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State/Territory Name: OH

State Plan Amendment (SPA) #: 22-0005

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

Financial Management Group

June 7, 2022

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

RE: Ohio State Plan Amendment (SPA) 22-0005

Dear Ms. Corcoran:

We have reviewed the proposed amendment to Attachments 3.1-A and 4.19-A of your Medicaid State plan submitted under transmittal number 22-0005 titled "Coverage and Limitations and Payment for Services: Inpatient and Outpatient Coverage Related to Chemical Dependency, Obsoleting Older State Plan Sections."

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 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 March 1, 2022. 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,

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REVISED

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0005

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.10, 440.20, 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 5,432
b. FFY 2023 $ 9,356

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A, Item 1, Page 1 of 2
Attachment 3.1-A, Item 1, Page 2 of 2 (new)
Attachment 3.1-A, Item 2-a, Page 1 of 2
Attachment 3.1-A, Item 2-a, Page 2 of 2 (new)
Attachment 4.19-A, Pages 1-2, 1-20, 1-21

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 3.1-A, Item 1, Page 1 of 1 (TN 15-004)

Attachment 3.1-A, Item 2-a, Page 1 of 1 (TN 17-032)

Attachment 4.19-A, Pages 1-2, 1-20, 1-21 (TN 17-029)
Attachment 4.19-A, Sec. 5101:3-2-02 (TN 05-010) (delete)

9. SUBJECT OF AMENDMENT

Coverage and Limitations and Payment for Services: Inpatient Coverage Related to Chemical Dependency, Obsoleting Older Sta

10. 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

11. SIGNATURE OF STATE AGENCY OFF

12. TYPED NAME: **MAUREEN M. CORCORAN**

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED
March 24 2022

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
3/24/2022

17. DATE APPROVED
June 7, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
3/1/2022

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director

22. REMARKS

Updates to 179 5/31/2022 - Block 1 update to TN#, Block 8 update to deleted pages

Instructions on Back

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Inpatient hospital services are provided pursuant to 42 CFR 440.10 and are those services provided to a patient during an inpatient stay in a hospital facility which meets Medicare conditions of participation as defined in 42 CFR 482 that continues beyond midnight of the day of admission, except in instances when, on the day of admission, a patient dies or is transferred to another inpatient unit within the hospital, or to another hospital.

Medicaid does not cover, as an inpatient service, those physicians' services furnished to individual patients. In determining whether services are covered as a physician service or a hospital service, Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

Medical supplies and equipment are covered inpatient services when provided as part of the inpatient stay. This includes implants and devices that are part of a surgical, immediate post-surgical, or early fitting procedure (e.g., pacemakers, halos, and prosthetic devices), appliances that are generally applied prior to discharge (e.g., initial prostheses) and other items that are medically necessary to permit or facilitate the patient's discharge from the hospital until such time as the recipient can obtain a permanent item or supply. Medical supplies and equipment provided to recipients for use outside the hospital are covered as described in Attachment 3.1-A, Item7-c.

Drugs are covered in an inpatient setting when administered to a patient during their inpatient hospital stay and are considered as an inpatient service.

Dental procedures are covered as an inpatient service if provided as an emergency dental procedure performed during the inpatient stay.

Vision care services are covered and reimbursed as inpatient when provided as part of the inpatient services. All vision care materials are covered and reimbursed in accordance with the provisions of Attachment 3.1-A, Item 12-d.

Items and services that are not medically necessary or are provided in a medically unnecessary place of service are not covered. These may include abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; services of an experimental nature; and dental procedures which can be performed in the dentist's office or other nonhospital setting.

The services of hospital staff as attendants during transportation are covered and reimbursed as an inpatient hospital service. Services related to the use and operation of a transport vehicle, including standard equipment and driver, are not reimbursed as an inpatient hospital service but rather as a transportation service under Attachment 3.1-A, Item 24-a.

A limited number of services are covered under the Ohio Medicaid program upon the provider obtaining prior authorization from the Ohio Medicaid agency or its designee. Limits on number or duration of services are not placed on beneficiaries aged 21 and younger when medically necessary. All inpatient psychiatric admissions, other than admissions under the Medicare Part A benefit or a Managed Care Entity, require pre-certification. The intent of the pre-certification process is to obtain clinical documentation of the admission and provide information that will facilitate the provision of services during the hospital stay.

2. a. Outpatient hospital services.

Outpatient services are provided pursuant to 42 CFR 440.20 and those professional services provided to a patient at a hospital facility which meets Medicare conditions of participation. Outpatient services include services provided to a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission. Services included under this benefit also include urgent care and behavioral health services provided in outpatient provider-based settings.

Outpatient services do not include direct-care services provided by a practitioner of physician services as defined in Attachment 3.1-A, Item 5a. In determining whether services are covered as a physician service or a hospital service, the Ohio Department of Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

Drugs administered in an outpatient setting are a covered outpatient service and reimbursed as described in Attachment 4.19B, Item 2a. Take-home drugs dispensed on an outpatient basis for use outside of the hospital are covered in Attachment 3.1-A, Item 12a.

Medical supplies and equipment are covered outpatient services when provided as part of the items that are covered for the care and treatment of the recipient during an outpatient stay. This includes implants and devices that are part of a surgical, immediate post-surgical, or early fitting procedure (e.g., pacemakers, halos, and prosthetic devices), appliances that are generally applied prior to discharge (e.g., initial prostheses), and other items that are medically necessary to permit or facilitate the patient's discharge from the hospital until such time as the recipient can obtain a permanent item or supply. Medical supplies and equipment provided to recipients for use outside the hospital are covered as described in Attachment 3.1-A, Item 7-c.

Dental procedures are only covered in an outpatient hospital setting when performed on an emergency basis in the emergency room or when the nature of the surgery or the condition of the patient precludes performing the procedure in the dentist's office or other non-hospital outpatient setting and the outpatient service is a Medicaid covered service.

Vision care services are covered and reimbursed as outpatient when provided as part of the outpatient services. All vision care materials are covered and reimbursed in accordance with the provisions of Attachment 3.1-A, Item 12-d.

Observation services are those services furnished on a hospital's premises which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

Items and services that are not medically necessary or are provided in a medically unnecessary place of service are not covered. These may include abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; services of an experimental nature; and dental procedures which can be performed in the

dentist's office or other non-hospital setting.

The services of hospital staff as attendants during transportation are covered and reimbursed as an outpatient hospital service. Services related to the use and operation of the transport vehicle, including standard equipment and driver, are not reimbursed as an outpatient hospital service but rather as a transportation service under Attachment 3.1-A, Item 24-a.

A limited number of services are covered under the Ohio Medicaid program upon the provider obtaining prior authorization from the Ohio Medicaid agency or its designee. Limits on number or duration of services are not placed on recipients aged 21 and younger when medically necessary.

(3) Ohio Medicaid will not reimburse freestanding psychiatric hospitals with more than 16 beds for inpatient psychiatric services rendered to recipients age 21 or older, but under age 65, except in accordance with the provisions of 42 CFR 438.6(e) effective as of October 1, 2016.

(4) Freestanding psychiatric hospitals with 16 or fewer beds may provide inpatient psychiatric services to recipients of any age and shall operate pursuant to the provisions of 42 CFR 482 subpart E effective as of October 1, 2016.

(5) Psychiatric admissions of recipients whose principal diagnosis is a mental disorder into hospitals not licensed by the Ohio Department of Mental Health and Addiction Services will not be reimbursed by the Medicaid program.

(H) Other Payment Policies

(1) A claim for inpatient services qualifies for interim payment on the 30th day of a consecutive inpatient stay and at 30-day intervals thereafter. Under interim payment, hospitals will be paid on a percentage basis of charges. The percentage will represent the hospital-specific Medicaid inpatient CCR as described in subsection (A)(1) of this section. For those hospitals which are not required to file a cost report, the statewide average Medicaid inpatient CCR will be used. The statewide average Medicaid inpatient CCR is computed by dividing the sum of the Medicaid inpatient costs as reported on the Medicaid cost report for all Ohio hospitals by the sum of Medicaid inpatient charges as reported on the Medicaid cost report for all Ohio hospitals. Interim payments are made as a credit against final payment of the final discharge bill. Amounts of difference between interim payment made and the prospective payment described in subsection (C) of this section, for the final discharge will be reconciled when the final admit thru discharge bill is processed.

(2) Except for psychiatric hospitals, payments for transfers are subject to the following provisions. If a hospital paid under the prospective payment system transfers an inpatient to another hospital or receives an inpatient from another hospital and that transfer is appropriate, then each hospital is paid a per diem rate for each day of the patient's stay in that hospital. The State's payment is based on the DRG/SOI under which the patient was treated at each hospital. The per diem rate is determined by dividing the product of the hospital's base rate multiplied by the DRG/SOI relative weight as described in subsection (C)(4) of this section by the statewide average length of stay calculated for the specific DRG/SOI into which the case falls. The sum of the per diem rate for each day is known as the per diem base payment. The per diem base payment cannot exceed the DRG base payment as described in subsection (C)(5) of this section, that would have been paid for the appropriate DRG/SOI. The total transfer payment is the sum of the lesser of the per diem base payment or the DRG base payment, plus capital, medical education and outlier allowances, as applicable.

(3) For inpatient services provided to patients who are discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part, payment will be made based on the DRG representing services provided in the acute care section and the services provided in the psychiatric unit distinct part.

(4) Transfers received by or discharging from a freestanding psychiatric hospital are not subject to the provisions of subsection (H)(2) of this section. For transfers from one unit of a hospital to another distinct unit of the same hospital, the claim with an admit source indicating that the transfer results in a separate claim to Medicaid is not subject to the provisions of subsection (H)(2) of this section, provided that the discharge status does not indicate transfer.

(5) In instances when a recipient's eligibility begins after the date of admission to the hospital or is terminated during the course of a hospitalization, payment will be made on a per diem basis as described in subsection (H)(2) of this section plus the allowance for capital, medical education and outliers, as applicable.

(6) A readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

(7) In the case of deliveries, the State requires hospitals to submit separate claims based respectively on the mother's individual eligibility and the child's individual eligibility.

(8) Payment for LARC devices provided postpartum will be paid in accordance with the State's Provider-Administered Pharmaceuticals fee schedule at the rate in effect on the date of service, when submitted on a separate claim. The fee schedule is published on the department's website, https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates. Payment for related obstetrical services will be made in accordance with the State's inpatient payment policies in effect on the date of discharge from the hospital.