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Client Alert: Ohio Enacts Sweeping Medicaid Fraud Reforms Through SB 315

*Ohio Legislature Passes Comprehensive Medicaid
Anti-Fraud and Program Integrity Legislation*

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Daphne L. Kackloudis

Jordan A. Burdick

Katherine H. Crawford

MEDIA CONTACT

Wendy M. Byrne

wbyrne@shumaker.com

Overview

On June 10, 2026, the Ohio General Assembly passed a significantly revised version of Senate Bill 315 (SB 315), originally a bill addressing Supplemental Nutrition Assistance Program (SNAP) card security, which was amended to incorporate sweeping Medicaid fraud reforms drawn from House Bill 795. The legislation passed the House by a vote of 85-10 and received unanimous concurrence in the Senate. The bill now heads to Governor Mike DeWine for signature.

This alert summarizes the key provisions of SB 315 that will affect Medicaid providers, managed care organizations (MCOs), and other stakeholders in Ohio's Medicaid program. These legislative reforms follow weeks of intense scrutiny of Ohio's Medicaid program prompted by allegations of widespread fraud among home health care providers.

Prior Authorization for Behavioral Health Services

All therapeutic behavioral health services now require prior authorization under SB 315. Providers of such services should prepare to adjust their billing and service delivery workflows accordingly.

Payment Suspension and Fraud Investigation Authority

The legislation empowers both the Ohio Department of Medicaid (ODM) and MCOs to take swift action when fraud is suspected. ODM is now required to suspend payment and require prepayment review of claims when the attorney general or auditor of state submits a credible allegation of fraud. The bill defines "credible allegation of fraud" broadly to include conduct such as falsified or fake check-ins, forged paperwork, double billing, identity misuses, impossible travel patterns, overlap with hospital claims, and coordinated billing rings.

The bill also authorizes the attorney general and auditor of state to issue subpoenas in Medicaid investigations.

Enhanced Criminal Penalties for Medicaid Fraud

SB 315 increases criminal penalties for Medicaid fraud. Under the new law, Medicaid fraud is upgraded from a first-degree misdemeanor to a fifth-degree felony at a minimum, with penalties escalating based on the value of the fraudulent conduct, up to a first-degree felony charge and a \$150,000 fine when the fraud exceeds \$750,000 in value.

Additionally, Medicaid fraud is now designated as a predicate offense under Ohio's corrupt activity (RICO-style) statutes, giving prosecutors additional tools to pursue coordinated fraud networks.

Electronic Visit Verification Requirements

SB 315 mandates electronic visit verification (EVV) as a condition of payment for in-home care services, requiring providers to clock in and out at the location where services are being provided. ODM is directed to maintain a performance dashboard tracking EVV metrics.

Notably, the final version of the bill exempts live-in family caregivers from EVV GPS tracking requirements, a significant departure from earlier versions that would have imposed those requirements on all caregivers, including family members. The bill does, however, require ODM to establish separate oversight mechanisms for family caregivers and may require high-risk providers or those with repeated violations to provide services through an agency rather than as an independent provider.

Family Caregiver Provisions

The final version of the bill removes a particularly controversial provision that appeared in earlier drafts of the legislation—a ban on family members being paid to provide personal care services to their own relatives on Medicaid waivers. The removal followed extensive testimony from disabled Ohioans and their advocates who warned that the ban could have devastating effects on individuals who depend on family members for in-home care.

Provider Enrollment and Oversight

The bill introduces several new requirements related to provider enrollment and ongoing oversight. ODM is required to conduct in-person reviews of individual providers or site inspections of entities before enrolling them as providers of home and community-based services. This requirement builds on executive actions already taken by Governor DeWine, including a six-month moratorium on new home health care and hospice provider enrollment.

Providers found to be high-risk or to have repeatedly violated departmental requirements may be required to deliver services through an agency rather than as an independent provider, a provision that could significantly impact smaller and solo practice providers.

Automated Fraud Detection and Third-Party Liability

ODM is required to use automated algorithmic analysis and insurance discovery engines to determine whether alternative primary coverage exists before making any Medicaid payment. This provision is designed to reduce improper payments by identifying instances where Medicaid should be the payer of last resort.

All-Payer Claims Database

The Ohio Department of Insurance is required to create an all-payer claims database. Health plans, MCOs, pharmacy benefit managers, and Medicare and Medicaid programs will be required to submit claims to the database, with the submission requirement taking effect in 2028.

Whistleblower Protections

The legislation includes new protections for employees who report suspected Medicaid fraud. Employers are prohibited from retaliating against employees who make good-faith reports of fraud based on a reasonable belief. Employees who experience retaliation are authorized to sue for reinstatement with back pay and reasonable attorney fees.

Reporting and Accountability

SB 315 establishes several new reporting and review mechanisms for Medicaid program integrity:

ODM is required to annually report on program integrity to the chairs and ranking members of the legislative committees overseeing Medicaid in the House and Senate. The House and Senate Medicaid committees are also required to meet annually to review a quarter of Medicaid waiver programs. ODM must issue a cost estimate for implementing the bill's provisions within 30 days of its effective date.

For 18 months following enactment, ODM is directed to ensure that individual MCOs enroll at least 10 percent of total managed care participants, a provision designed to prevent overconcentration in the managed care market.

Context and Legislative Process

These reforms developed rapidly in response to reports from a conservative media outlet alleging hundreds of millions of dollars in Medicaid fraud by home health care providers in Ohio. While ODM is still investigating those claims and has not publicly confirmed the fraud estimates cited in the reports, the allegations provided political momentum for comprehensive legislative action. The legislation also comes alongside executive actions taken by Governor DeWine, including the enrollment moratorium and mandatory GPS requirements for EVV.

Several legislators noted the compressed legislative timeline and cautioned that unintended consequences may emerge from provisions that did not receive extended hearings. Legislators on both sides of the aisle have indicated they expect continued Medicaid oversight and potential additional reforms in the next budget cycle.

Key Takeaways for Affected Stakeholders

Medicaid providers, particularly those in the home health and community-based services space, should take immediate steps to assess the impact of SB 315 on their operations. Providers should review their EVV compliance capabilities and prepare for mandatory clock-in and clock-out requirements at service delivery locations. Providers should also ensure their enrollment credentials are current and prepare for potential in-person site inspections.

Behavioral health providers should prepare for new prior authorization requirements for therapeutic services.

MCOs should review their internal fraud detection protocols and prepare to implement payment interruption procedures when fraud is suspected. All stakeholders should monitor forthcoming ODM rulemaking that will

elaborate on the details and timeline for implementation of many of these provisions.

Employers in the health care sector should also update their internal compliance policies to account for the new whistleblower protections and ensure that employees are aware of the anti-retaliation provisions.

We will continue to monitor the implementation of SB 315 and any related regulatory developments. Please contact Shumaker health care partner Daphne Kackloudis for questions about how these reforms may affect your organization.