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Substitute Bill Comparative Synopsis

Sub. S.B. 315
136th General Assembly

House Finance

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This comparative synopsis contains a summary of the provisions included in the l_136_3359 version of Sub. S.B. 315.

SNAP electronic benefit transfer cards (Enhanced Cybersecurity for SNAP Act)

(R.C. 5101.542 and 5101.5411)

- Codifies the bill's requirement that, beginning on the bill's effective date, the Department of Job and Family Services (ODJFS) must begin the transition to chip-enabled Supplemental Nutrition Assistance Program (SNAP) electronic benefit transfer cards by (1) ensuring that all new electronic benefit transfer cards that are issued are chip-enabled and (2) that existing electronic benefit transfer cards are replaced with chip-enabled cards under the Department's ordinary timeframe for replacing electronic benefit transfer cards.
- Adds provisions requiring the Director of Job and Family Services to ensure that the Department's website contains a mechanism that allows SNAP benefit recipients to report alleged fraudulent transactions to the Department.
- Removes the bill's FY 2027 appropriations, which consisted of the following: $2,250,000 in GRF ALI 600569, SNAP EBT Modernization; and $750,000 in federal Fund 3840 ALI 600610, Food Assistance Programs. Removes language that allows the ODJFS Director to certify to the OBM Director the available balances in these ALIs in FY 2027, as well as language reappropriating this balance to FY 2028.

Medicaid Program Integrity and Fraud Prevention Act

Adds provisions that do all of the following:

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

(R.C. 5164.42 and 5164.421)

- Requires the Department of Medicaid to require each claim for a service that is subject to EVV requirements under state or federal law, including services provided by in-home care service providers, to be supported by a validated EVV record as a condition of payment.
- Exempts from the definition of "in-home care services" (to the extent permitted under federal law) services that are not personal care in nature or that satisfy any of the following:
  - The services are residential services billed on a daily rate, habilitation services, or transportation services;
  - The services are provided under a home and community-based (HCBS) Medicaid waiver to an individual with developmental disabilities or to an individual who meets all criteria for a developmental disability other than that the disability manifested before age 22;
  - The services are provided in an ICF/IID or under the Assisted Living program.
- Requires the Department to establish standards and procedures for matching claims for Medicaid payment to EVV records, including standards that (1) require in-home care service providers to clock in and clock out when physically present at the location services are being provided, (2) utilize GPS-based verification to track when a provider clocks in and clocks out, (3) record timestamps and the total duration of delivered services, and (4) be capable of transmitting data directly to the Department for integration with other claims submissions.
- Specifies that the requirement to utilize GPS-based verification described above does not apply to in-home care services that are provided by a family caregiver that resides at the same residence as an individual receiving services.
- Additionally requires that all services provided under the self-direction model require a provider to clock in and clock out when physically present at the location where services are being provided.
- Permits the Department to deny, suspend, defer, or recoup payment for a claim that is not supported by a validated EVV record, after providing an affected provider with notice, training, technical assistance, and compliance education.
- Permits the Department to establish performance benchmarks or minimum compliance thresholds related to EVV.
- Additionally requires the Department to establish requirements under which high risk in-home care service providers are required to utilize additional verification methods.

EVV for nonemergency medical transportation services

(R.C. 5164.40 to 5164.406)

- Requires the Department to develop, procure, certify, or approve a process or system to obtain global positioning system (GPS) coordinates to verify nonemergency medical transportation services provided under the Medicaid program.
- Not later than six months after the bill's effective date, requires the Department to develop technical standards and a plan for implementing the requirements described above.
- Not later than 12 months after the bill's effective date, requires the Department to establish a pilot program for the requirements described above.
- Not later than 18 months after the bill's effective date, requires the Department to ensure full compliance with the requirements described above for all nonemergency medical transportation service providers.
- Requires the Department to establish a process by which a nonemergency medical transportation service provider may seek an exemption from the requirements described above.
- Not later than five years after the bill's effective date, requires the Department to develop and implement a system by which GPS 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.
- Requires the Department develop and implement automated fraud-detection tools to assist with identifying fraud through the use of the process or system described above.
- Requires the Department to submit an annual report to the General Assembly detailing the process or system described above.
- Requires the Department to adopt rules to implement the provisions described above.

EVV dashboard and report

(R.C. 5162.139 and 5162.17)

- Requires the Department to maintain a statewide EVV performance dashboard, updated not less than quarterly, that contains (1) statewide utilization rates of EVV, (2) rates of successful matching between EVV records and submitted claims for payment, (3) provider compliance trends, (4) the percentage of claims supported by verified EVV documentation, (5) aggregate statistics regarding manually adjusted EVV entries, and (6) any other metrics the Department determines appropriate for monitoring compliance, fraud prevention, and program integrity.
- Requires the Department to make aggregate statewide data available on the Department's website and to use the information collected to identify providers that may

require technical assistance, additional training, corrective action, or program integrity review.

- By March 1 of each year, requires the Medicaid Director to submit a report to the Governor, the Speaker of the House of Representatives, Senate President, and Auditor of State regarding EVV utilization and compliance and make the report publicly available on the Department's website 30 days after submitting it.

Medicaid provider enrollment

(R.C. 5164.302, 5164.303, 5164.304, 5164.305, 5164.331, and 5164.332)

- Requires the Department to conduct an in-person review of an individual or site inspection of an entity before enrolling the provider in the Medicaid program as a home- and community-based services provider.
- Thereafter, requires the Department to conduct subsequent in-person reviews or site inspections every three years.
- Requires the Department to deny, refuse to revalidate, suspend, or terminate a provider agreement if the Department determines that an individual or entity seeking enrollment as a Medicaid HCBS provider is principally located at the same address as six other active Medicaid HCBS providers or is principally located at the same address as another Medicaid HCBS provider when the address contains less than 1,000 square feet of space.
- Requires the Department to work with the Auditor of State whenever it is determined that a single address is the principal place of business for more than six Medicaid HCBS providers.
- 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 or telephone number as a current provider.
- Requires the Department to impose a temporary suspension of payment and conduct an investigation if the Department determines there is a suspicious increase in the number of claims for payment the provider submits within 60 days of entering into a provider agreement.
- Requires the Department to flag and investigate any time the Department determines that the number of monthly claims submitted increases by more than 100% without a corresponding increase in the number of Medicaid enrollees receiving services from the provider.
- Requires the Department to coordinate with the Attorney General to create a disclaimer form that provides an affirmative and explicit explanation of Ohio's Medicaid fraud penalties.
- Requires each person or government entity seeking to enroll in the Medicaid program as a provider to return a signed copy of the form to the Department, acknowledging that they have received and reviewed the form.

- Requires the Department to establish a standardized onboarding process for all providers that provides a link to the relevant administrative rules that describe provider agreement requirements.
- 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.
- 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.
- 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.
- Permits the Department to implement best practices from other states' Medicaid programs.

Provider agreement denial, suspension, or termination

(R.C. 5164.33)

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

Eligibility for Medicaid

(R.C. 5163.05)

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

Billing codes annual report

(R.C. 5162.1311)

- Requires the Department to prepare and submit an annual report to the General Assembly detailing all billing codes that represent an increase or decrease of greater than 50% in the utilization rate or total expenditures for a particular service from the previous state fiscal year and include data from the five years preceding the report.

Alternative payer evaluation

(R.C. 5162.19)

- Prior to the issuance of any payment on a claim for services provided under the Medicaid program, requires the Department to electronically evaluate all claims using automated algorithmic analysis and insurance discovery engines to determine whether an alternative primary coverage source exists.
- If an alternative primary insurance coverage source is identified, requires the claim for payment to be redirected to that source prior to any Medicaid payment being issued.

EVV tracking

(R.C. 2903.216)

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

Collection of overpayment

(R.C. 5164.57)

- Requires the Department to recover all overpayments to a provider when an audit determines and verifies an impossible claim submitted by a provider.

Provider revalidation and credentialing

(R.C. 5164.292 and 5164.32)

- Requires the Department to require specified Medicaid providers and facilities to provide the Department or Department's credentialing designee with specified information every 24 months.
- Permits the Department to request additional clarifying information at any time during the credentialing or recredentialing process.
- Authorizes the Department to require a provider or facility to provide information sooner than every 24 months if required under federal law or if the Medicaid Director determines that a shorter timeframe is necessary.
- Specifies that each Medicaid provider agreement expires not later than three years from its effective date, or sooner if determined necessary by the Medicaid Director (rather than five years under current law).

Family caregiver oversight

(R.C. 5164.41)

- Requires the Department to establish oversight mechanisms concerning services provided by a family caregiver under a HCBS Medicaid waiver component.

- Permits the Department to require a family caregiver the Department considers to be high risk or a repeat violator of the Department's family caregiver requirements to provide services through a waiver agency rather than as an independent provider.

Prior authorization for personal care services

(R.C. 5164.13)

- Requires the Department to require prior authorization for personal care services provided under the Medicaid program when the personal care services requested exceed the amount or scope of the services described in a written plan of care or individual service plan of an individual.
- Requires an independent provider or waiver agency to submit a signed and dated request to the Department to initiate a request for prior authorization and include supporting documentation that provides evidence that the requested services are medically necessary.
- Requires the Department to make a determination not later than ten business days after receiving all necessary information from an independent provider or waiver agency or not later than 48 hours when the request is for urgent care services.
- 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 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.
- 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.
- If a request for prior authorization is denied, permits an individual, independent provider, or waiver agency to appeal the denial.
- Exempts personal care services provided under a Medicaid waiver component administered by the Department of Developmental Disabilities from the prior authorization requirements described above.

Prior authorization for therapeutic behavioral services

(R.C. 5164.12)

- Requires the Department to impose a prior authorization requirement on all therapeutic behavioral services provided under the Medicaid program.

State employee fraud reporting

(R.C. 4113.52)

- Requires all state officials and employees to report to the Auditor of State, rather than to the Inspector General, alleged fraud, theft in office, or the misuse or misappropriation of public money by a state official or employee.

Medicaid fraud employment protections

(R.C. 5164.43)

- Prohibits an employer from retaliating against an employee because the employee made a good faith report that, based on a reasonable belief, Medicaid fraud has occurred.
- Authorizes an employee alleging an employer has violated the bill's retaliation prohibition to sue the employer for reinstatement with back pay, or for equitable relief, together with reasonable attorney's fees.

Medicaid fraud penalties

(R.C. 2913.40)

- 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);
  - 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 $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 $750,000, a first degree felony and a $150,000 fine.

Corrupt activity

(R.C. 2923.31)

- Specifies that Medicaid fraud constitutes corrupt activity under Ohio's Corrupt Activities Law.

Credible allegations of fraud

(R.C. 5164.36)

- 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, except for claims for services that were provided in accordance with an authorized individual service plan, and (7) coordinated billing rings.
- Except as provided under federal regulations, when the Attorney General or Auditor of State submits a credible allegation of fraud with evidence to the Department, requires the Department to suspend the provider's Medicaid payments either in whole or in part and require prepayment review of the provider's claims.
- Specifies that suspension of a provider agreement or payment described above may be in whole, in part, targeted to specified payments to a provider, or require prepayment review.
- If the Department suspends a provider agreement or payment based on a credible allegation of fraud submitted by the Attorney General or Auditor of State, requires the Department to afford a provider or owner a hearing and independent administrative review of the suspension.

Medicaid managed care organization (MCO) payment integrity

(R.C. 5167.23)

- Upon the identification of credible indicators of fraud, waste, or abuse, permits a Medicaid MCO to implement reasonable and timely payment integrity actions, including payment suspension and prepayment review and denial.
- Generally prohibits a Medicaid MCO from initiating prepayment review for a Medicaid provider without first obtaining approval from the Department.
- Permits an approved prepayment review to remain in effect for longer than six months without renewal.
- Authorizes a Medicaid MCO to place suspected high-risk providers on claims payment suspension during any open investigation or stand-down period after notifying and receiving approval for the suspension from the Department or Attorney General.
- Requires a Medicaid MCO to provide any provider placed on prepayment review or claims payment suspension with written notice of the decision and an opportunity to participate in the Medicaid MCO's established grievance processes.
- Upon completion of the grievance process described above, permits an affected provider to appeal a Medicaid MCO's decision to the Department.
- Generally requires a Medicaid MCO to complete all applicable deconfliction procedures in accordance with procedures established by the Department but permits a Medicaid

MCO to take an action described above prior to the completion of deconfliction procedures when necessary to prevent continued improper payments and to mitigate a program integrity risk.

- Requires a Medicaid MCO to maintain documented evidence of credible indicators of fraud, waste, and abuse that are the basis for an action taken above.

Medicaid MCO reporting of fraud, waste, or abuse

(R.C. 5167.18)

- Upon the identification of credible evidence of fraud, waste, or abuse or materially inconsistent billing, requires each Medicaid MCO to make a report to the Department.
- Requires the Department to refer any information received concerning potential fraud to the Attorney General for investigation in a timely manner.

Enrollment requirements for Medicaid MCOs

(R.C. 5167.03)

- For a period of 18 months, requires the Department of Medicaid to ensure that each Medicaid MCO plan enrolls at least 10% of the total number of participants in the care management system.

Medicaid Encounter Data System and risk matrix

(Section 4)

- 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 and risk matrix, including the operation of a potential system and risk matrix and the scope of work required by the Department to operationalize them.

All-payer claims database

(R.C. 3901.93)

- Requires the Superintendent of Insurance to establish and administer an all-payer claims database under which health plan issuers, pharmacy benefit managers, Medicaid MCOs, and the Medicaid and Medicare programs must submit their claims to the Superintendent for inclusion in the database.
- Delays until January 1, 2028, the requirement that a payer that is a health plan issuer submit claims to the Superintendent for inclusion in the database.
- 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.
- Directs the Superintendent to adopt rules to implement the bill's requirements, including those establishing standards for imposing penalties when claims are not submitted and

for maintaining the privacy and security of personal or health information contained in claims.

Medicaid integrity report

(R.C. 5162.138)

- Requires the Department of Medicaid to annually prepare and submit a report to the chairpersons and ranking members of the committees of the House and Senate with jurisdiction over Medicaid detailing the Department's efforts to ensure integrity within the Medicaid program.

General Assembly review of Medicaid waivers

(R.C. 103.413)

- Requires the standing committees of the House and Senate that primarily consider Medicaid legislation to meet jointly on an annual basis to conduct a review of ¼ of the Medicaid waivers operating within the Medicaid program.
- Requires the committees to conduct a review of all Medicaid waivers before conducting a subsequent review of any waiver.

Use of automated review tools

(R.C. 5162.90 and 5164.11)

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

Auditor of State subpoena authority

(R.C. 117.10)

- Authorizes the Auditor of State to issue subpoenas compelling the production of books, records, accounts, documents, electronically stored information, testimony, or other information relevant to any audit, examination, special audit, investigation, or review.
- Requires the Attorney General, upon the request of the Auditor, to bring an action in a court of competent jurisdiction to enforce compliance with a subpoena.

Attorney General investigations

(R.C. 109.85)

- In conducting an investigation concerning Medicaid, nursing homes, or other long-term care facilities under continuing law, authorizes the Attorney General to (1) administer oaths, (2) subpoena witnesses, (3) adduce evidence, and (4) subpoena the production of any book, document, record, or other relevant matter.

- Permits the Attorney General to designate a representative to inspect any relevant matter that is the subject of a subpoena issued above, if it is located outside Ohio.
- If a person fails without lawful excuse to obey a subpoena, permits the Attorney General to seek an order that (1) compels requested discovery, (2) adjudges the person in contempt of court, or (3) grants other relief that may be required until the person obeys the subpoena.
- If a court finds that a person's failure to comply with a subpoena was in bad faith or for the purpose of delay, authorizes the court to order the person to pay the reasonable expenses of the Attorney General, including attorney's fees, and invoke sanctions.

Cost estimate

(Section 3)

- Not later than 30 days after the bill's effective date, requires the Department to submit a report to the General Assembly with a cost estimate to implement the bill's provisions.

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