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Client Alert: Ohio Department of Medicaid Proposes New Provider Suspension Rules as Centers for Medicare & Medicaid Services Escalates Its Anti-Fraud Push

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Amidst heightened federal scrutiny of Medicaid fraud, waste, and abuse, the Ohio Department of Medicaid (ODM) recently proposed two new rules governing the suspension of Medicaid provider agreements and the suspension of claims payments. Ohio Administrative Code (OAC) 5160-1-17.5 replaces the current suspension rule, and OAC 5160-1-17.51 replaces the emergency rule ODM adopted on June 2, 2026.

Federal Context: Centers for Medicare & Medicaid Services (CMS) Targets a Sharp Rise in Suspensions

Federal regulators have made provider fraud a top enforcement priority, deploying new authorities, technologies, and coordination tools designed to stop improper payments before they are made. CMS seeks to quadruple provider suspensions within six months as part of CMS' overall crackdown on fraud. To that end, CMS has undertaken several measures that suggest providers face growing exposure:

- New exclusion authority. The Department of Health and Human Services (HHS) delegated permissive exclusion authority under Section 1128(b) of the Social Security Act to CMS, effective October 14, 2026. CMS may now exclude providers from Medicare, Medicaid, TRICARE, and other federal health care programs when a basis for exclusion exists, such as a provider's violation of the False Claims Act.
- Artificial Intelligence (AI)-driven, pre-payment detection. CMS is piloting AI and machine learning tools to flag suspicious Medicaid billing patterns, such as upcoding, billing for services never provided, and unusual geographic patterns. In addition to its pilot in Indiana, CMS has launched pilots with five other

states and plans to build a nationwide pre-payment system if they succeed.

- **Coordinated enforcement.** CMS is implementing a shared workspace for agency staff, states, law enforcement, Medicaid Fraud Control Units, and program integrity contractors to work together on high-risk provider fraud cases.
- **New-enrollee watchlist.** CMS began using an algorithm to monitor new providers and suppliers during their first six months of enrollment. Since deploying the algorithm, CMS has removed roughly 67 percent of providers and suppliers for noncompliance with federal health care program requirements.

Taken together, these measures mean providers may face exclusion, payment suspension, or claim denials at earlier stages in the fraud enforcement process. Because state Medicaid agencies implement payment suspensions under the same federal framework, providers should expect federal priorities to continue to shape state fraud enforcement activity.

Against this backdrop, ODM's two proposed rules would update and formalize its authority to suspend provider agreements and withhold claims payments. Key provisions of each rule are summarized below.

OAC 5160-1-17.5: Suspension of Medicaid Provider Agreements

- **Scope.** The rule covers all Ohio Medicaid providers.
- **Mandatory suspension.** ODM will now suspend a provider agreement and withhold claims payment, regardless of date of service, if there is a "credible allegation of fraud" or a disqualifying indictment against the provider or its owner, officer, authorized agent, associate, manager, or employee. ODM defines "credible allegation of fraud" as an ODM-verified allegation and includes falsified or fake checks-ins, forged paperwork, double billing for Medicaid services, identity misuse, impossible travel patterns, claims that overlap with a hospital stay that are not provided in accordance with an authorized individual service plan, and coordinated billing rings.
- **Discretionary suspension.** ODM may suspend a provider agreement if it has evidence that the provider poses a danger of immediate and serious harm to recipients. ODM or a participating managed care entity may also suspend if the provider or related persons pose a "significant risk to the integrity of the [M]edicaid program," including conduct that may lead to improper use of program resources or noncompliance with program requirements.
- **Cross-suspension.** If ODM suspends a provider, it may also suspend any other Medicaid provider agreements held by that provider.
- **Good cause exception.** A provider may now request a good cause exception to a suspension where the conditions of 42 C.F.R. 455.23 (Suspension of payments in cases of fraud) or Ohio Revised Code (ORC) 5164.36 are met.
- **Duration and reconsideration.** ORC 5164.36 and 42 C.F.R. 455.23 govern the duration of a suspension. Providers may request reconsideration under OAC 5160-70-02.

OAC 5160-1-17.51: Payment Suspension During a Pending Audit or Investigation

- **When it applies.** ODM will suspend claims payments without suspending a provider agreement where suspending the agreement would risk harm to members and ODM either (1) determines there is a credible allegation of fraud with an audit or investigation pending or (2) receives notice and a copy of an indictment against a non-institutional provider or its related persons.
- ODM may also suspend payments to any other entity in which the provider or its related persons serve in a similar role. During a provider's suspension period, the provider will not receive payments from ODM or from any managed care entities delegated by ODM to administer the Medicaid Program.
- **Provider duties.** When a provider receives notice of suspension, the provider must fully cooperate with

the audit, including responding to records requests within 30 days under OAC 5160-1-17.2.

- **Lifting the suspension.** ODM may lift the suspension in whole or in part if (a) ODM or a prosecuting authority determines there is insufficient evidence of fraud, waste, or abuse; (b) any related criminal case concludes through dismissal, conviction, guilty plea, or a finding of not guilty; or (c) good cause exists not to suspend under federal law (42 C.F.R. 455.23(e)-(f)).
- Providers must submit a written request within 30 calendar days of the notice of suspension. The ODM director or a designee not involved in the original decision will review the request. Providers cannot appeal the final reconsideration decision.
- **Termination and offset.** If ODM initiates termination of the provider agreement, the suspension remains in place until that process ends. When ODM lifts a suspension, it will first offset payments against the provider's debts owed to the Medicaid Program.

Key Takeaways for Providers

Moving forward, providers must assess their compliance with CMS and ODM anti-fraud policies and regulatory measures and should understand and advocate for their position in Ohio's new anti-fraud landscape. To do so, we recommend providers take the following actions:

- Consider commenting on the proposed rules. Ohio Medicaid providers should review the proposed rules now and consider whether to participate in the public comment process. A public hearing on the proposed rules will be held on November 16, 2026.
- Assess related-party exposure. Cross-suspension and the reach provisions mean an allegation against one owner, manager, or employee can affect multiple provider agreements and affiliated entities.
- Strengthen billing compliance. With CMS deploying AI to flag billing anomalies before payment, and ODM reinforcing its commitment to rooting out provider fraud, all providers should audit their claims for upcoding, documentation gaps, and atypical billing patterns.

If you have any questions about ODM's proposed rule changes or want assistance participating in the public comment process for the rules, please contact Daphne Kackloudis, Jordan Burdick, or Kate Crawford.