

State/Territory Name: Ohio

State Plan Amendment (SPA) OH-26-0007

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
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604



Financial Management Group

June 5, 2026

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

RE: TN OH-26-0007

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-26-0007, which was submitted to CMS on March 24th, 2026. The purpose of this plan amendment is to update Ohio's non-institutional Medicaid payment methodologies and fee schedules, to incorporate new, revised, and deleted CPT and HCPCS procedure codes and associated reimbursement provisions for multiple provider and service categories under Attachment 4.19-B.

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 Robert Bromwell at 410-786-5914 or via email at robert.bromwell@cms.hhs.gov.

Sincerely,

A solid black rectangular box redacting the signature of Todd McMillion.

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

1. TRANSMITTAL NUMBER
2 6 — 0 0 0 7

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
See attached addendum

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 \$ 0
b. FFY 2027 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See attached addendum

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)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


9. SUBJECT OF AMENDMENT

Payment for Services: Non-Institutional Payment Schedule Updates for 2026

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
SCOTT PARTIKA

13. TITLE
STATE MEDICAID DIRECTOR

14. DATE SUBMITTED
March 24, 2026

15. RETURN TO

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

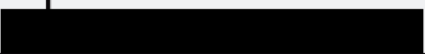
FOR CMS USE ONLY

16. DATE RECEIVED
March 24, 2026

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL


20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

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

22. REMARKS

CMS-179 Addendum for TN 26-0007

“Payment for Services: Non-Institutional Payment Schedule Updates for 2026”

Block 5, Federal Statute/Regulation Citation
Sections 1905(a)(3), (6), (7), (10), (11), (12), and (13) of the Act;
42 CFR 440.30, 440.60, 440.70, 440.100, 440.110, 440.120, and 440.130

Block 7, Page Number of Plan Sec. or Atch.	Block 8, Page Number of Plan Sec. or Atch., Superseded
Attachment 4.19-B, Item 3, Page 1 of 2	Attachment 4.19-B, Item 3, Page 1 of 2 (TN:25-001)
Attachment 4.19-B, Item 6-a Page 1 of 2	Attachment 4.19-B, Item 6-a, Page 1 of 2 (TN:25-001)
Attachment 4.19-B, Item 6-d-(2), Page 1 of 2	Attachment 4.19-B, Item 6-d-(2), Page 1 of 2 (TN:25-001)
Attachment 4.19-B, Item 7-c, Page 1 of 2	Attachment 4.19-B, Item 7-c, Page 1 of 2 (TN:25-001)
Attachment 4.19-B, Item 10, Page 1 of 2	Attachment 4.19-B, Item 10, Page 1 of 2 (TN:25-001)
Attachment 4.19-B, Item 11-b, Page 1 of 1	Attachment 4.19-B, Item 11-b, Page 1 of 1 (TN:23-042)
Attachment 4.19-B, Item 11-c, Page 1 of 1	Attachment 4.19-B, Item 11-c, Page 1 of 1 (TN:23-042)
Attachment 4.19-B, Item 12-c, Page 1 of 1	Attachment 4.19-B, Item 12-c, Page 1 of 1 (TN:25-001)
Attachment 4.19-B, Item 13-c, Page 1 of 1	Attachment 4.19-B, Item 13-c, Page 1 of 1 (TN:25-001)

3. Other laboratory and x-ray services.

Other laboratory and x-ray services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.30.

Payment for other laboratory and x-ray services is the lesser of the submitted charge or an established amount based on the Medicaid maximum for the service. For each clinical diagnostic laboratory test, the established amount is not to exceed the corresponding Medicare allowed amount.

The Medicaid maximum for other laboratory services is the amount listed on the Department's laboratory services fee schedule. For an existing laboratory service or a newly-covered laboratory service, the initial maximum payment amount is set at 75% of the applicable Medicare allowed amount listed in the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule. If the Medicare amount for a covered laboratory service becomes less than the current Medicaid maximum payment amount, then the Medicaid maximum payment amount for that service is reestablished at 75% of the current applicable Medicare allowed amount.

The Medicaid maximum for x-ray services is the amount listed on the Department's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule. For a newly-covered x-ray service represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. A payment reduction provision applies when more than one advanced imaging procedure is performed by the same provider or provider group for an individual patient in the same session. Payment is made for the primary procedure at 100%, payment for each additional technical component is made at 50%, and payment for each additional professional component is made at 95%. This payment reduction provision took effect on January 1, 2017.

Each code representing a newly covered laboratory or x-ray service is located on the agency's CPT and HCPCS Level II Procedure Code Changes schedule at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates> until it is moved to the laboratory services or MSRIAP fee schedule.

All Medicaid fee schedules and maximum payment amounts are published on the agency's website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's MSRIAP fee schedule was set as of January 1, 2026, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

Except as otherwise noted in the state plan, state-developed fee schedules and maximum payment amounts are the same for both governmental and private providers.

TN: 26-0007

Supersedes:

TN: 25-001

Approval Date: June 5, 2026

Effective Date: 01/01/2026

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
 - a. Podiatrists' services.

Payment for Podiatrists' services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new podiatry code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's MSRIAP fee schedule was set as of January 1, 2026, and is effective for services provided on or after that date. The site differential payment was set as of January 1, 2014, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

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Supersedes:
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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, continued.

d. Other Licensed practitioners' services, continued.

(2) Non-Physician Licensed Behavioral Health Practitioners

Payment for services delivered by Non-Physician Licensed Behavioral Health Practitioners (NP-LBHP), as outlined in Attachment 3.1-A, is the lesser of the billed charge or the Medicaid fee schedule established by the State of Ohio.

The agency's fee schedule rate was set as of January 1, 2026 and is effective for services provided on or after that date. The reimbursement rates for non-physician licensed behavioral health practitioner services rendered in a community behavioral health center certified by ODM or its designee shall be a flat fee for each covered service as specified on the established Medicaid fee schedule.

All rates are published on the Ohio Department of Medicaid (ODM) Fee Schedule and Rates website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers.

If a Medicare fee exists for a defined covered procedure code, the State will pay the following licensed practitioners at 100% of the Medicaid maximum for the service:

- Psychologists

If a Medicare fee exists for a defined covered procedure code, the State will pay the following independent practitioners at 85% of the Medicaid maximum for the service:

- Board-licensed school psychologists;
- Licensed professional clinical counselors (LPCCs);
- Licensed independent social workers (LISWs);
- Licensed independent marriage and family therapists (LIMFTs); and
- Licensed independent chemical dependency counselors (LICDCs).

If a Medicare fee exists for a defined covered procedure code, the State will pay the following practitioners requiring supervision at 85% of the Medicaid maximum for the service:

- Licensed professional counselors;
- Licensed chemical dependency counselors III;
- Licensed chemical dependency counselors II;
- Licensed social workers;
- Licensed marriage and family therapists;

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7. Home health services, continued.

c. Medical supplies, equipment, and appliances suitable for use in the home.

Payment for medical supplies, equipment, and appliances is the lesser of the submitted charge or an amount based on the Medicaid maximum for the item or service.

The State's Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule was set as of January 1, 2026.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. If no Medicare allowed amount is available, the initial Medicaid maximum payment amount is set at the unweighted average of the current maximum payment amounts for comparable procedures, services, or supplies. Each new DMEPOS code will be located on the State's CPT and HCPCS Level II Procedure Code Changes payment schedule until it is moved to the DMEPOS payment schedule.

Eligible pharmacy providers may dispense and receive payment for certain medical supply items without enrolling in Medicaid as DMEPOS providers. For these items dispensed beginning 02/16/2024, payment is the sum of two figures:

- (1) The lesser of submitted cost or the National Average Drug Acquisition Cost (NADAC) and
- (2) The appropriate professional dispensing fee (PDF) specified in Attachment 4.19-B, Item 12-a, for compounded drugs other than non-sterile compounds and total parenteral nutrition compounds.

If no NADAC has been published for an item, payment is the sum of two figures:

- (1) The least of the submitted cost, the Ohio Average Acquisition Cost (OAAC), or the wholesale acquisition cost (WAC) and
- (2) The appropriate professional dispensing fee (PDF) specified in Attachment 4.19-B, Item 12-a, for compounded drugs other than non-sterile compounds and total parenteral nutrition compounds.

For purposes of determining the PDF, newly enrolled pharmacies located within Ohio are deemed to have filled fewer than 50,000 prescriptions per year, and newly enrolled pharmacies located outside Ohio are deemed to have filled 100,000 or more prescriptions per year.

Except as otherwise noted in the plan, state-developed payment schedules and rates are the same for both governmental and private providers.

TN: 26-0007

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TN: 25-001

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10. Dental services.

Dental services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.100.

Payment for Dental services is the lesser of the billed charges or an amount based on the Medicaid maximum for the service, except for 'Rural Dental Providers.' The Medicaid maximum is the amount listed on the Department's Dental services fee schedule.

Effective for dates of service on and after January 1, 2016, the maximum reimbursement for dental services rendered by a provider whose office address is in a rural Ohio county is the lesser of the billed charges or 105 percent of the Medicaid maximum for the particular service.

All rates are published on the agency's website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's dental services fee schedule was set as of January 1, 2026, and is effective for services provided on or after that date.

Each new dental code will be located on the CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates> until it is moved to the Dental Services fee schedule.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Selected dental services are subject to a co-payment as specified in Attachment 4.18-A of the State plan.

TN: 26-0007

Supersedes:

TN: 25-001

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11. Physical therapy and related services, continued.

b. Occupational therapy.

Occupational therapy (OT) services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for OT services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new OT code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's MSRIAP fee schedule was set as of January 1, 2026, and is effective for services provided on or after that date.

Except as otherwise noted in the state plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Payment for OT services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for OT services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

Payment for OT services provided to residents of nursing facilities is included in the nursing facility per diem rate.

TN: 26-0007

Supersedes:

TN: 23-042Approval Date: June 5, 2026Effective Date: 01/01/2026

11. Physical therapy and related services, continued.

- c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Speech-language pathology and audiology (SLPA) services are covered as hospital, home health agency, physician, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (7), and (9) for reimbursement provisions.

Payment for SLPA services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new SLPA code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's MSRIAP fee schedule was set as of January 1, 2026, and is effective for services provided on or after that date.

Except as otherwise noted in the state plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Payment for SLPA services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for SLPA services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

Payment for SLPA services provided to residents of nursing facilities is included in the nursing facility per diem rate.

TN: 26-0007

Supersedes:

TN: 23-042

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Effective Date: 01/01/2026

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, continued.

c. Prosthetic devices.

Payment is the lesser of the submitted charge or an amount based on the Medicaid maximum. The Medicaid maximum for a prosthetic device is listed on the State's main Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new prosthetic device code can be found on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates> until it is moved to the DMEPOS payment schedule.

All Medicaid payment schedules and rates are published on the State's website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's DMEPOS payment schedule was set as of January 1, 2026, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, State-developed payment schedules and rates are the same for both governmental and private providers.

TN: 26-0007

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

c. Preventive services.

Payment for preventive services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

All rates are published on the agency's website at <https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's fee schedule was set as of January 1, 2026, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.