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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 20-0009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) 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



Division of Reimbursement Review

May 8, 2020

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Ohio State Plan Amendment 20-0009

Dear Ms. Corcoran:

We have reviewed the proposed Ohio State Plan Amendment (SPA) to Attachment 4.19-B, OH-20-0009, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 24, 2020. This plan amendment updates the payment for Outpatient Hospital Services implementation of Enhanced Ambulatory Patient Grouping (EAPG) 3.14.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 2, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any questions or need further assistance, please contact Debi Benson at 1-312-886-0360 or Deborah.Benson@cms.hhs.gov.

Sincerely,

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 20-009	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		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 January 2, 2020	
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"/> 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 F		7. FEDERAL BUDGET IMPACT: a. FFY 2020 \$917 thousands b. FFY 2021 \$1,234 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <u>Attachment 4.19-B:</u> Item 2-a, Pages 1-3 through 1-6		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <u>Attachment 4.19-B:</u> Item 2-a, Page 1-3 (TN 17-032) Item 2-a, Page 1-4 through 1-6 (TN 18-023)	
10. SUBJECT OF AMENDMENT: Payment for Services: Outpatient Hospital Services Implementation of EAPG 3.14			
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"/> OTHER, AS SPECIFIED: The State Medicaid Director is the Governor's designee	
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: MAUREEN M. CORCORAN		Carolyn Humphrey	
14. TITLE: STATE MEDICAID DIRECTOR		Ohio Department of Medicaid	
15. DATE SUBMITTED: March 24, 2020		P.O. BOX 182709	
		Columbus, Ohio 43218	
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 3/24/2020		18. DATE APPROVED: 05/08/2020	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/2/2020		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Todd McMillion		22. TITLE: Director, DRR	
23. REMARKS:			

Instructions on Back

Radiology services billed with valid CPT/HCPCS code(s) shall 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 2, 2020 consists of:

- (1) All outpatient hospital claims with dates of service from October 1, 2015 through September 30, 2018;
- (2) Cost reports submitted by Ohio hospitals to the State on its Medicaid cost report for the hospital years that end in state fiscal years 2016 (ODM 02930 rev. 4/2016) and 2017 (ODM 02930 rev. 4/2017); and
- (3) Inflation factors are computed for Ohio by Global Insight, which 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, 2020.

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

- (1) For each Ohio peer group, sum the total inflated cost for all cases; divided by
- (2) The number of cases assigned to each peer group; and multiply the result by a factor of 71.9%.
- (3) For each Ohio peer group, sum the relative weight values for all cases assigned to the peer group; divided by
- (4) The number of cases in the peer group.
- (5) Multiply the amount in subsection (G)(2) by the quotient of subsection (G)(3) and subsection (G)(4) of this section.
- (6) For non-Ohio peer groups, the peer group base rate is 70% of the statewide average.

(H) Risk corridors.

Effective for dates of service on or after August 1, 2017, the following will apply to Ohio hospital peer groups:

- (1) The peer group base rate calculated in subsection (G) of this section if the peer group base rate does not result in more than a 0% reduction or 5% gain in payments compared to the prospective payment system in effect prior to August 1, 2017; or

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- (2) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a 0% reduction or 5% gain in payments compared to the prior prospective payment system.

(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) A budget neutrality factor is applied to all EAPGs in each EAPG type:
 - (a) significant procedures are increased by 1.517;
 - (b) physical therapy and rehabilitation procedures are increased by 1.221;
 - (c) mental health and counseling procedures are increased by 1.138;
 - (d) radiologic procedures are increased by 0.886;
 - (e) diagnostic significant procedures are increased by 1.092;
 - (f) medical visits are increased by 1.187;
 - (g) ancillary services are increased by 1.532; and
 - (h) dental procedures, incidental services, drugs, durable medical equipment (DME), and unassigned services are increased by 1.254.

(J) Items conditionally payable outside of EAPG

(1) Pharmaceuticals.

- (a) For services rendered on or after August 1, 2017, reimbursement for outpatient hospital pharmaceuticals HCPCS J-code or Q-code billed with revenue center code 25X or 636 shall be the lesser of charges or the payment amounts in the provider-administered pharmaceutical fee schedule as published on the department's website, <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.
- (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 the State.
- (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 August 1, 2017, reimbursement for outpatient hospital DME shall be the lesser of charges or the payment amounts in the Medicaid durable medical equipment fee schedule as published on the department's website, <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

(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 to 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.

For dates of service during the interim period, reimbursement for claims assigned to dental service EAPG will be paid as follows:

(a) Children's hospitals, as defined in subsection (B) of this section, will be paid \$1,062.

(b) All other hospitals will be paid \$1,192.

(c) Payments shall be multiplied by any applicable discounting factor.

(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 ten dollars for individuals eighteen years of age or younger, contingent upon the EAPG grouper.

However, no payment will be made for vaccines that can be obtained at no cost through the federal VFC program.

- (c) Additional payments for designated free vaccines will be made in accordance with the discounting factors as determined by the EAPG grouper.

(6) Observation services.

- (a) For dates of service during the interim period: payment for observation HCPCS code G0378 will be made using an average rate.
- (b) Payments for observation services grouped to observation EAPG code, will be limited to a maximum of two consecutive days, except as provided in subsection (I)(6)(c) of this section.
- (c) Payments for observation services reported with HCPCS code G0378 will be made for up to 24 units per day or 48 consecutive units (which could extend over a three-day period).

(7) Outpatient Hospital Services

Outpatient Hospital Services are subject to a co-payment as referenced in Attachment 4.18-A of the State plan.

(K) Additional items paid outside of EAPG.

Behavioral health (BH) services.

- (1) All hospitals that meet the Medicare conditions of participation, have accreditation by national accrediting body and have accreditation for the BH services they provide, may provide outpatient BH services.
- (2) Each hospital claim for BH services must contain the following:
 - (a) HE modifier at the detail level for each BH CPT/HCPCS code;
 - (b) Revenue center code 0671, 0900, 0901, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919 or 1002 for each BH detail line; and
 - (c) A BH diagnosis code.

(L) Payment neutrality.

- (1) Outpatient hospital services provided between October 1, 2017 and September 30, 2018 were priced using the hospital-specific base rates as described in subsection (G) of this section to determine total hospital payments under EAPG version 3.9.
- (2) To determine total hospital payments for outpatient hospital services under EAPG version 3.14 after the effective date of this SPA, the hospital-specific base rates will be adjusted to achieve payment neutrality for each hospital.
- (3) No adjustment will be made for non-Ohio peer groups.

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TN: 18-023

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