State/Territory Name: Ohio

State Plan Amendment (SPA) OH-25-0028

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

July 28, 2026

Scott Partika
Director, Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, OH 43215

RE: TN OH-25-0028

Dear Director Partika:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-B OH-25-0028, which was submitted to CMS on December 31, 2025. The purpose of this plan amendment is to update Ohio's outpatient hospital reimbursement to Enhanced Ambulatory Patient Grouping (EAPG) relative weights.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 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 January 1, 2026. 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 Jerica Bennett at 410-786-1167 or via email at jerica.bennett@cms.hhs.gov.

Sincerely,

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

July 28, 2026

Scott R. Partika, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

Re: Ohio State Plan Amendment (SPA) 25-0028

Dear Director Partika:

We are issuing this letter as a companion to the Centers for Medicare & Medicaid Services'(CMS) approval of OH's State Plan Amendment (SPA) TN 25-0028. Ohio's SPA 25-0026 proposed to proposed increases to Enhanced Ambulatory Patient Grouping (EAPG) relative weights to support efforts aimed at reducing maternal and infant mortality rates and expanding access to behavioral health services, base rates for outpatient hospital services, and the flat rate payment amount for dental procedures. During our review of OH 25-0028, we identified certain issues with Ohio's current state plan, which are the subject of this letter.

Comprehensive Language

1. On Attachment 4.19-B, Item 2-a, Page 1-3 submitted with OH-25-0028, the state plan does not comprehensively describe the inflation factors used to inflate the total cost computed for each case in alignment with 42 CFR 440.30. Please amend the state plan language at (F)(3) to specifically indicate which inflation factors are used to calculate the inflated cost for all cases when calculating the EAPG Payment.

We are requesting your response on or before October 27, 2026, which is within 90 days from the date of this companion letter.

If you have any additional questions or need further assistance, please contact Jerica Bennett at 410-786-1167 or via email at jerica.bennett@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM

Danielle Motley, CMCS
Jeria Bennett, CMCS
Brandson Smith, CMCS
Keri Toback, CMCS
Christine Davidson, CMCS

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0028

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
January 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447, Subpart F

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 8,233,382
b. FFY 2027 $ 11,005,673

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Item 2-a, pp 1-3 through 1-5

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Item 2-a, pp 1-3 through 1-5 (TN 23-038)

9. SUBJECT OF AMENDMENT

Payment for Services: Outpatient Hospital Reimbursement

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
SCOTT PARTIKA

13. TITLE
STATE MEDICAID DIRECTOR

14. DATE SUBMITTED
December 31, 2025

15. RETURN TO

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

FOR CMS USE ONLY

16. DATE RECEIVED
12/31/202

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2026

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Radiology services billed with valid CPT/HCPCS code(s) will be reimbursed the lesser of charges or the assigned EAPG payment.

(F) Sources for Inputs in the Payment Formula

The dataset used as inputs in the payment formula and determination of relative weights established for dates of service on or after January 1, 2024 consists of:

(1) All outpatient hospital claims with dates of service from January 1, 2017 through June 30, 2021;

(2) Cost reports submitted by hospitals to ODM on its Ohio Medicaid hospital cost report for the hospital years that end in state fiscal years 2017 (ODM 02930 rev. 4/2017) through 2021 (ODM 02930 rev. 5/2021); and

(3) Inflation factors computed for Ohio by a nationally recognized research firm that computes similar factors for the Medicare program. The inflation factors were used to inflate the total cost computed for each case inflating it to June 30, 2024.

(G) Computation of Case Mix Adjusted Average Cost Per Case (Base Rate)

A case represents the aggregation and compilation of all detailed claim lines incurred for an individual on a single date of service by a single hospital. An individual case may therefore consist of any number of outpatient claim lines that occur on that same date and are associated with that hospital.

(1) For each Ohio peer group, calculate the total inflated cost for all cases, divide it by the number of cases assigned to each peer group and multiply the result as follows:
   (a) For teaching hospitals, by 70%;
   (b) For urban hospitals in the southeast region, by 68%;
   (c) For urban hospitals in the southwest region, by 63%; and
   (d) For all other Ohio hospitals, by 62%.

(2) For each Ohio peer group, sum the relative weight values for all cases assigned to the peer group, divided by the number of cases in the peer group.

(3) For each Ohio peer group, multiply the amount described in subsection (G)(1) by the result of subsection (G)(2) of this section.

(4) For non-Ohio peer groups, the peer group base rate is $93.14.

(5) The following peer group increases are effective for dates of service on or after January 1, 2026:
   (a) For critical access hospitals, 14.06% in addition to the result of subsection (G)(1)(d) of this section.
   (b) For rural hospitals, 22.61% in addition to the result of subsection (G)(1)(d) of this section.
   (c) For children's hospitals, 0.84% in addition to the result of subsection (G)(1)(d) of this section.
   (d) For teaching hospitals, 0.83% in addition to the result of subsection (G)(1)(a) of this section.
   (e) For all other Ohio hospitals, 0.83% in addition to the result of subsection (G)(1)(d) of this section.

(H) Risk corridors.

Effective for dates of service on or after January 1, 2024, the following will apply to Ohio hospital peer groups not classified as either critical access hospitals or rural hospitals, as defined in Attachment 4.19-A, section I, subsection (B):

(1) If the peer group base rate calculated in subsection (G) of this section results in the reduction of payments from current levels at the individual hospital level, the individual hospital base rate is adjusted to a 0% reduction in payments; or

(2) If the peer group base rate calculated in subsection (G) of this section results in the increase of payments that is greater than 10% from current levels at the individual hospital level, the individual hospital base rate is adjusted to a 10% increase in payments.

(I) Computation of Relative Weights

The relative weight is equal to:

(1) The average inflated cost per case within each EAPG; divided by

(2) The average inflated cost per case across all EAPGs.

(3) The relative weights in subsections (I)(1) and (I)(2) of this section are effective January 1, 2024.

(4) Adjustments to relative weights, effective January 1, 2026.

(a) The relative weights for neonates, obstetric procedures, pregnancy, childbirth, and the puerperium EAPG categories as calculated in subsections (I)(1) and (I)(2) of this section are increased by 48.64%.

(b) The relative weights for behavioral health services assigned to EAPG categories 16, 71, and 72, as calculated in subsections (I)(1) and (I)(2) of this section, are increased by 14.04%.

(J) Items conditionally payable outside of EAPG

(1) Pharmaceuticals.

(a) For services rendered on or after January 1, 2024, reimbursement for outpatient hospital pharmaceuticals HCPCS J-code or Q-code billed with revenue center code 025X or 0636 will be the lesser of charges or the payment amounts in the provider-administered pharmaceutical fee schedule as published on ODM's website, https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

(b) Additional payments for pharmaceuticals will be made in accordance with the discounting factors as determined by the EAPG grouper.

(c) Pharmaceutical line items without a National Drug Code will be denied payment by ODM.

(d) Charges listed in line items that carry revenue center code 025X or 636 with a provider-administered pharmaceutical HCPCS J-code or Q-code that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will be multiplied by 60% of the hospital's specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(2) Durable medical equipment (DME).

(a) Payments for DME may be made for all line items grouping to DME EAPG codes.

(b) For services rendered on or after January 1, 2024, reimbursement for outpatient hospital DME will be the lesser of charges or the payment amounts in the Medicaid durable medical equipment fee schedule as published on ODM's website, https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

(c) Payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.

(3) Independently billed services for drugs or medical supplies and devices.

(a) To request independently billed payment under EAPG, hospitals must report all services provided on the date of service; and

(b) Report modifier UB with the primary procedure performed. Claims submitted with modifier UB are subject to the following payment methodology:

(i) Charges listed in line items that carry revenue center codes 025X or 0636 with a provider administered HCPCS J-code or Q-code will pay in accordance with the provider-administered pharmaceutical fee schedule.

(ii) Charges listed in line items that carry revenue center code 025X without a provider-administered pharmaceutical CPT/HCPCS code or revenue center code 027X with or without a DME HCPCS code will be multiplied by 60% of the hospital specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(iii) Charges listed in line items that carry revenue center code 025X or 0636 with a provider-administered pharmaceutical HCPCS J-code or Q-code that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will be multiplied by 60% of the hospital's specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(iv) All other detail lines on the same date of service will be paid $0.

(4) Dental services.

(a) Reimbursement for items assigned to a dental service EAPG type will be paid at a flate rate of $1,430.00.

(b) Payments will be subject to any applicable factors described in subsection (E) of this section and rounded to the nearest whole cent.

(5) Vaccines for children (VFC).

(a) The administration of immunizations covered under the VFC program may be reimbursed for recipients 18 years or younger.

(b) Reimbursement for the administration of immunizations covered under the VFC program will be $10.00 for individuals 18 years of age or younger, contingent upon the EAPG grouper.