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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 25-0015

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group

June 5, 2026

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

RE: TN 25-0015

Dear Mr. Niehoff

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-A OH 25-0015, which was submitted to CMS on August 13, 2025. This plan amendment makes changes to the payment of Intermediate Care Facilities for individuals with intellectual disabilities.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Sudev Varma at 301-448-3916 or via email at sudev.varma@cms.hhs.gov

Sincerely,



Rory Howe
Director
Financial Management Group

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 5 — 0 0 1 5

2. STATE

OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION

42 CFR 440.150; 447 Subpart C; 483 Subpart I

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2025 \$ 15,665,500
b. FFY 2026 \$ 62,904,500

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, Supplement 2, Page 7, 9, 11, 12, 18, 23, 24

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Atch 4.19-D, Supp 2, pp 7, 9, 11, 12, 18 (TN 24-012)
Atch 4.19-D, Supp 2, Page 23 (TN 23-026)
Atch 4.19-D, Supp 2, Page 24 (TN 22-030)

9. SUBJECT OF AMENDMENT

Payment for Services: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Payment Changes

10. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME

MAUREEN M. CORCORAN

13. TITLE

STATE MEDICAID DIRECTOR

14. DATE SUBMITTED

August 13, 2025

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED

August 13, 2025

17. DATE APPROVED

June 5, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

Rory Howe

21. TITLE OF APPROVING OFFICIAL

Director of the Financial Management Group

22. REMARKS

Calculation of Direct Care Per Diem for Peer Groups 1, 2, 3, 4, and 5

A direct care per diem rate is established for each ICF-IID using allowable direct care costs as reported by each facility in accordance with the following calculation:

- 1) Calculate the direct care cost per diem for each provider by dividing the allowable direct care costs by the inpatient days reported on the same cost report.
- 2) Calculate the direct care cost per case mix unit for each provider by dividing the provider's direct care costs per diem by the annual average case mix score for the provider. The annual average case mix score is the average of the provider's scores for the March 31, June 30, September 30, and December 31 reporting period end dates for the calendar year corresponding to the calendar year for which costs are reported.
- 3) Determine the maximum cost per case mix unit for each peer group:
 - a. The maximum cost per case-mix unit for a peer group for a fiscal year, other than Peer Group 5 is the following percentage above the peer group's median cost per case-mix unit for that fiscal year.
 - i.* For Peer Group 1 use 16%.
 - ii.* For Peer Group 2 use 14%.
 - iii.* For Peer Group 3 use 18%.
 - iv.* For Peer Group 4 use 22%.
 - b. The maximum cost per case mix unit for Peer Group 5 is equal to the cost per case mix unit of the provider at the 95th percentile of all providers in Peer Group 5 for the calendar year preceding the fiscal year in which the rate will be paid.
- 4) The allowable cost per case mix unit is the lesser of the facility cost per case mix unit or the maximum cost per case mix unit for the peer group.
- 5) Multiply the allowable cost per case mix unit by the annual average case mix score for the provider and then multiply the product by an inflation factor to determine the direct care per diem for the facility.
 - a. The direct care inflation factor is 1.0629.

Calculation of Indirect Care Per Diem for Peer Groups 1, 2, 3, 4, and 5

An indirect care per diem rate is established for each ICF-IID using allowable indirect care costs as reported by each facility in accordance with the following calculation:

- 1) Divide the allowable indirect care costs by the greater of the inpatient days reported on the same cost report or imputed occupancy.
 - a. Imputed occupancy is 85% of the total number of bed days available based on the number of certified beds for the facility.
- 2) Multiply the result above by an inflation factor of 1.0355 to determine the inflated indirect care costs per diem.
- 3) The maximum rate for an ICF-IID's peer group shall be the following percentage above the peer group's median per diem indirect care costs for the applicable cost report year:
 - a. For Peer Group 1 that percentage is 8%;
 - b. For Peer Group 2 and Peer Group 3 that percentage is 10%;
 - c. For Peer Group 4 and Peer Group 5 that percentage is 12%.
- 4) Determine the maximum efficiency incentive for each peer group:
 - a. The maximum efficiency incentive for Peer Group 1 is 5% of the maximum per diem calculated for the peer group in Item 3 above.
 - b. The maximum efficiency incentive for Peer Groups 2, 3, 4, and 5 is 6% of the maximum per diem calculated for the peer group in Item 3 above.
- 5) The allowable indirect care per diem rate is:
 - a. If the inflated indirect care cost per diem is higher than the maximum inflated indirect care cost per diem for the peer group, the indirect care per diem rate is equal to the maximum inflated indirect care cost per diem for the peer group.
 - b. If the inflated indirect care cost per diem is lower than the maximum inflated indirect care cost per diem for the peer group, the indirect care cost per diem is equal to the sum of the following:
 - i. The inflated indirect care cost per diem;
 - ii. The efficiency incentive calculated as the difference between the amount of the per diem indirect care costs for the applicable cost report year and the maximum rate established for the ICF/IID peer group under Section 4 above.

TN: 25-0015
Supersedes:
TN: 24-012

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Calculation of Capital Per Diem for Peer Groups 1, 2, 3, 4, and 5

A capital per diem rate is established for each ICF-IID based on the determined fair rental value of the facility, allowable secondary buildings, and equipment costs. The result is compared to the facility's actual allowable reported capital costs and limited if the result is greater than costs. Any non-extensive renovations approved under the Retiring Methodology and not covered in this calculation are grandfathered in. The details are as follows:

Facility Fair Rental Value Calculation

1. Square footage cap
 - a. From the cost report, determine the total square footage of the facility and the number of beds.
 - b. Divide the total square footage by the number of beds to get the number of square feet per bed.
 - c. The minimum limit for square feet per bed is 200.
 - d. The maximum limit for square feet per bed is set by peer group as follows:
 - i. Peer Group 1-A provider has downsized or partially converted five beds or 10% of the previous capacity, whichever is less: 1000
 - ii. Peer Group 1 provider has not downsized or partially converted the minimum required in (d.i.) above: 550
 - iii. Peer Group 2 provider has downsized or partially converted five beds or 10% of the previous capacity, whichever is less: 1000
 - iv. Peer Group 2 provider has not downsized or partially converted the minimum required in (d.iii.) above: 750
 - v. Peer Group 3: 850
 - vi. Peer Group 4: 900
 - vii. Peer Group 5: 900
 - e. For purposes of the fair rental value calculation the facility's allowable square footage shall be adjusted to reflect the minimum or maximum limits described above if the facility's calculated square feet per bed falls outside those limits.
2. Value per square foot
 - a. The value per square foot is based on the provider's peer group and county.
 - b. Use the following values by peer group (updated annually):
 - i. Peer Groups 1 and 2: RS Means Construction Cost Estimating Data for Assisted-Senior Living, use \$258.87;

Facility Fair Rental Value Calculation, continued

- ii. Peer Groups 3, 4, and 5: RS Means Construction Cost Estimating Data for Nursing Home, use \$271.47.
 - c. The amount in (2b) is adjusted by a modifier published for each major metropolitan area by RS Means. The modifier applies to the county or counties that contain the metropolitan area. For counties that do not contain a metropolitan area as published by RS Means, the modifier is assigned by an appropriate proxy, which is the metropolitan city that most accurately represents the county – for example, Columbus for Franklin County or Akron for Summit County.
3. Effective Age calculation
- a. The initial construction year is assumed as the effective age unless renovations and/or additions have been reported.
 - i. Age is based on the cost report year. For example, a facility built in the cost report year would have the age of zero.
 - ii. Maximum age of a facility is 40 years.
 - iii. Minimum age of a facility is zero.
 - b. Each reported renovation or addition re-ages the facility. The re-aging is calculated as follows:
 - c. Additions:
 - i. For each square footage addition (positive value) the provider reports calculate the new bed equivalent.
 - 1. Multiple the square footage of the addition by the value per square foot from Item 2 above.
 - 2. Divide that amount by \$70,000 to get the new bed equivalent.
 - 3. Multiply the new bed equivalent by the project age to get the weighted new bed equivalent.
 - ii. For each bed addition (positive value, ignore reductions) the provider reports calculate the weighted new bed equivalent by multiplying the number of beds added by the age of the addition.
 - iii. Total the weighted new bed equivalent of all bed and square footage additions for each provider.
 - d. Renovations:
 - i. Disregard any renovations reported which are 40 or more years old.
 - ii. For each allowable renovation reported take the project cost and divide by \$70,000 to get the new bed equivalent.
 - iii. Multiply the new bed equivalent by the age of the renovation to get the weighted age of the renovation.

Calculation of Other Protected Per Diem for Peer Groups 1, 2, 3, 4, and 5

Another protected per diem rate is established for each ICF-IID using allowable other protected costs as reported by each facility in accordance with the following calculation:

- 1) Subtract allowable franchise permit fee costs from the total allowable other protected costs;
- 2) Divide the amount in item 1 above by the total inpatient days reported on the same cost report for the facility to determine the other protected costs per diem;
- 3) For Peer Groups 1, 2, 3, 4, and 5 multiply the other protected costs per diem by an inflation factor which is 0.9424;
- 4) Add Medicaid's portion of the franchise permit fee per diem rate to determine the other protected costs per diem rate.

TN: 25-0015
Supersedes:
TN: 24-012

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Direct Support Personnel Payment

Each ICF-IID shall receive a direct support personnel payment equal to 2.04% of ICF/IID's desk-reviewed, actual, allowable, per Medicaid day direct care costs from the applicable cost report year.

Quality Incentive Payment

1. Calculate the relative weight point value for the fiscal year
 - a. Multiply the number of inpatient days the ICF/IID had for the applicable cost report year by the number of quality points the ICF/IID was awarded
 - b. Determine the sum of all ICF/IID products calculated under section a
 - c. Determine the amount equal to one percent of the total desk-reviewed, actual, allowable direct care costs of all ICF/IID for the applicable cost report year
 - d. Divide the amount determined under section c by the sum determined under section b
2. Calculate the number of points the ICF/IID was awarded
3. Multiply the relative weight point value by the points awarded to the ICF/IID

Professional Workforce Development Add On

Each ICF-IID shall receive a professional workforce development payment equal to 10.405% for FY26 of the ICF/IID's desk-reviewed, actual, allowable, per Medicaid day direct care costs from the applicable cost report year.

TN: 25-0015
Supersedes:
TN: 23-026

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