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Client Alert: Ohio General Assembly Moves to Legislate Anti-Fraud Measures

The Ohio House Medicaid Committee adopted a substitute bill for House Bill 795, now known as the Ohio Medicaid Program Integrity and Fraud Prevention Act. The substitute bill significantly expands the original version of House Bill 795, intended to improve the electronic visit verification program.

Key Provisions

Provider Enrollment, Revalidation, Credentialing, and Prior Authorization

- Requires providers seeking enrollment in Medicaid to offer home and community-based services (HCBS) to first undergo an in-person review or onsite inspection. Thereafter, the Ohio Department of Medicaid (ODM) is required to conduct in-person reviews or site inspections every three years.
- Denies enrollment in Medicaid if a provider shares a principal address with more than two other HCBS providers or occupies less than 1,000 square feet at an address shared with another HCBS provider.
- Requires provider agreement renewals take place every three (3) years; currently, these agreements are up for renewal every five (5) years. The ODM will deny, refuse to revalidate, suspend, or terminate a provider agreement for those who have not submitted a claim for one (1) year.
- Imposes a prior authorization requirement for all Medicaid-funded therapeutic behavioral health services.
- Requires certain providers and facilities to submit credentialing information every twenty-four (24) months.

Enhanced Criminal Penalties and Enforcement

- Increases Medicaid fraud charges from a first-degree misdemeanor to a fifth-degree felony, with graduated enhancements up to a first-degree felony with a potential prison term for fraud exceeding \$150,000.
- Permits courts to require restitution of up to 200 percent of the value of services, payable to the newly

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RELATED PROFESSIONALS

Daphne L. Kackloudis
Katherine H. Crawford
Jordan A. Burdick

MEDIA CONTACT

Wendy M. Byrne
wbyrne@shumaker.com

created Medicaid Program Integrity Fund, which will finance the Attorney General's fraud enforcement, analytics, and whistleblower operations.

- Expands the definition of "credible allegation of fraud" to include falsified check-ins, forged paperwork, double billing, identity misuse, impossible travel patterns, hospital-overlap claims, and coordinated billing rings. Requires the ODM to suspend provider payments and impose pre-payment review of the provider's claims following submission of a credible allegation of fraud by the Attorney General.

Medicaid Managed Care Organizations (MCO) Transparency

- Requires the ODM to establish and maintain a database of Medicaid encounter data submitted by MCOs.
- Requires MCOs to submit quarterly reports including, but not limited to, the total number of services rendered, total spending on medical claims, non-claims expenditures, non-benefit services, and total spending on prescription drugs. The ODM will publish an annual report that summarizes MCO performance and service utilization.

Alternative Payment Evaluation

- Prior to making any payment on a claim for services, the ODM will be required to evaluate the claim using automated algorithmic analysis and insurance discovery engines to identify whether an alternative primary coverage source exists. If identified, the ODM will redirect the claim to the coverage source before making a Medicaid payment.

Electronic Verification Systems

- Requires in-home care service providers to use an ODM-approved electronic verification system, which will record and verify data elements related to the delivery of Medicaid services.
- Requires providers identified as high risk to use additional identity verification measures such as fingerprint, facial recognition, voice recognition, or PIN-based authentication as a condition of receiving payment. Providers may be identified as high risk if they are flagged for issues such as impossible travel times, billing outliers, or hospital-overlap claims.

Whistleblower Protections

- Includes whistleblower protections for employees who make good-faith reports of Medicaid fraud and who are unlawfully retaliated against by their employer. Employees may sue their employer for back pay or equitable relief, and collect attorneys' fees, as a result.

Key Takeaways and Next Steps

The substitute bill demonstrates an effort to increase oversight of the Medicaid program and fraud enforcement. If adopted, the bill will significantly increase compliance obligations and risk of exposure for a broad range of health care industry participants. Medicaid providers should evaluate their operational readiness for these increased requirements.

Please reach out to Daphne Kackloudis, Jordan Burdick or Kate Crawford if you have questions about the Ohio Medicaid Program Integrity and Fraud Prevention Act.