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State/Territory Name: OH

State Plan Amendment (SPA) #: 14-021

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

AUG 25 2015

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

RE: Transmittal Number (TN) 14-0021

Dear Mr. McCarthy:

The Centers for Medicare and Medicaid Services (CMS) has reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 14-0021. Effective October 1, 2014, this SPA proposes to pay hospitals that have traditionally been paid on a reasonable cost basis, to be paid on prospective cost basis with no settlement to actual cost.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 14-0021 is approved effective October 1, 2014. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Fredrick Sebree at (217) 492-4122 or via email at Fredrick.Sebree@cms.hhs.gov.

Sincerely,

[redacted]

Timothy Hill
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **14 - 021**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2014**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447 Subpart C	7. FEDERAL BUDGET IMPACT: (thousands) a. FFY 2015 $(5,168) b. FFY 2016 $(5,168)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Page 1 Attachment 4.19-A, Page 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A, Page 1 Attachment 4.19-A, Page 2 Attachment 4.19-A, Appendix 5101:3-2-22

10. SUBJECT OF AMENDMENT:
Non-DRG Prospective Payment for Hospital Services

11. 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**

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Becky Jackson** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **JOHN B. McCARTHY**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: 12/29/2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: AUG 25 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2014	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin FAN	22. TITLE: Deputy Director, FMG

23. REMARKS:

Methods and Standards for Establishing Payment Rates Inpatient Hospital Services

The State has in place a public process which complies with the requirements of Section 1902 (a)(13)(A) of the Social Security Act. Except as noted below, all hospital services provided by Medicaid providers of inpatient hospital services are reimbursed under a DRG based prospective payment system (PPS).

A. **Hospital Services Subject to Non-DRG Prospective Payment**

For hospital services subject to non-DRG prospective payment, providers are paid by applying a percentage of the hospital's ratio of cost to allowed charges. Billing must reflect the hospital's customary charge for the service rendered. Payment is made for those items and services recognized as reasonable and allowable under Title XVIII standards and principles. Hospital services subject to non-DRG prospective payment include:

1. Freestanding rehabilitation hospitals, as described at 42 CFR 412.23(b), which are excluded from the Medicare PPS shall be reimbursed at 90% of historical costs.

2. Freestanding long-term hospitals, as described at 42 CFR 412.23(e), which are excluded from the Medicare PPS shall be reimbursed at 90% of historical costs.

3. Hospitals that are excluded from Medicare's PPS due to providing services, in total; which are excluded due to a combination of long-term care and rehabilitative services.

4. Hospitals licensed as Health Insuring Corporations which limit services to Medicaid recipients to those enrolled in a health insuring corporation or to short-term services provided on an emergency basis.

5. For all hospitals, capital-related costs are subject to reasonable cost related prospective reimbursement at 85% of historical costs.

6. Hospitals recognized by Medicare as cancer hospitals, as described at 42 C.F.R. 412.23(f) shall be reimbursed on a three year step-down; 97% for discharges 10/1/14 – 6/30/15, 94% for discharges 7/1/15 – 6/30/16 and 91.7% for discharges on or after 7/17/16.

All non-DRG prospective payments are not subjected to retrospective reimbursement. This reimbursement policy applies to all inpatient discharges and outpatient services occurring on or after October 1, 2014.

B. Hospital Services Subject to Prospective Reimbursement:

For hospital services other than those described in **(A),** payments are made on a prospective per discharge basis. Although the payment rate is fixed in terms of not being subject to cost reconciliation (with the exception of capital-related costs), payment amounts will vary according to: the DRG to which the case is assigned; the peer group to which the hospital is assigned; the size and cost (as applicable) of a hospital's medical education program, where applicable; and finally, the degree to which a particular case is excessively lengthy or costly (outlier cases for which additional payments are made). The payment rate for a discharge is calculated as follows:

Average Cost Per Discharge	**X**	**Relative Weight for the DRG**	**X**	**Add-on Amount for Capital**	**X**	**Add-on Amount for Medical Education**

Additional payments for outlier cases are made for cases which exceed outlier thresholds (see section 5)

1. Calculation of the Average Cost Per Discharge

The average cost per discharge (ACD) is calculated using inflated hospital base year cost report data (generally either calendar year 1985 or fiscal year 1986), subject to certain adjustments and limitations,

A hospital's Medicaid inpatient costs are standardized to include Medicaid's portion of malpractice costs reported on the 1986 Medicare cost report and to exclude a number of "non-operating" costs. Costs excluded are Medicaid inpatient capital, indirect medical education, and direct medical education. Capital and direct medical education costs are removed from total Medicaid inpatient costs by subtraction; indirect medical education costs are removed by dividing by 1 plus the hospital's indirect percentage. An additional standardization step is taken for hospitals in the major teaching hospital peer group to remove the effect of varying wage rates since these hospitals are dispersed geographically throughout the slate. These wage-sensitive costs are then brought back into payment rates using a wage factor specific to each wage area.

For hospitals with an ACD that exceeds cost-increase limits determined by the