

## **Table of Contents**

**State/Territory Name: OH**

**State Plan Amendment (SPA) #: 13-007**

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 S2-26-12  
Baltimore, Maryland 21244-1850



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APR 02 2014

John McCarthy  
Director  
Office Department of Medicaid  
P.O. Box 182709  
50 West Town Street, Suite 400  
Columbus, Ohio 43218

RE: Ohio State Plan Amendment (SPA) 13-007

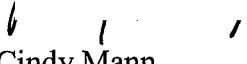
Dear Mr. Davis:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 13-007. Effective for services on or after January 10, 2013, this amendment proposes technical changes to coverage and reserve bed reimbursement methodologies for intermediate care facilities for individuals with intellectual disability (ICF/ID) services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 13-007 is approved effective January 10, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (312) 353-9860.

Sincerely,

  
Cindy Mann,  
Director

Enclosure

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>13 -007 (REVISED)</b>	2. STATE <b>OHIO</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
<b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b> <b>TO: REGIONAL ADMINISTRATOR</b> <b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b> <b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b>		4. PROPOSED EFFECTIVE DATE January 10, 2013	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> <b>AMENDMENT</b> COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.150 42 CFR 447 Subpart C 42CFR 483, Subpart I		7. FEDERAL BUDGET IMPACT: a. FFY 2013    \$ 0 thousands b. FFY 2014    \$ 0 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 3.1-A, Item 15, Page 1 of 1  Attachment 4.19-B, Item 15, Page 1 of 1  Attachment 4.19-C, Supplement 2, Page 1 of 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Attachment 3.1-A, Pre-Print Page 7, Item 15, Page 1 of 1, Reference Supplement 2 (TN 93-39)  Attachment 4.19-B, Reference Pre-Print Page 7 and Supplement 2 of Attachment 3.1-A, Item 15, Page 1 of 1 (TN-93-39) Attachment 4.19-C, Supplement 2, Page 1 of 1 (TN 07-011)	
10. SUBJECT OF AMENDMENT: Intermediate care facility services			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The State Medicaid Director is the Governor's designee	
12. SIGNATURE OF STATE AGENCY OFFICIAL: _____		16. RETURN TO:	
13. TYPED NAME: <b>John B. McCarthy</b>		Becky Jackson Ohio Department of Medicaid P.O. BOX 182709 Columbus, Ohio 43218	
14. TITLE: <b>STATE MEDICAID DIRECTOR</b>			
15. DATE SUBMITTED: <b>3/28/13</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>APR 02 2014</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JAN 10 2013</b>		20. SIGNATURE OF REGIONAL OFFICIAL: _____	
21. TYPED NAME: <b>Penny Thompson</b>		22. TITLE: <b>Deputy Director, Policy &amp; Financial Mgt. LMS</b>	
23. REMARKS:			

Instructions on Back

15. a. Services in an Intermediate care facility services for individuals with intellectual disabilities or related conditions (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
- b. Including such services in a public institution (or distinct part thereof).

Intermediate care facility services for individuals with intellectual disabilities are covered by Ohio Medicaid in accordance with 42 CFR 440.150.

TN: 13-007  
Supersedes:  
TN: 93-39

Approval Date: APR 02 2014

Effective Date: 01/10/2013

15. Intermediate Care Facility Services.

See Attachment 4.19-C, Supplement 2; Attachment 4.19-D, Supplement 2; and Attachment 4.19-D.

TN: 13-007  
Supersedes:  
TN: 93-39

Approval Date: APR 02 2014

Effective Date: 01/10/2013

**Payment for Reserved Beds**

**Leave Days**

The State of Ohio will make payments to reserve a bed for a recipient during temporary absence for hospitalization, visits with relatives and friends and participation in therapeutic programs outside the facility when the resident's plan of care provides for the absence for up to thirty days in a calendar year. Requests for additional leave days must be prior authorized. Payment for authorized leave days will be equal to the facility's per diem rate.

TN: 13-007  
Supersedes:  
TN: 07-011

Approval Date: APR 02 2014

Effective Date: 01/10/2013