www.lsc.ohio.gov

OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research and Drafting

Legislative Budget Office

Substitute Bill Comparative Synopsis

Sub. H.B. 795

136th General Assembly

House Medicaid

Jason Hoskins, Attorney

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

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
Family caregivers	Prohibits a spouse, parent, child, grandparent, grandchild, great-grandparent, great-grandchild, brother, sister, aunt, uncle, nephew, niece, cousin, or a step-relation of an individual enrolled in a Medicaid waiver component from receiving Medicaid payment for providing personal care services covered under the waiver component (R.C 5166.04(M); conforming change R.C. 5164.41(C)).	No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
Medicaid Program Integrity Fund	Establishes the Medicaid Program Integrity Fund within the state treasury and specifies that the fund consists of all monies recovered as a result of Medicaid fraud including restitution, civil settlements, forfeitures, and any other fraud-related recoveries (R.C. 109.852).	No provision.
	Authorizes the Attorney General to use money from the fund for fraud enforcement, fraud analytics, whistleblower administration, verification oversight, and program integrity operations (R.C. 109.852).	No provision.
	Declares that it is the intent of the General Assembly to create the fund as a mechanism for providing funding for Medicaid fraud investigation that does not require general revenue funds (R.C. 109.852(B)).	No provision.
Supplemental Nutrition Assistance Program (SNAP) broad based categorical eligibility	Unless required under federal law, prohibits the gross income limits for an eligible SNAP household from exceeding the standards established under federal law (R.C. 5101.5411(B)).	No provision.
	Unless required by federal law, specifies that a household is not categorically eligible for SNAP if any members of the household receive or are authorized to receive any	No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	noncash, in-kind, or other similar benefit (R.C. 5101.5411(C)).	
Unclaimed funds	Requires the Medicaid Director, by February 1 of each year, to provide the Director of Commerce with a list of all Medicaid providers who have had a provider agreement suspended or terminated due to fraudulent activity (R.C. 5164.54(A)).	No provision.
	Requires the Director of Commerce, by March 1 of every year, to provide the Medicaid Director with a list of any individual identified by the Medicaid Director who has unclaimed funds delivered or reported to the state (R.C. 5164.54(B)).	No provision.
	Requires the Department of Medicaid to file a claim to recover unclaimed funds from the Director of Commerce on behalf of an individual identified by the Department (R.C. 5164.54(C)).	No provision.
	Requires the Director of Commerce to pay a claim to the Department of Medicaid for any amount owed by an individual to the Department and requires the Department to adjust any amounts owed by an individual based on amounts received in unclaimed funds (R.C. 5164.54(C)).	No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	Establishes a similar process for the Attorney General (in collaboration with the Auditor of State) for individuals against whom a finding for recovery or improper payments has been issued for actions related to the Medicaid program and the Director of Job and Family Services for individuals who have had a provider agreement suspended or terminated due to fraudulent activity (R.C. 109.851 and 5101.88).	No provision.
Restitution for Medicaid fraud	Permits a court to require a person who commits Medicaid fraud to pay restitution in an amount not to exceed 200% of the value of the property, services, or funds obtained and that restitution amounts must be paid to the Medicaid Program Integrity Fund (R.C. 2913.40(E)(2)).	No provision.
Designation as a peace officer	Adds the Inspector General and a deputy Inspector General to the definition of "peace officer" while either is engaged in the scope of the official's duties related to the investigation of Medicaid fraud (R.C. 109.71, 109.77, 121.483, and 2935.01).	No provision.
Award for reporting fraud	Allows the Auditor of State to issue an award for reporting fraud of up to 10% of the amount of the fraud recovery if certain conditions are satisfied (R.C. 117.103 and 117.104).	No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
Hospice care programs	Revises existing and imposes new requirements on hospice care programs, including regarding license application and renewal, license suspension and termination, change of ownership, staffing and personnel qualifications, surveys, monitoring and reporting, and a moratorium on new hospice care programs and changes in ownership (R.C. 3712.01, 3712.03, 3712.04, 3712.06, 3712.062, 3712.20, 3712.21; Section 4).	No provision.
Medicaid provider disclaimer form	No provision.	Requires the Department of Medicaid to coordinate with the Attorney General to create a disclaimer form that provides an affirmative and explicit explanation of the penalties specified under Ohio law for Medicaid fraud (R.C. 5164.303(A)).
	No provision.	Requires each person or government entity seeking to enroll in the Medicaid program as a provider to return a signed copy of the disclaimer form to the Department, acknowledging that the person or government entity has received and reviewed the form as a condition of enrolling in the Medicaid program as a provider (R.C. 5163.303(B)).
Standardized onboarding process for providers	No provision.	Requires the Department to establish a standardized onboarding process for all providers with a valid provider agreement

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
		with the Department that provides instruction and an explanation of all relevant state and federal laws governing the Medicaid program, including the relevant requirements for home care and personal care service providers established by the Department of Medicaid, the Department of Developmental Disabilities, and the Department of Aging (R.C. 5164.304).
Ownership disclosure	No provision.	As a condition of entering into or revalidating a Medicaid provider agreement, requires each person or government entity to disclose to the Department the identity of each person with at least a 5% direct or indirect ownership interest in the person or entity (R.C. 5164.305(A)).
	No provision.	Requires the Department to verify those ownership disclosures against the exclusion list maintained by the U.S. HHS Office of Inspector General, prior Medicaid sanctions in another state, and prior convictions for fraud (R.C. 5164.305(B)).
	No provision.	Requires the Department to enter into all agreements necessary to share information and data with Medicaid MCOs to enable parallel verification of the information described above, subject to confidentiality and privacy laws (R.C. 5164.305(C)).

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	No provision.	Permits the Department to implement best practices from other states' Medicaid programs (R.C. 5164.305(D)).
Medicaid provider criminal records check	No provision.	Repeals a current law provision authorizing a Medicaid provider or waiver agency to conditionally employ an individual subject to a criminal records check before receiving the results of the criminal records check (R.C. 5164.34(H) and 5164.342(G)).
Electronic verification for nonemergency medical transportation services	Requires the Department to develop, procure, certify, or approve one or more systems for the electronic verification of nonemergency medical transportation services (R.C. 5164.40 to 5164.407).	Instead, requires the Department to develop, procure, certify, or approve a process or system to obtain global positioning system coordinates to verify nonemergency medical transportation services (R.C. 5164.401(A) and 5164.403(A)).
	Specifies that for purposes of the requirement described above, "nonemergency medical transportation" does not include transportation conducted by an emergency medical service organization licensed by the State Board of Emergency Medical, Fire, and Transportation Services (R.C. 5164.40(F)).	Same, but further specifies that the definition of "nonemergency medical transportation" also does not include transportation provided by a nonemergency medical service organization licensed by the State Board of Emergency Medical, Fire, and Transportation Services (R.C. 5164.40(F)).
	Requires the system developed, procured, certified, or approved by the Department to be capable of capturing breadcrumb location	No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	data throughout the duration of a transport (R.C. 5164.401(b)(2)(C)). Requires the Department to develop automated fraud-detection tools to assist with identifying fraud through the use of the electronic verification systems described above, including the monitoring of anomalous and irregular route patterns taken by nonemergency medical transportation service providers (R.C. 5164.405(A)(2)).	 Same, but requires the monitoring of anomalous or irregular patterns (R.C. 5164.404(A)(2)).
Electronic verification for in-home care services	Requires the Department of Medicaid to develop, procure, certify, or approve one or more systems for the electronic verification of in-home care services (R.C. 5164.40 to 5164.407). Requires the Department to establish a verification system under which high risk in-home care service providers are required to verify data regarding the services provided and requires the Department to establish	Instead, requires that in-home care services be verified through the existing electronic visit verification system and further specifies that "in-home care services" excludes (1) residential services billed on a daily rate, (2) habilitation services, (3) transportation services under a developmental disabilities level of care home and community-based services (HCBS) Medicaid waiver, (4) services provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or (5) services provided under the Assisted Living Program (R.C. 5164.42(A)(3) and (B)(3)). Same, but clarifies that a claim for payment that overlaps with a stay in a hospital is not a basis for designating a provider as high-risk if the services were provided in accordance

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	criteria for classifying high risk providers (R.C. 5164.404(A) and (B)).	with an authorized individual service plan (R.C. 5164.421(B)(3)).
Credible allegation of fraud	Expands the definition of "credible allegation of fraud" for purposes of the Medicaid program enforcement to include (1) falsified or fake check-ins, (2) forged paperwork, (3) double billing for Medicaid services, (4) identity misuse, (5) impossible travel patterns, (6) hospital-overlap claims, and (7) coordinated billing rings (R.C. 5164.36(A)(1)).	Same, but clarifies that a claim for payment that overlaps with a stay in a hospital is not a basis for a credible allegation of fraud if the services were provided in accordance with an authorized individual service plan (R.C. 5164.36(A)(1)).
	Except as provided under federal regulations, when the Attorney General or Auditor of State submits a credible allegation of fraud to the Department, requires the Department to suspend the provider's Medicaid payments either in whole or in part and require pre-payment review of the provider's claims (R.C. 5164.36(B)(3)).	Same, but clarifies that the Department must take those actions when the Attorney General or Auditor of State submits a credible allegation of fraud with evidence (R.C. 5164.36(B)(3)).
	If the Department suspends a provider agreement or payment based on a credible allegation of fraud submitted by Attorney General or Auditor of State, requires the Department to afford a provider or owner a hearing and independent administrative review of the suspension not later than ten business days after the suspension takes effect (R.C. 5164.36(D)(2)).	Removes the requirement that the hearing and independent administrative review take place within ten business days of the suspension (R.C. 5164.36(D)(2)).

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
Medicaid fraud penalties	Modifies the existing law penalties for Medicaid fraud as follows: ▪ Establishes Medicaid fraud as a fifth degree felony, and a $1,000 fine (rather than a first degree misdemeanor); ▪ Enhances the penalty level as follows if the value of the property, services, or funds meets certain dollar amounts: ▫ For amounts greater than $1,000 and less than $5,000, a fourth degree felony, and a $5,000 fine; ▫ For amounts greater than $5,000 and less than $25,000, a third degree felony, and a $25,000 fine; ▫ For amounts greater than $25,000 and less than $75,000, a third degree felony with a presumption for a prison term, and a $75,000 fine; ▫ For amounts greater than $75,000 and less than $150,000, a second degree felony, and a $150,000 fine, and if a court imposes a prison term, it must impose a mandatory prison term for a second degree felony under continuing law;	Instead, modifies the existing law penalties for fraud as follows: ▪ Establishes Medicaid fraud as a fifth degree felony, and a $1,000 fine (rather than a first degree misdemeanor); ▪ For amounts greater than $1,000 and less than $7,500, a fourth degree felony, and a $5,000 fine; ▪ For amounts greater than $7,500 and less than $75,000, a third degree felony, and a $25,000 fine; ▪ For amounts greater than $75,000 and less than $150,000, a third degree felony with a presumption for a prison term, and a $75,000 fine; ▪ For amounts greater than $150,000 and less than $750,000, a second degree felony, and a $150,000 fine; ▪ For amounts greater than $750,000, a first degree felony, and a $150,000 fine. (R.C. 2913.40(E) and 2929.01).

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	▫ For amounts greater than $150,000, a first degree felony, and a $150,000 fine, and if a court imposes a prison term, it must impose a mandatory prison term for a first degree felony under continuing law. (R.C. 2913.40(E)(1) and 2929.01.)	
Medicaid participant audits, improper payments, and conflicts of interest	Requires entities participating in the Medicaid program (referred to as risk contractors) and their subcontractors to (1) have audits completed by independent auditors that do not have a conflict of interest, (2) identify, report on, and repay improper payments, (3) develop corrective action plans to address improper payments, and (4) share information and direct the independent auditor to share information with the Department of Medicaid, the Inspector General, and the Auditor of State (R.C. 5162.85, 5162.87, 5162.88, and 5162.89). Requires the Department to publish audits, reports of improper payments, and corrective action plans (R.C. 5162.87, 5162.88, and 5162.89). Prohibits conflicts of interest for actuarial firms providing services to Medicaid program participants (R.C. 5162.89).	No provision. No provision. No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
Medicaid MCO payment integrity	Generally prohibits a Medicaid MCO from initiating prepayment review for a Medicaid provider without first obtaining approval from the Department (R.C. 5167.23(C)(1)). Authorizes a Medicaid MCO to place suspected high-risk providers on claims payment suspension during any open investigation or stand-down period by providing notice of the suspension to the Department (R.C. 5167.23(C)(2)).	Instead, permits a Medicaid MCO to initiate prepayment review for a Medicaid provider without first obtaining approval from the Department (R.C. 5167.23(C)(1)). Same, but requires the Medicaid MCO to receive approval from the Department or Attorney General when placing a provider on claims payment suspension and further requires a Medicaid MCO to provide an affected provider with notice and an opportunity to participate in the Medicaid MCO's established grievance process, and appeal to the Department following the grievance process (R.C. 5167.23(C)(2) and (3)).
Medicaid MCO fraud reporting	Upon the identification of credible evidence of fraud or materially inconsistent billing, requires each Medicaid MCO to make a report to the Department (R.C. 5167.18). Upon receiving a report from a Medicaid MCO identifying credible evidence of fraud or materially inconsistent billing, requires the Department to refer that information to the Attorney General for investigation (R.C. 5167.18).	Same, but additionally requires the Medicaid MCO to make a report to the Department concerning the identification of credible evidence of waste and abuse (R.C. 5167.18). Same, but clarifies that the Department must refer potential fraud to the Attorney General in a timely manner (R.C. 5167.18).

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
Medicaid provider enrollment	Requires the Department to deny, refuse to revalidate, suspend, or terminate a provider agreement if the Department determines that an individual or entity seeking enrollment as an HCBS provider is principally located at the same address as two other active HCBS Medicaid providers or is principally located at the same address as another HCBS Medicaid provider when the address contains less than one thousand square feet of space (R.C. 5164.302(B)). Requires the Department to conduct an investigation if it determines that an individual or entity seeking initial enrollment as a provider shares the same address, business signage, or telephone number as a current provider (R.C. 5164.331).	Instead requires denial, refusal to revalidate, suspension, or termination of a provider agreement if the individual or entity seeking entity seeking enrollment as a HCBS provider is principally located at the same address as six other active HCBS Medicaid providers (R.C. 5164.302(B)). Same, but removes the requirement if an applicant shares the same business signage as a current provider (R.C. 5164.331).
Prior authorization for personal care services	Establishes required criteria for making prior authorization determinations for personal care services, including that only the minimum amount of service time for personal care services necessary to safely address a recipient's documented functional limitations and support needs may be authorized (R.C. 5164.13(C)(1) and (D)(1)). Requires the Department of Medicaid to establish standardized maximum time	Instead, requires an independent provider or waiver agency to submit a signed and dated request to the Department to initiate a request for prior authorization for personal care services and include supporting documentation that provides evidence that the requested services are medically necessary (R.C. 5164.13(C)). No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	allowances for common personal care tasks and services (R.C. 5164.13(E)(1)).	
	Generally prohibits prior authorization for personal care services from exceeding 90 days and requires the Department to conduct periodic reassessments before approving any renewal, extension, increase, or continuation of personal care services (R.C. 5164.13(C)(2)).	No provision.
	No provision.	Requires the Department to make a determination not later than 10 business days after receiving all necessary information from an independent provider or waiver agency (R.C. 5164.13(D)).
	No provision.	Specifies that the Department must determine that personal care services are medically necessary if the services satisfy the following: ▪ The services are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes; ▪ The services are of an appropriate type, amount, duration, scope, and intensity; ▪ The services are the most efficient, effective, and lowest cost alternative

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
		that, when combined with other services, ensure the health and welfare of the individual receiving the services; ▪ The services protect the individual from substantial harm expected to occur if the requested services are not authorized. (R.C. 5164.13(E)).
	No provision.	When the Department makes a determination regarding a request for prior authorization, requires the Department to provide written notification to the independent provider or waiver agency either setting forth the reason for denial or indicating that prior authorization has been approved (R.C. 5164.13(G)).
	No provision.	If a request for prior authorization is denied, permits an individual, independent provider, or waiver agency to appeal the denial (R.C. 5164.13(H)).
	Prohibits a provider from submitting a claim for Medicaid payment for personal care services that exceeds the amount approved through prior authorization and subjects a provider that knowingly bills for unauthorized service time or exceeds approved service limits to payment denial, recoupment,	No provision.

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	administrative sanctions, termination from participation in Medicaid, referral to the Attorney General, and any applicable civil or criminal penalties authorized by law (R.C.5164.13(G)).	
	Requires the Department to establish auditing and utilization review procedures to verify that billed services do not exceed authorized service amounts and that approved services remain limited to the minimum amount necessary (R.C. 5164.13(H)).	No provision.
	Exempts personal care services provided under a Medicaid waiver component administered by the Department of Developmental Disabilities from the prior authorization requirements described above (R.C. 5164.13(I)).	Same, but applies the exemption to the prior authorization requirements described above (R.C. 5164.13(I)).
Medicaid Encounter Data System	Requires the Department to establish and maintain a Medicaid Encounter Data System (R.C. 5162.86).	Instead, requires the Department to prepare and submit a report to the General Assembly, not later than March 31, 2027, regarding the creation of a Medicaid encounter data system, including the operation of a potential system and the scope of work required by the Department to operationalize such a system (Section 4).
Risk matrix	Requires the Department to contract with a vendor to establish a risk matrix to connect	Instead, requires the Department to prepare and submit a report to the General Assembly,

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	individuals with the National Provider Identifier records associated with providers (R.C. 5162.18).	not later than March 31, 2027, regarding the creation of a risk matrix, including the operation of a potential matrix and the scope of work required by the Department to operationalize the risk matrix (Section 4).
All-payer claims database	Specifies that the Superintendent of Insurance must make claims information included in the all-payer claims database established under the bill available to any person or government entity and that a person must obtain a subscription from the Department of Insurance to access information in the database (no subscription is required for statewide elected officers or state agencies) (R.C. 3901.93(B)(4)).	Instead, specifies that the Superintendent may require a person to obtain a subscription from the Department of Insurance to access information in the database, in accordance with continuing law governing the availability of public records (R.C. 3901.93(B)(4)).
ODM provider agreement denial, suspension, or termination	Requires the Medicaid Director to deny, refuse to revalidate, suspend, or terminate the Medicaid provider agreement of any provider that has not submitted a claim for payment to the Department for a period of one year (R.C. 5164.33(A)(2)). To the extent permitted under state or federal law, requires the Department to share information concerning the Medicaid Director's decision to deny, refuse to revalidate, suspend, or terminate a provider agreement with any other board or commission responsible for regulating a	Instead, requires the Medicaid Director only to suspend the provider agreement of a provider that has not submitted a claim for payment to the Department for a period of one year (R.C. 5164.33(A)(2)). Clarifies that the sharing of information must be made to a state board or commission (R.C. 5164.33(E)).

Topic	Previous Version (I_136_3280-2)	Latest Version (I_136_3280-5)
	component of the health care industry (R.C. 5164.33(E)).	
	No provision.	Permits the Medicaid Director to take either of the following actions when the Director determines the action is in the best interests of Medicaid recipients or the state: ▪ Place a provider or entity at a high risk of fraud on heightened scrutiny when suspension, termination, or exclusion of the provider will result in access to care issues for Medicaid recipients; ▪ Deny an application for a provider agreement or refuse to revalidate a provider agreement, including applications or revalidations where the applicant is an owner of, or individual that resides with an owner of, a current or former Medicaid provider whose provider agreement was terminated or suspended by the department (R.C. 5164.33(A)(1)(c) and (d)).

SUHB0795-5-136/ts