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State/Territory Name: OH

State Plan Amendment (SPA) #: 21-0027

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

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

Financial Management Group

December 15, 2021

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

RE: Ohio State Plan Amendment (SPA) 21-0027

Dear Ms. Corcoran:

We have reviewed the proposed amendment to Attachments 4.19-D of your Medicaid State plan submitted under transmittal number 21-0027 titled, "Payment for Services: Nursing Facility Services – SFY 22-23 Budget Bill Changes."

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 implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2021. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **21-027**	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 **July 1, 2021**	

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:	7. FEDERAL BUDGET IMPACT:
Section 1902(a)(30)(A) of the Social Security Act Section 1905(a)(4)(A) of the Social Security Act	a. FFY 2021 $25,155 thousands b. FFY 2022 $115,640 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4-19-D, Supplement 1 Section 001.3, page 1 of 1 Section 001.18.1, pages 1-2 of 2 Section 001.20, page 1 of 1 Section 001.20.1, page 1 of 1	**Attachment 4.19-D, Supplement 1** Section 001.3, page 1 of 1 (TN 16-013) Section 001.17, pages 1-2 of 2 (TN 19-030) Delete Section 001.18, page 1 of 1 (TN 19-030) Delete Section 001.18.1, pages 1-3 of 3 (TN 19-030) Section 001.20, page 1 of 1 (TN 11-022) Section 001.20.1, page 1 of 1 (TN 18-020)

10. SUBJECT OF AMENDMENT: Payment for Services: Nursing Facility Services – SFY 22-23 Budget Bill Changes

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:
13. TYPED NAME: **MAUREEN M. CORCORAN**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: September 29, 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/29/2021	18. DATE APPROVED: December 15, 2021
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2021	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Rory Howe	22. TITLE: Director, Financial Management Group

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

Rebasing

The Department of Medicaid shall conduct a rebasing of nursing facility rates at least once every 5 state fiscal years. The base year, first used for rates in state fiscal year 2022, is calendar year 2019. The maximum amount paid for rebasing in state fiscal years 2022 and 2023 shall not exceed $125,000,000 in each fiscal year.

When the department conducts a rebasing, it shall conduct the rebasing for only the direct care, ancillary and support, and tax cost centers. A nursing facility provider shall spend money received from the rebasing conducted in state fiscal year 2022 on the following cost centers only, and in the order listed:

1) direct care
2) ancillary and support
3) tax

A nursing facility provider shall spend 70% of any additional dollars received by the provider as a result of rebasing on direct care costs, including employee salaries.
A nursing facility shall reimburse the department for any amounts, plus interest, that are not spent in accordance with the above requirements.

Calculation of the Quality Incentive Payment Rate

For state fiscal years 2022 and 2023, each nursing facility's per Medicaid day quality incentive payment rate shall be determined as follows:

1) Determine the sum of the quality scores determined according to the Quality Scores section below.
2) Determine the average quality score by dividing the sum determined in paragraph 1) above by the number of nursing facilities for which a quality score was determined.
3) Determine the sum of the total number of Medicaid days for all of the calendar year preceding the fiscal year for which the rate is determined for all nursing facilities for which a quality score was determined.
4) Multiply the average quality score determined in paragraph 2) above by the sum determined in paragraph 3) above.
5) Determine the value per quality point by determining the quotient of the following:
   a) The sum determined in paragraph 3) of the Fiscal Year Amounts section below.
   b) The product determined in paragraph 4) above.
6) Multiply the value per quality point determined in paragraph 5) above by the nursing facility's quality score determined according to the Quality Scores section below.

Quality Scores

A nursing facility's quality score for state fiscal years 2022 and 2023 shall be the sum of the total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics based on the most recent four-quarter average data available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

1) The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers during the measurement period.
2) The percentage of the nursing facility's long-stay residents who had a urinary tract infection during the measurement period.
3) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened during the measurement period.
4) The percentage of the nursing facility's long-stay residents who had a catheter inserted and left in their bladder during the measurement period.

In determining a nursing facility's quality score for state fiscal years 2022 and 2023, the Department of Medicaid shall make the following adjustment to the number of points that CMS assigned to the nursing facility for each of the quality metrics specified above:

1) Unless paragraph 2) or 3) below apply, divide the number of the nursing facility's points for the quality metric by 20.
2) If CMS assigned the nursing facility to the lowest percentile for the quality metric, reduce the number of the nursing facility's points for the quality metric to zero.
3) If the nursing facility's total number of points for state fiscal year 2022 or state fiscal year 2023 for all of the quality metrics specified above is less than a number of points that is equal to the 25th percentile of all nursing facilities, reduce the nursing facility's points to zero for that fiscal year.

A nursing facility shall not receive a quality incentive payment for state fiscal years 2022 or 2023 if the facility is assigned to the federal Special Focus Facility List on the first day of May of the calendar year for which the rate is being determined.

Fiscal Year Amounts

The total amount to be spent on quality incentive payments for state fiscal years 2022 and 2023 shall be the following:

1) Determine the following amount for each nursing facility.
   a) The amount that is 5.2% of the nursing facility's base rate for nursing facility services provided on the first day of the fiscal year.
   b) Add $1.79 to the amount determined in paragraph a) above.
   c) Multiply the amount determined in paragraph b) above by the number of the nursing facility's Medicaid days for the calendar year preceding the fiscal year for which the rate is determined.
2) Determine the sum of the products determined in paragraph c) above for all nursing facilities for which the product was determined for the state fiscal year.
3) To the sum determined in paragraph 2) above, add $25 million in state fiscal year 2022 and $125 million in state fiscal year 2023.

Non-Standard Rates

Change of Operator (CHOP)
For an entering operator that begins participation in the Medicaid program, the operator's initial rate shall be the rate the exiting operator would have received had the exiting operator continued to participate in the Medicaid program.

A nursing facility that undergoes a change of operator during state fiscal years 2022 or 2023 shall not receive a quality incentive payment for the state fiscal year in which the CHOP occurs.

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, the case mix score 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 amount determined by dividing a facility's projected tax costs by the number of inpatient days the facility would have for the calendar year in which it obtains an initial provider agreement if its occupancy rate were 100%. If a new facility does not submit the documentation required to support its projected tax costs, or if the Department of Medicaid determines the documentation to be unsatisfactory, the tax rate component equals the median tax rate component for the facility's ancillary and support peer group.
5) Add $14.65 to the sum of the direct care, ancillary and support, capital, and tax rate components as determined above.
6) During the first state fiscal year of operation, a nursing facility shall not receive a quality incentive payment.