Revised Code and fraud-detection tools implemented under this</u> | 2503 |
| <u>section. The department may suspend a medicaid provider's</u> | 2504 |
| <u>provider agreement for failing to comply with an audit or</u> | 2505 |
| <u>investigation conducted under this section.</u> | 2506 |
| <u>(C) If an audit or investigation conducted in accordance</u> | 2507 |
| <u>with this section results in a credible allegation of fraud as</u> | 2508 |
| <u>defined in section 5164.36 of the Revised Code, the department</u> | 2509 |
| <u>shall handle the credible allegation in accordance with that</u> | 2510 |
| <u>section and refer the credible allegation to the attorney</u> | 2511 |
| <u>general for investigation.</u> | 2512 |
| <u>Sec. 5164.405.</u> <u>Annually, the department of medicaid shall</u> | 2513 |
| <u>submit a report to the general assembly detailing electronic</u> | 2514 |
| <u>verification systems developed, procured, certified, or approved</u> | 2515 |
| <u>under section 5164.401 of the Revised Code. The report shall be</u> | 2516 |
| <u>submitted to the general assembly in accordance with section</u> | 2517 |
| <u>101.68 of the Revised Code and detail all of the following:</u> | 2518 |
| <u>(A) The verified number of service claims submitted</u> | 2519 |
| <u>through electronic verification systems;</u> | 2520 |
| <u>(B) The number of claims denied or recouped;</u> | 2521 |
| <u>(C) The number of cases of fraud referred to the medicaid</u> | 2522 |
| <u>fraud control unit as a result of electronic verification</u> | 2523 |
| <u>systems;</u> | 2524 |
| <u>(D) The number of provider sanctions issued as a result of</u> | 2525 |
| <u>electronic verification system data;</u> | 2526 |

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| <u>(E) The total amount of cost savings to the medicaid</u> | 2527 |
| <u>program achieved as a result of electronic verification systems;</u> | 2528 |
| <u>(F) Any impacts to medicaid recipient access to medicaid</u> | 2529 |
| <u>services that result from the use of electronic verification</u> | 2530 |
| <u>systems;</u> | 2531 |
| <u>(G) Any additional information or data the department</u> | 2532 |
| <u>considers relevant concerning electronic verification systems.</u> | 2533 |
| <u>Sec. 5164.406. The department of medicaid shall adopt</u> | 2534 |
| <u>rules in accordance with Chapter 119. of the Revised Code to</u> | 2535 |
| <u>implement sections 5164.40 to 5164.406 of the Revised Code. The</u> | 2536 |
| <u>rules shall address all of the following:</u> | 2537 |
| <u>(A) Technical standards for electronic verification</u> | 2538 |
| <u>systems developed, procured, certified, or approved under</u> | 2539 |
| <u>section 5164.401 of the Revised Code including GPS intervals,</u> | 2540 |
| <u>breadcrumb location data parameters, and criteria for</u> | 2541 |
| <u>certification of electronic verification systems;</u> | 2542 |
| <u>(B) Procedures by which a provider may seek an exemption</u> | 2543 |
| <u>from electronic verification requirements under section 5164.402</u> | 2544 |
| <u>of the Revised Code;</u> | 2545 |
| <u>(C) Protocols by which the department will conduct audits</u> | 2546 |
| <u>and enforcement of electronic verification requirements under</u> | 2547 |
| <u>section 5164.404 of the Revised Code;</u> | 2548 |
| <u>(D) Other standards and procedures as necessary to</u> | 2549 |
| <u>implement sections 5164.40 to 5164.406 of the Revised Code.</u> | 2550 |
| <u>Sec. 5164.41. (A) As used in this section, "home and</u> | 2551 |
| <u>community-based services medicaid waiver component" has the same</u> | 2552 |
| <u>meaning as in section 5166.01 of the Revised Code.</u> | 2553 |
| <u>(B) The department of medicaid shall establish oversight</u> | 2554 |

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| <u>mechanisms concerning services provided by a family caregiver</u> | 2555 |
| <u>under a home and community-based services medicaid waiver</u> | 2556 |
| <u>component. Oversight may include any of the following:</u> | 2557 |
| <u>(1) Quarterly audits;</u> | 2558 |
| <u>(2) Enhanced check-in review;</u> | 2559 |
| <u>(3) Annual recertification as a medicaid provider;</u> | 2560 |
| <u>(4) Independent case manager verification;</u> | 2561 |
| <u>(5) Caps on hours of compensated care absent documented</u> | 2562 |
| <u>medical necessity;</u> | 2563 |
| <u>(6) Forensic review triggers;</u> | 2564 |
| <u>(7) Background check monitoring pursuant to section</u> | 2565 |
| <u>5164.341 of the Revised Code through the retained applicant</u> | 2566 |
| <u>fingerprint database established under section 109.5721 of the</u> | 2567 |
| <u>Revised Code.</u> | 2568 |
| <u>(C) The department may require a family caregiver who the</u> | 2569 |
| <u>department considers to be high risk or who has repeatedly</u> | 2570 |
| <u>violated the department's requirements concerning family</u> | 2571 |
| <u>caregivers to provide services through a waiver agency as</u> | 2572 |
| <u>defined in section 5164.342 of the Revised Code, rather than as</u> | 2573 |
| <u>an independent provider.</u> | 2574 |
| <u>Sec. 5164.42.</u> (A) <u>As used in this section and section</u> | 2575 |
| <u>5164.421 of the Revised Code:</u> | 2576 |
| <u>(1) "Electronic visit verification" has the same meaning</u> | 2577 |
| <u>as in section 1903(1) of the "Social Security Act," 42 U.S.C.</u> | 2578 |
| <u>1396b(1).</u> | 2579 |
| <u>(2) "GPS-based verification" means real-time satellite</u> | 2580 |
| <u>location data that can be used to confirm the physical presence</u> | 2581 |

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| <u>of a person or device in a specified location.</u> | 2582 |
| <u>(3) (a) "In-home care services" include all of the</u> | 2583 |
| <u>following:</u> | 2584 |
| <u>(i) Personal care services as defined in 42 C.F.R.</u> | 2585 |
| <u>440.167;</u> | 2586 |
| <u>(ii) Home health services covered by the medicaid program</u> | 2587 |
| <u>as part of the home health services benefit pursuant to 42</u> | 2588 |
| <u>C.F.R. 440.70;</u> | 2589 |
| <u>(iii) Services provided under a medicaid home and</u> | 2590 |
| <u>community-based services medicaid waiver component as defined in</u> | 2591 |
| <u>section 5166.01 of the Revised Code;</u> | 2592 |
| <u>(iv) Any other medicaid services that are provided to a</u> | 2593 |
| <u>medicaid recipient in either a residential or community setting.</u> | 2594 |
| <u>(b) "In-home care services" does not include residential</u> | 2595 |
| <u>services billed on a daily rate, habilitation services,</u> | 2596 |
| <u>transportation services under a developmental disabilities level</u> | 2597 |
| <u>of care home and community-based services medicaid waiver</u> | 2598 |
| <u>component, services provided in an ICF/IID, or services provided</u> | 2599 |
| <u>under the assisted living program as defined in section 173.51</u> | 2600 |
| <u>of the Revised Code.</u> | 2601 |
| <u>(B) (1) The department of medicaid shall require each claim</u> | 2602 |
| <u>for a service that is subject to electronic visit verification</u> | 2603 |
| <u>requirements under state or federal law, including claims</u> | 2604 |
| <u>submitted by in-home care service providers, to be supported by</u> | 2605 |
| <u>a validated electronic visit verification record as a condition</u> | 2606 |
| <u>of payment.</u> | 2607 |
| <u>(2) The department shall establish standards and</u> | 2608 |
| <u>procedures for matching claims for medicaid payment to</u> | 2609 |

electronic visit verification records. The standards and 2610
procedures shall identify the data elements necessary to 2611
validate that the service billed was delivered to a medicaid 2612
recipient, including the type of service performed, the 2613
individual receiving the service, the date of service, the 2614
location of service delivery, the individual providing the 2615
service, and the time the service began and ended. 2616

(3) The standards described in division (B) (2) of this 2617
section shall do all of the following: 2618

(a) Require in-home care service providers to clock in and 2619
clock out when physically present at the location where services 2620
are being provided; 2621

(b) Utilize GPS-based verification to track when a 2622
provider clocks in and clocks out; 2623

(c) Record timestamps and the total duration of delivered 2624
services; 2625

(d) Be capable of transmitting data directly to the 2626
department for integration with other claims submissions. 2627

(4) In addition to the standards described in divisions 2628
(B) (2) and (3) of this section, all services provided under the 2629
self-direction service model shall require a provider to clock 2630
in and clock out when physically present at the location where 2631
services are being provided. 2632

(C) (1) The department may deny, suspend, defer, or recoup 2633
payment for a claim that is not supported by a validated 2634
electronic visit verification record. 2635

(2) Prior to taking an action described in division (C) (1) 2636
of this section, the department shall provide affected providers 2637

with notice, training, technical assistance, and compliance 2638
education regarding claim validation requirements established 2639
under this section. 2640

(D) The department may establish performance benchmarks or 2641
minimum compliance thresholds related to electronic visit 2642
verification utilization, matching accuracy, manual entry rates, 2643
modified visit rates, late visit entry rates, and unmatched 2644
claim rates. 2645

(E) The medicaid director shall adopt rules under section 2646
5164.02 of the Revised Code to implement this section. The rules 2647
shall establish all of the following: 2648

(1) Claim validation procedures; 2649

(2) Standards for verified electronic visit verification 2650
records; 2651

(3) Good-cause exemptions; 2652

(4) Corrective action processes; 2653

(5) Procedures for technical assistance and provider 2654
remediation; 2655

(6) Phased implementation schedules by provider type or 2656
service category; 2657

(7) Standards for denying, suspending, deferring, or 2658
recouping payment for claims not supported by validated 2659
electronic visit verification records. 2660

(F) Nothing in this section prohibits the department, the 2661
auditor of state, the attorney general, or any other authorized 2662
state or federal entity from conducting a post-payment review, 2663
audit, investigation, enforcement action, or recovery action 2664

related to a claim subject to electronic visit verification 2665
requirements. 2666

Sec. 5164.421. (A) In addition to the electronic visit 2667
verification system described in section 5165.42 of the Revised 2668
Code, the department of medicaid shall establish requirements 2669
under which high risk in-home care service providers are 2670
required to verify data regarding the services provided to a 2671
medicaid recipient. 2672

(B) The department shall establish criteria under which an 2673
in-home care service provider is considered to be a high-risk 2674
provider. The criteria shall at a minimum include all of the 2675
following: 2676

(1) Repeated mismatches in check-in data; 2677

(2) Data that indicates impossible travel times; 2678

(3) Claims data that overlaps with a medicaid recipient's 2679
stay in a hospital for services that were not provided in 2680
accordance with an authorized individual service plan; 2681

(4) Unusual outliers in billing data; 2682

(5) Other data indicators that demonstrate a high risk of 2683
fraud. 2684

(C) Each in-home care service provider classified by the 2685
department as a high risk provider shall satisfy the 2686
requirements established under this section, including that the 2687
high-risk provider utilize fingerprint scanning, facial 2688
recognition, vocal recognition, a secure personal identification 2689
number, or other approved verification method as a condition of 2690
receiving payment for services provided under the medicaid 2691
program. 2692

(D) The department shall not sell or otherwise distribute 2693
any data transmitted or stored as part of a provider's use of 2694
electronic visit verification under this section. No such data 2695
shall be used for any purpose other than to verify medicaid 2696
payment claims submitted by a provider and reduce fraud within 2697
the medicaid program. 2698

Sec. 5164.43. (A) As used in this section: 2699

(1) "Employee" means any person who performs a service for 2700
wages or other remuneration for an employer. 2701

(2) "Employer" means any person who has one or more 2702
employees and includes an agent of an employer, the state or any 2703
agency or instrumentality of the state, and any political 2704
subdivision or any agency or instrumentality thereof. 2705

(B) No employer shall discharge, demote, reassign, or take 2706
any punitive action against an employee because the employee, 2707
based on a reasonable belief, submitted a good faith report that 2708
an instance of fraud occurred in the medicaid program. 2709

(C) An employee alleging an employer has violated division 2710
(B) of this section may commence an action in any court of 2711
competent jurisdiction for reinstatement with back pay, if the 2712
action is based on discharge, or for equitable relief, together 2713
with reasonable attorney's fees. 2714

Sec. 5164.57. (A) (1) Except as provided in division (A) (2) 2715
and division (E) of this section, the department of medicaid may 2716
recover a medicaid payment or portion of a payment made to a 2717
medicaid provider to which the provider is not entitled if the 2718
department notifies the provider of the overpayment during the 2719
five-year period immediately following the end of the state 2720
fiscal year in which the overpayment was made. 2721

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

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

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

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

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

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

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

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

provider. 2751

(C) The department may recover an overpayment under this 2752
section prior to or after any of the following: 2753

(1) Adjudication of a final fiscal audit that section 2754
5164.38 of the Revised Code requires to be conducted in 2755
accordance with Chapter 119. of the Revised Code; 2756

(2) Adjudication of a finding under any other provision of 2757
state statutes governing the medicaid program or the rules 2758
adopted under those statutes; 2759

(3) Expiration of the time to issue a final fiscal audit 2760
that section 5164.38 of the Revised Code requires to be 2761
conducted in accordance with Chapter 119. of the Revised Code; 2762

(4) Expiration of the time to issue a finding under any 2763
other provision of state statutes governing the medicaid program 2764
or the rules adopted under those statutes. 2765

(D) (1) Subject to division (D) (2) of this section, the 2766
recovery of an overpayment under this section does not preclude 2767
the department from subsequently doing the following: 2768

(a) Issuing a final fiscal audit in accordance with 2769
Chapter 119. of the Revised Code, as required under section 2770
5164.38 of the Revised Code; 2771

(b) Issuing a finding under any other provision of state 2772
statutes governing the medicaid program or the rules adopted 2773
under those statutes. 2774

(2) A final fiscal audit or finding issued subsequent to 2775
the recovery of an overpayment under this section shall be 2776
reduced by the amount of the prior recovery, as appropriate. 2777

(E) The department shall recover all overpayments to a 2778
provider when an audit determines and verifies an impossible 2779
claim submitted by the provider, such as when a provider has 2780
submitted a claim for providing in-home care services, as 2781
defined in section 5164.40 of the Revised Code, on a date when 2782
the recipient was in the hospital or when a provider has 2783
submitted claims for providing in-home services to recipients 2784
located at different addresses at the same time. 2785

(F) Nothing in this section limits the department's 2786
authority to recover overpayments pursuant to any other 2787
provision of the Revised Code. 2788

Sec. 5167.18. Each medicaid managed care organization 2789
shall comply with federal and state efforts to identify fraud, 2790
waste, and abuse in the medicaid program. Upon the 2791
identification of credible evidence of fraud, waste, or abuse, 2792
or materially inconsistent billing, each medicaid managed care 2793
organization shall make a report to the department of medicaid. 2794
The department shall refer potential fraud in a timely manner to 2795
the attorney general for investigation. 2796

Sec. 5167.23. (A) As used in this section, "deconfliction" 2797
means the systematic coordination between medicaid managed care 2798
organizations and multiple state and federal oversight agencies 2799
to share investigative data, eliminate overlapping inquiries, 2800
and streamline the prosecution of fraudulent medicaid providers. 2801

(B) Upon the identification of credible indicators of 2802
fraud, waste, or abuse, a medicaid managed care organization may 2803
implement reasonable and timely payment integrity actions, 2804
including payment suspension and prepayment review and denial. 2805

(C) (1) A medicaid managed care organization may initiate 2806

prepayment review for a medicaid provider without first 2807
obtaining approval from the department of medicaid. 2808
Notwithstanding any provision of law to the contrary, a 2809
prepayment review initiated under this section may remain in 2810
effect for longer than six months without renewal. 2811

(2) A medicaid managed care organization may place 2812
suspected high-risk providers, as determined by the medicaid 2813
managed care organization, on claims payment suspension during 2814
any open investigation or stand-down period. A medicaid managed 2815
care organization shall notify and obtain approval from the 2816
department or the attorney general prior to implementing claims 2817
payment suspension under this section. 2818

(3) A medicaid managed care organization shall provide a 2819
provider placed on claims payment suspension under division (C) 2820
(2) of this section with written notice of the decision and an 2821
opportunity for the provider to participate in the 2822
organization's grievance process established in accordance with 2823
section 5167.11 of the Revised Code. Upon completion of any 2824
grievance process, an affected provider may seek an appeal of a 2825
medicaid managed care organization's decision with the 2826
department of medicaid. 2827

(D) Following the initiation of payment integrity actions, 2828
a medicaid managed care organization shall complete all 2829
applicable deconfliction procedures in accordance with 2830
procedures established by the department. A medicaid managed 2831
care organization may take an action described in this section 2832
prior to the completion of deconfliction procedures when 2833
necessary to prevent continued improper payments and to mitigate 2834
a program integrity risk. 2835

(E) A medicaid managed care organization shall maintain 2836

documented evidence of credible indicators of fraud, waste, and 2837
abuse that are the basis for an action taken under this section. 2838
The department shall ensure that all actions taken under this 2839
section are consistent with state and federal law. 2840

Section 2. That existing sections 109.85, 117.10, 2841
2903.216, 2913.40, 2923.31, 4113.52, 5164.32, 5164.33, 5164.34, 2842
5164.342, 5164.36, 5164.57, and 5167.18 of the Revised Code are 2843
hereby repealed. 2844

Section 3. Not later than thirty days after the effective 2845
date of this section, the Department of Medicaid shall submit a 2846
report to the General Assembly with a cost estimate to implement 2847
this act. The report shall include a comparison of state funds 2848
and expected matching federal funds necessary to develop, 2849
procure, certify, or approve electronic verification systems 2850
described in section 5164.401 of the Revised Code. The report 2851
shall also analyze expected cost savings for the Medicaid 2852
program that result from implementation of electronic 2853
verification systems. 2854

Section 4. Not later than March 31, 2027, the Department 2855
of Medicaid shall prepare and submit a report to the General 2856
Assembly in accordance with section 101.68 of the Revised Code 2857
regarding the creation of a Medicaid encounter data system. The 2858
report and study shall examine the operation of a potential 2859
Medicaid encounter data system, including the scope of work 2860
required by the Department to operationalize such a system. 2861

Section 5. This act shall be known as the Ohio Medicaid 2862
Program Integrity and Fraud Prevention Act. 2863

Section 6. The General Assembly, applying the principle 2864
stated in division (B) of section 1.52 of the Revised Code that 2865

amendments are to be harmonized if reasonably capable of 2866
simultaneous operation, finds that the following sections, 2867
presented in this act as composites of the sections as amended 2868
by the acts indicated, are the resulting versions of the 2869
sections in effect prior to the effective date of the sections 2870
as presented in this act: 2871

Section 117.10 of the Revised Code as amended by both H.B. 2872
59 and S.B. 67 of the 130th General Assembly. 2873

Section 2923.31 of the Revised Code as amended by both 2874
H.B. 199 and H.B. 405 of the 132nd General Assembly. 2875