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## Substitute Bill Comparative Synopsis

**Sub. H.B. 795**

**136<sup>th</sup> General Assembly**

House Medicaid

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

Topic	Previous Version (I_136_3280)	Latest Version (I_136_3280-2)
Electronic verification for nonemergency medical transportation services	Requires the Department of Medicaid 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).	Same, but specifies that “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)).

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Eligibility for Medicaid	No provision.	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 (R.C. 5163.05; see 42 United States Code 1903(v)(5)).
Billing codes annual report	Requires the Department to prepare and submit an annual report to the General Assembly detailing all billing codes that represent an increase or decrease of greater than 50% for a particular service from the previous year and include data from the preceding five years concerning the billing code or service (R.C. 5162.1311).	Same, but clarifies that the report must detail increases or decreases of greater than 50% in the utilization rate or total expenditures for a particular service from the previous state fiscal year, and that the report must include data concerning any identified billing code utilization rate or expenditure data for an identified service from the five years preceding the report (R.C. 5162.1311).
Alternative payer evaluation	Prior to the issuance of any payment on a claim for services provided under the Medicaid program, requires the Department to electronically evaluate all claims using automated algorithmic analysis and insurance discovery engines to determine whether an alternative primary coverage source exists (R.C. 5162.19(A) and (B)).	Same, but defines “alternative primary insurance coverage source” as coverage that is not Medicaid, including Medicare or a health benefit plan as defined under continuing law (R.C. 5162.19(A)).
Provider revalidation and credentialing	Requires the Department to require specified Medicaid providers and facilities to provide the Department or Department’s credentialing designee with specified	Same, but adds that the Department may request additional clarifying information at any time during the credentialing or recredentialing process (R.C. 5164.292(E)).

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	information every 24 months (R.C. 5164.292(A) to (C)).	
Medicaid provider enrollment	<p>Requires the Department to deny, refuse to revalidate, suspend, or terminate a provider agreement if the Department determines that an individual or entity seeking enrollment as a provider of home- and community-based services (HCBS) under the Medicaid program is principally located at the same address as two other existing 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)).</p> <p>Requires the Department to work with the Auditor of State whenever it is determined that a single address is the principal place of business for more than two HCBS Medicaid providers (R.C. 5164.302(C)).</p>	<p>Same, but instead refers to active (rather than existing) HCBS Medicaid providers (R.C. 5164.302(B)).</p> <p>Instead, requires the Department to make a referral to the Auditor of State whenever it is determined that a single address is the principal place of business for more than six HCBS Medicaid providers (R.C. 5164.302(C)).</p>
Family caregivers	No provision.	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

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	Permits the Department to require a family caregiver who the Department considers to be high risk or a repeat violator of the Department's family caregiver requirements to provide services through a waiver agency rather than as an independent provider (R.C. 5164.41(C)).	under the waiver component (R.C. 5166.04(M)).  Same, but due to the prohibition above regarding family caregivers, applies only to services that are not personal care services (R.C. 5164.41).
Prior authorization for personal care services	No provision.  No provision.  No provision.	Specifies that no payment for personal care services provided under the Medicaid program may be made without prior authorization (R.C. 5164.13(B)).  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 allowances for common personal care tasks and services (R.C. 5164.13(E)(1)).

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	No provision.	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.	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, 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)).
	No provision.	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

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	No provision.	<p>administered by the Department of Developmental Disabilities from the prior authorization requirements described above (R.C. 5164.13(I)).</p> <p>Requires the Medicaid Director to adopt rules to implement the requirements described above (R.C. 5164.13(J)).</p>
Award for reporting fraud	<p>Allows the Auditor of State to issue an award for reporting fraud of up to \$10,000 if all of the following apply:</p> <ul style="list-style-type: none"> <li>▪ The person reports the fraud through the Auditor of State’s fraud reporting system;</li> <li>▪ A public office or public official is found liable for the fraud in a civil action or criminal action as a result of the person reporting fraud;</li> <li>▪ The person who reports the fraud is not found liable for the fraud in a civil or criminal action.</li> </ul> <p>(R.C. 117.103 and 117.104.)</p>	<p>Allows the Auditor of State to issue an award for reporting fraud of up to 10% of the amount of the fraud recovery if all of the following apply:</p> <ul style="list-style-type: none"> <li>▪ The person reports the fraud through the Auditor of State’s fraud reporting system;</li> <li>▪ The report of fraud materially contributes to an audit for fraud, an investigation of fraud, the discovery of fraud, or the filing of a civil or criminal action for fraud;</li> <li>▪ The report of fraud results in a fraud recovery;</li> <li>▪ The person who reports fraud is not found liable for or convicted of, and does not plead guilty to or otherwise is found to have participated in, the fraud;</li> </ul>

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	No provision.	<ul style="list-style-type: none"> <li>▪ The person satisfies any additional eligibility requirements established by the Attorney General.</li> </ul> <p>(R.C. 117.103 and 117.104(B) and (C).)</p> <p>Prohibits an award for reporting fraud from reducing, redirecting, delaying, or otherwise interfering with (1) a restitution order, (2) a finding of recovery issued by the Auditor of State, (3) the recovery of audit costs, (4) fines, court costs, or attorney’s fees, and (5) investigation costs (R.C. 117.104(D)).</p>
	No provision.	Prohibits an award for reporting fraud from being made until any public office or entity harmed by fraud is fully reimbursed for harm caused by fraud, unless otherwise determined by the Attorney General (R.C. 117.104(E)).
	No provision.	Permits the Attorney General to adopt rules establishing eligibility requirements for a person to receive an award, procedures for determining award amounts, and standards for protecting the confidentiality of a person reporting fraud (R.C. 117.104(G)).
Credible allegation of fraud	Upon a credible allegation of fraud submitted to the Department by the Attorney General, requires the Department to suspend the provider agreement and Medicaid payments	Same, but (1) also requires the Department to take these actions if the credible allegation of fraud is submitted by the Auditor of State, (2) removes a requirement that the

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	of a provider either in whole or in part and requires the Department to adhere to any recommendation issued by the Attorney General (R.C. 5164.36(B)(3)).	Department take an action as directed by the Attorney General, and (3) exempts the Department from taking these actions if federal regulations provide otherwise (R.C. 5164.36(B)(3)).
Medicaid fraud fines	No provision.	Creates mandatory fines for the offense of Medicaid fraud so that a person found guilty of an offense is subject to a fine of \$1,000 for a fifth degree felony, \$5,000 for a fourth degree felony, \$25,000 for a third degree felony, \$75,000 for a third degree felony that carries a presumption of a prison term, and \$150,000 for a first degree felony or second degree felony (R.C. 2913.40(E)(1)).
Corrupt activity	No provision.	Specifies that Medicaid fraud constitutes corrupt activity (R.C. 2923.31(I)(2)(c)).
Forensic audit and compliance framework	<p>Requires the Auditor of State to establish an independent forensic audit and compliance framework for monitoring the Medicaid program, including monitoring Medicaid providers considered to be at high risk of committing fraud within the Medicaid program (R.C. 117.61(A)).</p> <p>Permits the Auditor to contract with outside forensic auditors and compliance professionals as necessary to operate the framework (R.C. 117.61(B)).</p>	<p>No provision.</p> <p>No provision.</p>

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	Prohibits any standing committee of the House of Representatives or Senate from holding a hearing on legislation concerning the integrity of the Medicaid program unless a forensic audit has been conducted (R.C. 117.61(C)).	No provision.
Medicaid managed care organization (MCO) payment integrity	<p>No provision.</p> <p>No provision.</p> <p>No provision.</p> <p>No provision.</p>	<p>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 (R.C. 5167.23(B)).</p> <p>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)).</p> <p>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)).</p> <p>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</p>

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	No provision.	<p>above prior to the completion of deconfliction procedures when necessary to prevent continued improper payments and to mitigate a program integrity risk (R.C. 5167.23(D)).</p> <p>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 (R.C. 5167.23(E)).</p>
Medicaid MCO reporting of fraud	No provision.	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).
Medicaid Encounter Data System	<p>Requires each Medicaid MCO to submit specified information to the Department on a quarterly basis for inclusion in a Medicaid Encounter Data System (R.C. 5162.86).</p> <p>Upon the request of a member of the public, requires the Department to make information available on the Medicaid</p>	<p>Same, but also requires the Department to maintain information concerning the fee-for-service component and all Medicaid waiver components and make that information available as part of the Medicaid Encounter Data System (R.C. 5162.86(G)).</p> <p>No provision.</p>

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	Encounter Data System available in print format (R.C. 5162.86(E)(1)).	
All-payer claims database	Authorizes the Superintendent to make the claims information in the all-payer claims database established under the bill available to persons and government entities only through a subscription with the Department of Insurance, except that claims information must be made available to the General Assembly and state departments for free and without subscriptions (R.C. 3901.93(B)(4)).	Instead, specifies that the Superintendent must make claims information included in the database 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)).
Medicaid participant audits, improper payments, and conflicts of interest	<p>For purposes of the requirement that a risk contractor or subcontractor (1) have an audit completed by independent auditors, (2) identify, report on, and develop corrective action plans to address improper payment, defines a “risk contractor” as specified entities that have, or seek to qualify for a contract with the Department to provide or arrange for covered services to Medicaid program enrollees (R.C. 5162.85(R)).</p> <p>Before a required audit may begin, requires a risk contractor or subcontractor to authorize and direct an independent auditor to share progress, findings, reports, opinions, management letters, and working papers with the Department and the Inspector General (R.C. 5162.87(E)(2)).</p>	<p>Instead, defines a “risk contractor” as any entity participating in the Medicaid program (R.C. 5162.85(R)).</p> <p>Same, but also includes the Auditor of State as an entity with whom the information must be shared (R.C. 5162.87(E)(2)).</p>

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Hospice care programs	No provision.	Reduces the period of time a hospice program license is valid from three years to one (R.C. 3712.04(C)).
	No provision.	Removes the Department of Health's authority to set fees for initial hospice licensure and license renewal of up to \$600 and to establish fee increases of up to 50% with Controlling Board approval, and instead sets hospice licensure and license renewal fees at \$700 each (R.C. 3712.03 and 3712.04).
	No provision.	Requires an applicant for hospice licensure to post a \$100,000 surety bond with the Department when the application is approved and maintain that bond for five years (R.C. 3712.04(B) and 3712.062).
	No provision.	Requires a license for initial hospice licensure and license renewal to include the following information: <ul style="list-style-type: none"> <li data-bbox="1398 1068 1881 1235">▪ The name of any owner of the hospice, its chief administrator, and its medical director, with evidence a background check has been completed for all of them;</li> <li data-bbox="1398 1263 1881 1398">▪ Professional discipline, health care facility license revocation, and criminal charges, convictions, or guilty pleas pertaining to health care</li> </ul>

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		fraud or abuse associated with the hospice owner, its chief administrator, or its medical director; <ul style="list-style-type: none"> <li>▪ Any other names the hospice uses;</li> <li>▪ Identification of the service area in which the applicant proposes to operate;</li> <li>▪ Any other information required by the Department.</li> </ul> (R.C. 3712.04(A) and 3712.01).
	No provision.	Requires the name of the hospice on an application for initial licensure or license renewal to match the name of the hospice listed on any certification through the United States Centers for Medicare and Medicaid Services (CMS) (R.C. 3712.04(A)).
	No provision.	Requires an applicant for a hospice care program license to identify the geographic service area in which it intends to operate and to document that the applicant has sufficient administrative, clinical, and financial capacity to serve that area (R.C. 3712.04(A)).
	No provision.	Prohibits the Department from issuing or renewing a license if the applicant, an owner of the hospice, the chief administrator, or the medical director has been excluded from

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	No provision.	participation in Medicare or Medicaid or has been convicted of or pleaded guilty to a crime pertaining to health care fraud or abuse (R.C. 3712.04).
	No provision.	Permits the Department to require an out-of-state applicant to submit the results of any inspection or survey of a hospice that shares at least 30% ownership with the hospice applying for licensure (R.C. 3712.04(G)).
	No provision.	Permits the Department to require an out-of-state applicant to disclose any negative performance history for the chief administrator or medical director of the hospice in the ten years preceding the date of application, including professional discipline and criminal charges, convictions, or guilty pleas pertaining to health care fraud or abuse (R.C. 3712.04(G)).
	No provision.	Permits the Department to suspend or revoke a hospice license for specified reasons (R.C. 3712.04(D)).
	No provision.	Prohibits a hospice from changing owners for the first five years of licensure, unless an owner is deceased (R.C. 3712.04(J)).
	No provision.	Requires hospices to apply to the Department for change of ownership on an

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	No provision.	application that includes all the information on the initial application (R.C. 3712.04(J)).
	No provision.	Requires the Department to survey a hospice for compliance with laws and rules within six months of approving a change in ownership application (R.C. 3712.04(J)).
	No provision.	Permits the Department to adopt rules establishing procedures for the review, approval, and denial of applications for change in ownership (R.C. 3712.03(B)).
	No provision.	Requires a hospice to maintain adequate staffing to provide coverage to patients within its geographic service area (R.C. 3712.06).
	No provision.	Requires a hospice to only admit new patients for whom a nurse employed by the hospice is located within a two-hour travel radius (R.C. 3712.06).
	No provision.	Requires a hospice to maintain an independent commercial office with visible signage and basic operational infrastructure including secure file storage and a continuously answered telephone line (R.C. 3712.06(L)).
	No provision.	Prohibits someone from serving as the chief administrator for more than one hospice

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	No provision.	unless each hospice for whom the person serves as the chief administrator shares at least 50% ownership in common (R.C. 3712.20(A)(1)).
	No provision.	Generally prohibits someone from serving as the medical director for more than two hospices unless each hospice for whom the person serves as the medical director shares at least 50% ownership in common (R.C. 3712.20(A)(2)).
	No provision.	Permits the Department to adopt rules exempting hospices in rural areas from medical director employment restrictions (R.C. 3712.03).
	No provision.	Requires a hospice to notify the Department within ten days of employing a new chief administrator or medical director (R.C. 3712.20(B)).
	No provision.	Requires the Department to establish a process through which a hospice care program may update, correct, or challenge Department records identifying the chief administrator or medical director of the program (R.C. 3712.20).
	No provision.	Requires the Department, in consultation with associations representing hospices, to select a set of hospice care measures to be

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		monitored by the Department using data available through CMS (R.C. 3712.21).
	No provision.	Requires the monitored data to include measures of live discharge rates, family satisfaction, service delivery, and transitions of care (R.C. 3712.21).
	No provision.	Requires the Department, in consultation with associations representing hospices, to establish thresholds for measures that require the Department to survey a hospice within six months for compliance with laws and rules (R.C. 3712.21).
	No provision.	Requires the Department to monitor the measures on a quarterly basis and permits the Department to contract with a data management company to do so (R.C. 3712.21).
	No provision.	Requires the Department to submit an annual report to the Secretary of the U.S. Department of Health and Human Services identifying hospices that exceeded 100% of the hospice aggregate cap (R.C. 3712.21).
	No provision.	Requires the Department to establish a threshold for the hospice aggregate cap utilization rate that requires the Department to conduct a compliance survey (R.C. 3712.21).

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	No provision.	For six months after the bill's effective date, generally prohibits the Department from issuing a new license for a hospice care program or accepting new applications for a hospice care program change of ownership, unless an owner is deceased (Section 4).
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 (R.C. 109.71, 109.77, 121.483, and 2935.01).	Same, but limits the inclusion of the Inspector General and a deputy Inspector General to instances related to the investigation of Medicaid fraud (R.C. 109.71, 121.483, and 2935.01).
Attorney General investigations	No provision.	<p>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 (R.C. 109.85(A)).</p> <p>Permits the Attorney General to designate a representative to inspect any relevant matter that is the subject of a subpoena issued above, if the matter is located outside the state (R.C. 109.85(B)).</p> <p>If a person fails without lawful excuse to obey a subpoena, permits the Attorney General to seek an order that (1) compels requested</p>

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	No provision.	<p>discovery, (2) adjudges the person in contempt of court, or (3) grants other relief that may be required until the person obeys the subpoena (R.C. 109.85(D)).</p> <p>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 (R.C. 109.85(E)).</p>
Publicly funded child care (PFCC) provider contracts	<p>Extends the disciplinary authority of the Department of Children and Youth (DCY) regarding PFCC providers by allowing DCY to also suspend or terminate the provider's contract (R.C. 5104.32(D)).</p> <p>Establishes an additional ground upon which DCY can take action against a PFCC provider – if evidence demonstrates that the provider acted with intent to commit fraud against the PFCC program (R.C. 5104.32(D)(3)).</p> <p>Defines fraud against the PFCC program to mean an intentional act or omission to deceive for purposes of obtaining or retaining payments under the PFCC care program that</p>	<p>No provision.</p> <p>No provision.</p> <p>No provision.</p>

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	<p>a PFCC provider is not entitled to obtain or retain (R.C. 5104.32(D)(3)).</p> <p>Requires the DCY Director to revoke the license of a child care center, child day camp, licensed preschool or school child program, licensed type B home, or type A home, and a county department of job and family services to revoke the certificate of a certified in-home aide, if the center, camp, program, home, or in-home aide had its PFCC provider contract terminated for acting with intent to commit fraud against the PFCC program and, in the case of DCY-licensed providers, specifies that they are then forever ineligible for licensure (R.C. 3301.58, 5104.03, 5104.12, and 5104.22).</p>	<p>No provision.</p>