

## **Table of Contents**

**State/Territory Name: OH**

**State Plan Amendment (SPA) #: 17-004**

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

**MAY 01 2017**

Barbara Sears, Director  
Ohio Department of Medicaid  
P.O. Box 182709  
50 West Town Street, Suite 400  
Columbus, Ohio 43218

RE: Ohio State Plan Amendment (SPA) 17-004

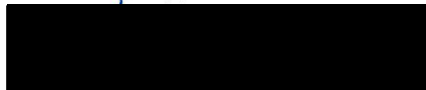
Dear Ms. Sears:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 17-004. Effective February 1, 2017, this SPA provides Changes in reimbursement to nursing facilities for Medicaid services through an enhanced payment rate for nursing facilities that provide services to ventilator dependent individuals and that meet the criteria and conditions to participate in the department's alternative purchasing model for the provision of services to ventilator dependent individuals.

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 17-004 is approved effective February 1, 2017. We are enclosing the HCFA-179 and the amended plan pages.



If you have any questions, please contact Fred Sebree at (217) 492-4122 or [Fredrick.sebree@cms.hhs.gov](mailto:Fredrick.sebree@cms.hhs.gov).

Sincerely,



Kristin Fan  
Director

Enclosure

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>17-004</b>	2. STATE <b>OHIO</b>
<b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		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 <b>February 1, 2017</b>	
5. TYPE OF PLAN MATERIAL (Check One):			
<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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(13)(A) of the Social Security Act Section 1902(a)(30)(A) of the Social Security Act 42 C.F.R. 447.205		7. FEDERAL BUDGET IMPACT: a. FFY 2017    \$17.2 thousands b. FFY 2018    \$27.0 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  <b>Attachment 4.19-D, Supplement 1:</b> Section 001.20.1, page 1 of 1 Section 001.20.2, page 1 of 1 Section 001.20.3, page 1 of 1 Section 001.20.4, pages 1-2 of 2 Section 001.20.5, pages 1-2 of 2		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Attachment 4.19-D, Supplement 1:</b> Section 001.21, page 1 of 1 (TN 11-022) Section 001.22, page 1 of 1 (TN 11-022) Section 001.23, page 1 of 1 (TN 14-023) Section 001.24, pages 1-2 of 2 (TN 16-009)	
10. SUBJECT OF AMENDMENT: Payment for Services: Nursing Facility Services – Ventilator Program			
11. GOVERNOR'S REVIEW (Check One):			
<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"/> <b>OTHER, AS SPECIFIED:</b> The State Medicaid Director is the Governor's designee	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: <b>BARBARA R. SEARS</b>		Carolyn Humphrey Ohio Department of Medicaid P.O. BOX 182709 Columbus, Ohio 43218	
14. TITLE: <b>STATE MEDICAID DIRECTOR</b>			
15. DATE SUBMITTED: <b>February 23, 2017</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>MAY 01 2017</b>	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>FEB 01 2017</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Kimster FAN</b>		22. TITLE: <b>Director, FMCe</b>	
23. REMARKS:			

**Instructions on Back**

New Facility

The initial rate for a facility with a first date of licensure or Medicaid certification on or after July 1, 2006, including a facility that replaces one or more existing facilities shall be calculated as follows:

- 1) The direct care rate component equals the product of the direct care price determined for the facility's peer group and the facility's case mix score.
  - a) If the nursing facility replaces an existing facility that participated in the Medicaid program immediately prior to the first day the new facility begins to participate in the Medicaid program is the semiannual case mix score most recently determined for the facility being replaced, adjusted for any difference in the number of beds between the new facility and the facility being replaced.
  - b) For all other new facilities, the case mix score shall be the median annual average case-mix score for the facility's peer group.
- 2) The ancillary and support rate component equals the ancillary and support price determined for the facility's peer group.
- 3) The capital cost rate component equals the capital price determined for the facility's peer group.
- 4) The tax rate component equals the median tax rate component for the facility's ancillary and support peer group.
- 5) The quality incentive payment equals the mean quality incentive payment made to nursing facilities.

*Added and Replaced Beds*

If a nursing facility adds or replaces one or more Medicaid certified beds, the rate for the added or replaced bed equals the rate for the nursing facility's existing bed.

TN 17-004 Approval Date MAY 01 2017  
Supersedes  
TN 11-022 Effective Date 02/01/2017

Outlier

An outlier is a facility or unit in a facility serving residents with diagnoses or special care needs that require direct care resources not measured adequately by the MDS 3.0 or who serve residents with special care needs otherwise qualifying for consideration. An outlier rate is a contracted rate and may differ from a standard rate as follows:

- 1) The direct care rate component may be increased if deemed necessary based on analysis of historical direct care costs if the provider had previously been a Medicaid provider, a comparison of direct care costs and staffing ratios of facilities caring for individuals with similar needs, a comparison of payment rates paid by private insurers or other states, and an analysis of the impact on historical costs if there are plans to change the patient mix.
- 2) The ancillary and support rate component may be increased due to increased expenses deemed necessary by the Ohio Department of Medicaid for treatment of individuals requiring outlier services.
- 3) The capital rate component may be adjusted to reflect costs of specialized high cost equipment or their capital expenditures necessary for treatment of individuals requiring outlier services.

Individuals must receive prior approval for outlier services.

Low Resource Utilization Residents

The per diem rate for nursing facility services provided to low resource utilization residents shall be a flat rate instead of the facility-specific total per diem rate. Low resource utilization residents are those residents who are assigned to the PA1 and PA2 resource utilization groups, which are assigned the two lowest relative resource weights possible: 1.0000 and 1.1111.

Beginning in state fiscal year 2017, payment for low resource utilization residents shall be as follows:

- 1) \$91.70 per Medicaid day. \$91.70 per Medicaid day is established using the following methodology:
  - a) Using Minimum Data Set version 3.0 (MDS 3.0) data and data from the Medicaid Information Technology System (MITS), determine which nursing facility residents in Ohio were assigned to the PA1 or PA2 resource utilization groups who successfully transitioned from a nursing facility into the community and received Medicaid services for the entire state fiscal year 2014.
  - b) Using claims data from MITS, determine Medicaid costs for state fiscal year 2014 incurred by each individual in a) above. Claims data includes costs for the following:
    - i) State plan home health services. Services include those provided by a physical therapist, occupational therapist, speech/language pathologist, registered nurse, and nurse aide.
    - ii) Waiver services. Services include home delivered meals, homemaker services, chore services, personal care services, emergency response systems, minor home modifications, transportation, and home medical equipment and supplies.
    - iii) Mental health and addiction services. Services include diagnostic psychological evaluations, pharmacologic management, alcohol and/or drug assessments, screenings, and services, mental health assessments, and partial hospitalizations.
    - iv) Durable medical equipment. Services and items include occupational therapy re-evaluations, infusion supplies, waterproof tape, non-sterile gloves, gauze, walkers, toilet rails, seats, stools, and benches, hospital beds, power operated vehicles, and disposable briefs and underpads.
  - c) Calculate the average of the costs determined in b) above. This represents the average per diem direct care costs for individuals who receive Medicaid services in the community, or \$7.32.
  - d) Calculate the statewide average of ancillary and support prices for all Ohio nursing facilities in state fiscal year 2014. This equals the ancillary and support cost component of the low resource utilization per diem rate, or \$55.54.
  - e) Calculate the statewide average of capital prices for all Ohio nursing facilities in state fiscal year 2014. This equals the capital cost component of the low resource utilization per diem rate, or \$11.29.

TN 17-004 Approval Date MAY 01 2017

Supersedes

TN 16-009 Effective Date 02/01/2017

- f) Calculate the statewide average of tax prices for all Ohio nursing facilities in state fiscal year 2014. This equals the tax rate component of the low resource utilization per diem rate, or \$1.11.
  - g) Calculate the statewide average of the quality incentive price for all Ohio nursing facilities in state fiscal year 2014. This equals the quality incentive payment portion of the low resource utilization per diem rate, or \$16.44.
  - h) The low resource utilization total per diem rate of \$91.70 equals the sum of the amounts calculated in c), d), e), f), and g) above.
- 2) An additional \$23.30 per Medicaid day shall be paid for a total of \$115.00 per Medicaid day if the nursing facility cooperates with the ombudsman program in efforts to help the facility's low resource utilization residents receive the services that are most appropriate for their level of care needs.



**Ventilator Program**

Under the Ohio Department of Medicaid (ODM) nursing facility (NF) ventilator program, ODM will pay an enhanced per Medicaid day payment rate to NFs that provide services to ventilator dependent individuals, and that elect to participate in an alternative purchasing model for the provision of services to ventilator dependent individuals. In order to qualify as an ODM NF ventilator program provider and receive enhanced payments, a nursing facility must provide all of the following services:

- 1) For at least five hours per week, the services of a licensed respiratory therapist or the services of a registered nurse who has worked for a minimum of one year with ventilator dependent individuals. The licensed respiratory therapist or the registered nurse, as applicable, shall provide direct care to the ventilator dependent individuals.
- 2) If ordered by a physician, initial assessments for physical therapy, occupational therapy, and speech therapy within 48 hours of receiving the order for a ventilator dependent individual.
- 3) If ordered by a physician, up to two hours of therapies per day, six days per week for each ventilator dependent individual.
- 4) In emergency situations as determined by a physician, access to laboratory services that are available 24 hours per day, seven days per week, with a turnaround time of four hours.
- 5) For new admissions, administer pain medications to a ventilator dependent individual within two hours from the receipt of the physician order.

In addition to providing all of the services listed above, a nursing facility must meet all of the following criteria in order to receive enhanced payments under the ODM NF ventilator program:

- 1) Be a licensed and Medicaid certified NF and meet the requirements for NFs in accordance with 42 U.S.C. 1396r.
- 2) Provide services to individuals who are ventilator dependent and have Medicaid as their primary payer.
- 3) Cooperate with ODM or its designee during all provider oversight and monitoring activities including but not limited to:
  - a) Being available to answer questions pertaining to the ODM NF ventilator program.
  - b) Providing necessary requested documentation.
  - c) Providing required quarterly reports and, as applicable, a requested plan of action.
- 4) Designate a discrete unit within the NF for the use of individuals in the ODM NF ventilator program.
- 5) Have ventilators connected to emergency outlets, which are connected to an on-site backup generator in an amount sufficient to meet the needs of the ventilator dependent individuals.
- 6) Have not been in the centers for Medicare and Medicaid services (CMS) special focus facility (SFF) program for the previous six months.

- 7) Have a valid ODM 03623 form "Ohio Medicaid Provider Agreement for Long Term Care Facilities" and an approved ODM 10198 form, "Provider Agreement for Ventilator Services in Nursing Facilities."

Enhanced Payment for Ventilator Services

The per Medicaid day payment rate for the state fiscal year for ventilator dependent individuals in NFs that participate in the ODM NF ventilator program shall be 60% of the statewide average of the total per Medicaid day payment rate for long-term acute care hospital (LTACH) services for the prior calendar year. NFs may have their enhanced NF ventilator program payment reduced by a maximum of 5% if their number of ventilator-associated pneumonia (VAP) episodes exceeds, for two consecutive quarters, the maximum number of VAP episodes determined by ODM. The reduced payment will become effective during the next quarter and shall remain in effect for the entire quarter.

TN 17-004 Approval Date MAY 01 2017

Supersedes

TN NEW Effective Date 02/01/2017