Table of Contents

State/Territory Name: Ohio

State Plan Amendment (SPA) #: 25-0017

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

October 1, 2026

Scott Partika
State Medicaid Director
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

RE: TN 25-0017

Dear Director Partika,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-D OH-25-0017, which was submitted to CMS on September 17, 2025. This plan amendment transitions the Nursing Facility Reimbursement to the Patient Driven Payment Model.

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,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REVISED

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0017

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
Section 1905(a)(4)(A) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Atch 4.19-D, Supp 1, Sec 001.8, page 1
Atch 4.19-D, Supp 1, Sec 001.8.2, page 1 of 1
Atch 4.19-D, Supp 1, Sec 001.8.2, Appendix B (new)
Atch 4.19-D, Supp 1, Sec 001.18.1, page 3 of 4
Atch 4.19-D, Supp 1, Sec 001.20, page 1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Atch 4.19-D, Supp 1, Sec 001.8, page 1 (11-022)
Atch 4.19-D, Supp 1, Sec 001.8.2, pages 1-2 of 2 (16-012)
Atch 4.19-D, Supp 1, Sec 001.18.1, page 3 of 4 (23-023)
Atch 4.19-D, Supp 1, Sec 001.20, page 1 (24-021)

9. SUBJECT OF AMENDMENT
Nursing Facility Reimbursement Transition to Patient-Driven Payment Model (PDPM)

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
[redacted]

12. TYPED NAME
MAUREEN M. CORCORAN

13. TITLE
STATE MEDICAID DIRECTOR

14. DATE SUBMITTED
September 16, 2025

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

FOR CMS USE ONLY

16. DATE RECEIVED
September 17, 2025

17. DATE APPROVED
10/1/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director of the Financial Management Group

22. REMARKS

Calculating the Direct Care Rate

A facility-specific direct care rate component is calculated by multiplying the peer group price by a facility-specific semi-annual case mix score. For rates effective on the first day of July 2025, the price is multiplied by the provider's choice of either the Optional State Assessment (OSA) semi-annual Medicaid case mix score for the quarters ending December 31, 2024 and March 31, 2025, or the frozen first quarter 2023 case mix score. Subsequently, rates are adjusted for changes in acuity effective July 1 and January 1 of the fiscal year. The July 1 acuity adjustment will be made using the semi-annual Medicaid case mix scores for the preceding quarters ending December 31 and March 31. The January 1 acuity adjustment will be made using semi-annual Medicaid case mix scores for the preceding quarters ending June 30 and September 30.

Beginning with rates for the period of January 1, 2026, and ending the day before the department's next rebasing conducted after that date takes effect, the department will calculate semiannual rates by multiplying each cost per case mix unit by the PDPM case mix index adjusted by the case mix multiplier. The case mix multiplier calculated at January 1, 2026, will be used to equalize the RUG and PDPM case mix scores during the transition from RUG to PDPM. The case mix multiplier will be calculated for each direct care peer group by dividing the peer group average case mix score using the RUG-based semi-annual case mix scores in effect on December 31, 2025, by the peer group average PDPM nursing component semi-annual case mix score effective January 1, 2026.

Beginning January 1, 2026, the increase or decrease in a nursing facility's direct care rate will be one-third of the difference between the direct care rate on January 1, 2025, and the direct care rate determined utilizing PDPM case mix scores calculated above. In fiscal year 2027, the increase or decrease to a nursing facility's direct care rate will be two-thirds of the difference between the direct care rate on January 1, 2025, and the direct care rate determined utilizing PDPM case mix scores calculated above. Thereafter, a nursing facility's direct care rate will be determined utilizing PDPM case mix scores calculated above, with no phase-in of the rate applied.

Nursing Facility Classification System

The Ohio case mix payment system is transitioning from using the resource utilization groups (RUG) classification system to the Patient-Driven Payment Model (PDPM during state fiscal year (SFY) 2026 and 2027, as described in section 001.8.

The RUG classification system

The RUG classification system is a methodology for grouping nursing facility residents into case mix groups in a way that is clinically meaningful and uses criteria that sufficiently differentiates one group from another. Ohio uses version IV (RUG IV),the fifty-seven grouper model, of the RUG classification system.

The PDPM classification system

The PDPM classification system is the prospective payment system for classifying residents based on the unique needs and characteristics of each resident, rather than the quantity of therapy services provided. Only the nursing index of the PDPM classification system will be used.

Both classifications are based on items in the MDS 3.0. If a resident meets the criteria for placement in more than one group, the resident will be placed in a group according to the hierarchy. In descending order, the hierarchy of major categories used is as follows:

a) Rehabilitation (RUG only).
b) Extensive services.
c) Special care high.
d) Special care low.
e) Clinically complex.
f) Behavioral symptoms and cognitive performance.
g) Reduced physical function.

Each of the groups is assigned a relative resource weight according to federal case mix indexes.

Residents whose MDS 3.0 forms contain missing or out-of-range responses to data elements used to determine the classifications shall be assigned to a default group. The lowest relative resource weight for each classification system is used as the weight for the default group.

Appendix A: RUG Classification System Relative Resource Weights
Appendix B: PDPM Case Mix Indexes

Appendix B- PDPM Case Mix Indexes

Table 1: PDPM Case-Mix Associated Indexes

PDPM Group	Nursing CMG	Nursing CMI
A	ES3	3.84
B	ES2	2.90
C	ES1	2.77
D	HDE2	2.27
E	HDE1	1.88
F	HBC2	2.12
G	HBC1	1.76
H	LDE2	1.97
I	LDE1	1.64
J	LBC2	1.63
K	LBC1	1.35
L	CDE2	1.77
M	CDE1	1.53
N	CBC2	1.47
O	CA2	1.03
P	CBC1	1.27
Q	CA1	0.89
R	BAB2	0.98
S	BAB1	0.94
T	PDE2	1.48
U	PDE1	1.39
V	PBC2	1.15
W	PA2	0.67
X	PBC1	1.07
Y	PA1	0.62

Quality Incentive Payments

All nursing facilities eligible for a quality incentive payment will have the calculated amount added to the facility's per diem Medicaid rate, which is calculated semi-annually for January 1 and July 1, and paid per qualifying Medicaid day billed. The incentive payment is calculated and paid differently for certain providers as follows:

A nursing facility shall not receive a quality incentive payment if the facility is assigned to the federal Special Focus Facility List Table A on the first day of May of the calendar year for which the rate is being determined.

New providers shall receive the median quality points for the fiscal year in which the new facility obtains an initial provider agreement and the immediately following fiscal year. Entering providers from a change of operator with an effective date of July 1, 2025 or later shall not receive a quality add-on for a minimum of six (6) months.

Non-Standard Rates

Change of Operator (CHOP)
For an entering operator that begins participation in the Medicaid program, the operator's initial rate shall be the rate the exiting operator would have received had the exiting operator continued to participate in the Medicaid program.

A nursing facility that undergoes a change of operator with an effective date of July 1, 2025 or later shall not receive a quality incentive payment for a minimum of six (6) months after the CHOP occurs.