DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

March 5, 2026

Scott R. Partika
Director Ohio Department of Medicaid
50 West Town Street, 4th Floor
Columbus, OH 43215

Dear Scott Partika:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Ohio's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on June 26, 2025, and a final revised preprint was received on December 31, 2025. The proposal has a control name of OH_VBP.Fee_AMC.PC.SP.D.Oth_New_20250101-20251231.

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform percentage increase for qualified practitioner services at an academic medical center, primary care and specialty physician services, and dental services, as well as a value-based performance payment to providers who attain quality performance target(s), starting July 1, 2025 for the rating period covering January 1, 2025 through December 31, 2025, incorporated into capitation rates via a separate payment term up to $11,858,152.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

Based on CMS's preliminary determination, this SDP proposal likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS is preparing a notice of proposed rulemaking to revise 42 CFR part 438 as required under section 71116. CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of a grandfathered SDP (as specified in item 4 of the current SDP preprint form for the twelve-month rating period amount of $23,716,304) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.03.05 09:19:05 -05'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   January 1, 2025 - December 31, 2025
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2025
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Medicaid Managed Care (MMC) Program
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $23,716,304 (Annualized), $11,858,152 (6 month estimated payment)
   a. Identify the estimated federal share of this state directed payment: $15,350,378 (Annualized), $7,675,189 (6 month estimated payment)
   b. Identify the estimated non-federal share of this state directed payment: $8,365,926 (Annualized), $4,182,963 (6 month estimated payment)

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☒ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

There are two components to this SDP, a fee schedule component and a value-based component.

For the fee schedule component, managed care entities (MCE) will pay participating providers monthly directed payments allocated based on each MCEs enrollment. Monthly payments are designed to equal 95% of the difference between base rate payments and the average commercial rate (ACR).

The value-based component will be paid on achievement of the performance metric in Table 8. The value-based component is equal to the actual utilization at the ACR less the fee schedule component.

In this way, the total payments are based on utilization in the program period and with an estimated 0.20% pay for performance.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Stakeholders%2C%20Partners/MedicaidStatePlan/Sections/GPA/Attachment_B_-_Methods_and_Standards_for_Establishing_Payment_Rates.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

☒ Quality Payment/Pay for Performance (Category 2 APM, or similar)
☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
☐ Multi-Payer Delivery System Reform
☐ Medicaid-Specific Delivery System Reform
☐ Performance Improvement Initiative
☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

This state-directed payment initiative is a strategic lever in advancing ODM's NextGen objectives, as outlined in the Ohio Medicaid Managed Care quality strategy, with a focus on population health management and measurable quality improvement. ODM takes a collaborative approach to outcomes improvement in order to leverage the collective impact of state agencies, payors, health systems, providers, and community organizations. Keys to success of collaboratives include alignment of quality measures and the use of a proven framework such as the Model for Improvement to guide and accelerate improvement work.

In 2025, participants will focus on improving behavioral health outcomes for children, i.e., the 1–7-day follow-up visit after ED encounter for Mental Health (EDM), Ages 0-17 years measure. In 2025, a provider's potential earned value-based payment is equal to 0.20% of a provider's total payment as described in the response to Question 8. Providers will be eligible to earn the value-based payment by meeting or exceeding the performance target listed in Table 1.

In 2026, a provider's potential earned value-based payment is equal to 0.20% of a provider's total payment as described in the response to Question 8. An additional measure from ODM's Quality Strategy for children will be added to the value-based payment arrangement. This additional measure will also align with the Outcomes Acceleration for Kids (OAK) collaborative. Providers will be eligible to earn the value-based payment by meeting or exceeding the performance targets for the 2025 value based measure and the measure added in 2026.

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. See New_Child_sdp-4386c-preprint-addendum - Dayton.xlsx						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

1 – 7-day follow-up visit after ED encounter for Mental Health (EDM), Ages 0-17 years: The performance target is to improve or maintain the gap between the CY 2022 baseline and the benchmark. The benchmark was set at 57.20% based on the best performing children's hospital region in Ohio plus10%.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

For 2025 the target must be met in Table 1. in order to receive the value-based payment.

c. For state-developed measures, please briefly describe how the measure was developed?

1 – 7-day follow-up visit after emergency department (ED) encounter for Mental Health (EDM), Ages 0-17 years is defined as: The percentage of hospital system ED visits for a primary diagnosis of mental health (MH) among members 17 years old or younger on the date of the visit which had a qualifying follow-up visit within 7 days. Exclusions for this measure include ED visits with an observation stay on the same date of service and ED visits followed within 7 days by another ED visit for MH or an inpatient admission for any diagnosis. This measure was developed internally by ODM's data and quality teams with input from Medicaid managed care organizations.

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☒ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

This payment arrangement is designed to be a multi-year effort in support of the goals and objectives of the ODM's quality strategy. This submission represents the first year of the larger multi-year effort. Additional measures and performance requirements will be introduced in future years.

15. Use the checkboxes below to make the following assurances:

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

- **a.** Check the basis for the fee schedule selected above.
  - **i.** ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]
  - **ii.** ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
  - **iii.** ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
    - **1.** If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- **b.** Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

- **a.** ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- **b.** Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- **c.** Indicate the number of exemptions to the requirement:
  - **i.** Expected in this contract rating period (estimate)
  - **ii.** Granted in past years of this payment arrangement
- **d.** Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

The directed payment will result in an increase of 183% to base Medicaid payments

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The uniform increase paid to MCOs will be calculated to bring payments to eligible health systems up to a predetermined percentage of the ACR. To estimate the uniform increase amounts, payments at the ACR will be calculated based on actual utilization during the rate year. Total payments for this program year, will be based on utilization over the six-month period of July 1, 2025, through December 31, 2025.

0.2% of the total state directed payment for the rate year will be reserved and paid to providers based on their attainment of quality performance targets

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract
To determine the level of the increase, the state calculated the statewide average commercial rate, which is consistent with economy and efficiency as codified in § 42 CFR 438.6(c)(2)(iii).

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☒ professional services at an academic medical center
- ☒ primary care services
- ☒ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☒ dental services
- ☒ Other: Behavioral health inpatient and outpatient services are not separately identified and are identified in inpatient and outpatient services. Also, see response to question 20b below.

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Services provided by qualified practitioners who are employed or affiliated with a freestanding children's hospital participating and located in the Outcomes Acceleration for Kids (OAK) Learning Network's Dayton/West Central Region and affiliated with a public medical school will be eligible for directed payments.

Eligible services must be billed under one of the group national provider identifier (NPI) numbers that are affiliated with the freestanding children's hospital (identified by tax ID number) and identified by ODM.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

One of the key population focuses in the Ohio Medicaid Quality Strategy is children and to support those efforts, the Outcomes Acceleration for Kids (OAK) Network has been created. Each OAK Network region has its own provider lead that will be addressing its specific regional needs within an overall state framework. As such the provider class is designed to support the OAK Network in alignment with these efforts.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The directed payment is a uniform percentage increase. Ohio managed care entities will be required to provide the same percentage increase to all providers who meet the eligibility criteria.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☐

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Qualified Practitioners employed or affiliated with pediatric hospitals in the Dayton/West Central region participating in the OAK Network and affiliated with a public medical school	39.0%	61.0%			100% of ACR
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

a. ☐ Medicare payment/cost

b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*

c. ☒ Other; Please define: average commercial rate

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The average commercial rate and Medicaid rate ceiling were calculated in accordance with methodology specified in CMS's fee-for-service guidance, Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation. Provider data at the CPT code level was the basis for this analysis. In accordance 42 CFR 438.6 (c)(2)(iii)(A) the average commercial rate demonstration is specific to Ohio since it uses only provider data from eligible practitioners from calendar year 2023. The data used is specifically related to professional services in Medicaid and includes total reimbursement by third-party payers, including patient liability, such as copays and deductibles. The average commercial rate demonstration excludes data from FQHCs, RHCs, and non-commercial payers.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

This directed payment is set at the Average Commercial Rate (ACR), a benchmark established by the Centers for Medicare & Medicaid Services (CMS) to ensure appropriate and reasonable payments in both fee-for-service (FFS) and managed care. For state directed payments, this limit has been codified at § 42 CFR 438.6(c)(2)(iii).

The state believes that using the ACR creates a balanced and effective payment system that encourages provider participation and ensures access to quality care for Medicaid enrollees. CMS has codified the use of the ACR for supplemental payments in both FFS and managed care, formalizing this approach to support a consistent and reliable payment structure.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

August 2025

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MCR-OH-MMC-20250101-20251231-CERTIFICATION-20241218	December 30, 2024	No	
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

August 2025

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.

b. ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Separate payment terms offer administrative simplicity to the state agency administering the directed payments, ease of tracking and verification of accurate payment from the MCO’s/OhioRISE plan and reduces burden on MCO’s/OhioRISE by limiting the need to update systems to integrate and account for inclusion of directed payments in monthly cap rates and ensuring that PMPM’s impacted by the directed payments are captured correctly and corresponding directed payment occurs. Due to the mid-year implementation and the need to operationalize the directed payments as efficiently as possible, the state elected to administer these payments through a separate payment term.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

a. ☐ State general revenue

b. ☒ Intergovernmental transfers (IGTs) from a State or local government entity

c. ☐ Health Care-Related Provider tax(es) / assessment(s)

d. ☐ Provider donation(s)

e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Wright State University	State University	$8,700,563	No	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

Fully executed MOU will be shared with CMS prior to approval of this state directed payment.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/About%20Us/QualityStrategy/ODM_PHQ
- **b.** The effective date of quality strategy. May 16, 2025

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year): May 202
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. See New_Child_sdp-4386c-preprint-addendum - Dayton.xlsx		
b.		
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement is a vital element of an integrated strategy aimed at fostering collaborative, person-centered care for Ohio's Pediatric Medicaid Managed Care beneficiaries. Participating providers will concentrate on enhancing patient outcomes across various domains. The state will assess the performance of all participants based on quality metrics, process improvements, and collaborative improvement models. Additional performance metrics are expected to be introduced as the program progresses.

Participants of this SDP program will be required to support and participate in the statewide learning network for children, i.e., Outcomes Acceleration for Kids (OAK) comprised of other pediatric providers participating in SDP programs, ODM, Medicaid managed care entities, and others as applicable. The improvement work is organized into domains aligned with the pediatric population streams in ODM's quality strategy, i.e., healthy children, behavioral health, and chronic conditions. OAK is actively working on quality improvement work for the aligned measures in each pediatric domain.
In 2025, participants will focus on improving behavioral health outcomes for children, i.e., the 1 – 7-day follow-up visit after ED encounter for Mental Health (EDM), Ages 0-17 years measure In 2026, all the domains and accompanying measures that are active in OAK will be added. In subsequent years, OAK will expand its scope by introducing additional measures and requiring participants to fold these measures into this value-based arrangement —ensuring a comprehensive, data-driven approach to improving pediatric health outcomes statewide. In order to promote transparency and accountability, ODM will publicly report results for measures included in the OAK learning network (listed below) to indicate progress on advancing quality strategy goals and objectives for all population streams for children.

Healthy Children
Well Care Visits: Children 0-15 months, Overall & Designated Subpopulation
Well-Child Visits: Children 12-17 years, Overall & Designated Subpopulation

Behavioral Health (Child)
1 – 7-day follow-up visit after ED encounter for Substance Use (EDS), Ages 10-17 years Overall and Designated Subpopulations
1 – 7-day follow-up visit after ED encounter for Mental Health (EDM), Ages 0-17 years Overall and Designated Subpopulation

Chronic Conditions (Child)
Asthma Medication Ratio: Ages 5-11, Overall & Designated Subpopulation
Asthma Medication Ratio: Ages 12-18, Overall & Designated Subpopulation
Sickle Cell Disease: Transcranial Ultrasound

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See New_Child_sdp-4386c-preprint-addendum - Dayton.xlsx				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

This is the first 6 months of this program.

PREPRINT SUBSECTION IIA: VALUE-BASED PAYMENT/DELIVERY SYSTEM REFORM
ADDENDUM TABLE 1.A. PAYMENT ARRANGEMENT PROVIDER PERFORMANCE MEASURES

Directions

1. In Table 1.A below, use the rows to add more measure(s) to Table 1 that the State will tie to provider performance under this value-based payment or delivery system reform arrangement (provider performance measures). States may also use Table 1.A in lieu of completing Table 1 in the preprint. Input data only in beige cells in columns B - H.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 1 in the preprint, please delete Tabs 2.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 1.A: Payment Arrangement Provider Performance Measures

Column1	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes
Data Format	Free text	Set values (select one)	Year (CY or FY YYYY)	Percent (#.##%)	Free text	Percent (#.##%)	Free text
			Baseline year must be added after the first year of the payment arrangement	Baseline percentage must be added after the first year of the payment arrangement	If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment		If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.
Example:	*Percent of High-Risk Residents with Pressure Ulcers - Long Stay*	*Centers for Medicare & Medicaid Services*	*CY 2018*	*9.23%*	*Year 2*	*8.00%*	
a	1–7-day follow-up visit after ED encounter for Mental Health (FDM), Ages 0-17 years	State-defined	CY 2024	41.25%*	Year 1	Gap between baseline and benchmark is maintained or improved	* Proxy baseline **Benchmark** = 54.05% **Denominator**: ED visits with a primary diagnosis of a MH condition. The member must be 17 years of age or younger on the date of the ED visit. **Numerator**: A visit with a date of service between 1 and 7 days following the ED visit, billed on an outpatient or professional claim, with a primary MH or SUD diagnosis and with a BH provider or for BH treatment
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PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS
ADDENDUM TABLE 7.A. PAYMENT ARRANGEMENT QUALITY STRATEGY GOALS AND OBJECTIVES

Directions

7. Use Table 7.A below to add any goal(s) and objective(s) this payment arrangement is expected to advance as they appear in the state Quality Strategy (include page numbers). States may also use Table 7.A in lieu of completing Table 7 in the preprint. Input data only in beige cells in the three columns.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 7 in the preprint, please delete Tabs 1.A - 6.A and 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 7.A: Payment Arrangement Quality Strategy Goals and Objectives

Column1	Goal(s)	Objective(s)	Quality strategy page #
Data Format	**Free text**	**Free text**	**Free text**
Example:	Improve care coordination for enrollees with beahvioral health conditions	Increase the number of managed care patients receiving follow-up behavior health counseling by 15%	pp. 20-22
a.	Goal 4: Increase Availability of comprehensive & coordinated BH services, reduce BH & SUD related mortality	4.1: Increase 7-day follow-up after an ED visit for mental health among children & adolescents	pp.11
b.			
c.			
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xx.			
yy.			
zz.			
aaa.			
bbb.			
ccc.			
ddd.			
eee.			
fff.			
ggg.			
hhh.			
iii.			
jjj.			
kkk.			
lll.			
mmm.			
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ooo.			
ppp.			
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PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS
ADDENDUM TABLE 8.A. EVALUATION MEASURES, BASELINE AND PERFORMANCE TARGETS

Directions

8. Use Table 8.A below to add each measure the State intends to use in the evaluation of this payment arrangement, including (1) the baseline year, (2) the baseline statistics, and (3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. States may also use Table 8.A in lieu of completing Table 8 in the preprint. Input data only in beige cells in columns B - F.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 8 in the preprint, please delete Tabs 1.A - 7.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 8.A: Evaluation Measures, Baseline and Performance Targets

Column1	Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes
Data Format	Free text	Free text	Percentage (00.0%)	Percentage (00.0%)	Free text. If the State will deviate from the measure specification, please describe here. If the State is using a state-specific measure, please define the numerator and denominator here. In addition, describe any planned data or measure stratifications (for example, age, race, or ethnicity) the State will use to evaluate the payment arrangement.
Example:	*Flu Vaccinations for Adults Ages 19 - 64 (FVA-AD); NQF # 0039*	CY 2019	34.0%	34.0%	
	1–7-day follow-up visit after ED encounter for Mental Health (EDM), Ages 0-17 years	CY 2024	41.25%*	Gap between baseline and benchmark is improved	* Proxy baseline **Benchmark** = 54.05% **Denominator**: ED visits with a primary diagnosis of a MH condition. The member must be 17 years of age or younger on the date of the ED visit. **Numerator**: A visit with a date of service between 1 and 7 days following the ED visit, billed on an outpatient or professional claim, with a primary MH or SUD diagnosis and with a BH provider or for BH treatment.
	Transcranial Ultrasound for sickle cell	CY 2024	45.00%*	Gap between baseline and benchmark is improved	* Proxy baseline **Benchmark** = 88.00% **Denominator**: Members at least 2 years of age on the first day of the measurement period and no older than 15 years of age on the last day of the measurement period. They also must have at least two claims during the measurement period with a qualifying diagnosis (primary or secondary) of Sickle Cell Disease (Table A1). If the claim also has a diagnosis (primary or secondary) contained in the excluded condition list (Table A2), the claim does not count towards the two-claim minimum. Systems will also conduct supplemental medical record review to fully identify members with sickle cell disease for whom a transcranial ultrasonography test is clinically appropriate. **Numerator**: Members with a qualifying transcranial ultrasonography test (Table A3) during the measurement period.