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**State/Territory Name: OH**

**State Plan Amendment (SPA) #: 23-0023**

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

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

**Financial Management Group**

January 17, 2024

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

RE: Ohio State Plan Amendment (SPA) 23-0023

Dear Ms. Corcoran:

We have reviewed the proposed amendment to Attachments 4.19-D of your Medicaid State plan submitted under transmittal number 23-0023 titled "Payment for Services: Nursing Facility Services Payment Updates."

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 July 1, 2023. 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

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

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 23-0023

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
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Sec. 1905(a)(4)(A) of the Act; 42 CFR 447 Subchapter C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 49,766,951
b. FFY 2024 $ 200,598,853

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See attached addendum

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Payment for Services: Nursing Facility Services Payment Updates

*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 OFFICIAL
[redacted]

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

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED
September 29, 2023

15. RETURN TO
**Greg Niehoff**
**Ohio Department of Medicaid**
**P.O. BOX 182709**
**Columbus, Ohio 43218**

***FOR CMS USE ONLY***

16. DATE RECEIVED
9/29/2023

17. DATE APPROVED
January 17, 2024

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS



***Instructions on Back***

| TN 23-023 CMS-179 Addendum | |
|---|---|
| Block 7 | Block 8 - Superseded |
| Atch 4.19-D, Supp 1, Sec 001.3, page 1 | Atch 4.19-D, Supp 1, Sec 001.3, page 1 (21-027) |
| Atch 4.19-D, Supp 1, Sec 001.7, page 1 | Atch 4.19-D, Supp 1, Sec 001.7, page 1 (16-013) |
| Atch 4.19-D, Supp 1, Sec 001.10, page 1 | Atch 4.19-D, Supp 1, Sec 001.10, page 1 (13-021) |
| Atch 4.19-D, Supp 1, Sec 001.12, page 1 | Atch 4.19-D, Supp 1, Sec 001.12, page 1 (16-013) |
| Atch 4.19-D, Supp 1, Sec 001.15 page 1 | Atch 4.19-D, Supp 1, Sec 001.15 page 1 (11-022) |
| Atch 4.19-D, Supp 1, Sec 001.18.1 pages 1, 2 | Atch 4.19-D, Supp 1, Sec 001.18.1 pages 1, 2 (21-027) |
| Atch 4.19-D, Supp 1, Sec 001.18.1 page 3,4 (new) | |
| Atch 4.19-D, Supp 1, Sec 001.20, page 1 | Atch 4.19-D, Supp 1, Sec 001.20, page 1 (21-027) |
| Atch 4.19-D, Supp 1, Sec 001.20.1, page 1 | Atch 4.19-D, Supp 1, Sec 001.20.1, page 1 (21-027) |
| Atch 4.19-D, Supp 1, Sec 001.20.4, page 1 | Atch 4.19-D, Supp 1, Sec 001.20.4, page 1 (19-030) |

*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 2024, is calendar year 2022.

When the department conducts a rebasing, it shall conduct the rebasing for only the direct care and tax cost centers.

For fiscal years 2024 and 2025, the Department of Medicaid shall include in each nursing facility's base rate only 40% of the increase in its rate for direct care costs due to the rebasing conducted pursuant to section 5165.36 of the Revised Code.

*Calculation of Direct Care Price*

A direct care price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

1) Group providers into the peer groups defined above.
2) Using calendar year 2022 as the base year, calculate the direct care cost per diem for each provider by dividing the direct care costs the provider reported on the base year Ohio Medicaid cost report by the inpatient days reported on the same cost report.
3) Calculate the direct care cost per case mix unit (CPCMU) for each provider by dividing the provider's direct care cost per diem by the annual average case mix score for the provider during the base year. The annual average case mix score is the average of the quarterly case mix scores for all residents regardless of payer during the base year.
4) Determine the CPCMU of the provider at the 70th percentile in each peer group. When making this determination, exclude providers without a 12-month cost report in the base year and providers whose direct care costs are more than one standard deviation from the mean direct care costs in the peer group.
5) For fiscal years 2024 and 2025, the Department of Medicaid shall include in each nursing facility's base rate only 40% of the increase in its rate for direct care costs due to the rebasing conducted pursuant to section 5165.36 of the Revised Code.

*Calculating the Ancillary and Support Price and Rate*

An ancillary and support price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

1) Group providers into the peer groups defined above.
2) Calculate the ancillary aud support cost per diem for each provider by dividing the ancillary and support costs the provider reported on the base year cost report by the greater of inpatient days or 90% of licensed bed days available. For purposes of calculating the facility's occupancy rate and licensed bed days available, the department shall include any beds the nursing fiiicility removes from its Medicaid certified capacity unless the nursing facility also removes the beds from its ltcensed bed capacity.
3) Determine the ancillary and support per diem of the provider at the 25th percentile in each peer group. When making this determination, exclude providers without a 12-month cost report in the base year and providers whose ancillary and support costs are more than one standard deviation from the mean ancillary and support costs in the peer group.
4) The provider's ancillary and support rate component is equal to the ancillary and support price for the peer group.
5) Ancillary and Support cost center is not part of the FY 2024 rebasing.

*Calculating the Capital Price and Rate*

A capital price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

1) Group providers into the peer groups defined above.
2) Using calendar year 2014 as the base year, calculate the capital cost per diem for each provider by dividing the capital costs the provider reported on the base year Ohio Medicaid cost report by the licensed bed days available. For purposes of calculating the facility's licensed bed days available, the department shall include any beds the nursing facility removes from its Medicaid certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.
3) Determine the capital per diem of the provider at the 25th percentile in each peer group.
4) The provider's capital rate component equals the capital price for the provider's peer group.

***Taxes***

The tax rate component is calculated on a facility specific basis and reflects costs incurred for real estate taxes, personal property taxes and corporate franchise taxes. To calculate the tax rate component, the tax costs reported on the facility's cost report in the base year are divided by the licensed bed days available in the base year.

If a nursing facility had a credit regarding its real estate taxes reflected on its cost report for calendar year 2003, the facility's rate for tax costs (until the fiscal year for which the department redetermines all nursing facilities' rates for tax costs) will be calculated using the tax costs paid for calendar year 2004 by the number of licensed bed days available in calendar year 2004.

***Calculation of the Quality Incentive Payment Rate***

For each state fiscal year, a 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.

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**Quality Scores**

A nursing facility's quality score for a state fiscal year 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, or CMS's successor metrics as described below, based on the most recent four-quarter average data, or the average data for fewer quarters in the case of successor metrics, 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.

If CMS ceases to publish any of the metrics specified, the department shall use the nursing facility quality metrics on the same topics that CMS subsequently publishes.

In addition to these quality measures, if the nursing facility's occupancy is greater than 75%, add 7.5 points to the provider's quality score for state fiscal year 2024 and 3.0 for fiscal year 2025 and beyond. The department shall utilize the facility's occupancy rate for licensed beds reported on its cost report for the calendar year preceding the fiscal year for which the rate is determined or, if the facility is not required to be licensed, the facility's occupancy rates for certified beds. If the facility surrenders licensed or certified beds before the first day of July of the calendar year in which the fiscal year begins, the department shall calculate a nursing facility's occupancy rate by dividing inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of the number of days in the calendar year and the facility's number of licensed, or applicable, certified beds on the first day of July of the calendar year in which the fiscal year begins.

Beginning with state fiscal year 2025, four (4) new measures will be added to the quality scores:

1) The percentage of the nursing facility's long-stay residents whose need for help with daily activities has increased;
2) The percentage of the nursing facility's long-stay residents experiencing one or more falls with major injury;
3) The percentage of the nursing facility's long-stay residents who were administered an antipsychotic medication;
4) Adjusted total nurse staffing hours per resident per day using quintiles instead of deciles by using the points assigned to the higher of the two deciles that constitute the quintile.

In determining a nursing facility's quality score for a state fiscal year, 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 calculated for or during a state fiscal year for all of the quality metrics except occupancy specified above is less than a number of points that is equal to the 25$^{th}$ percentile of all nursing facilities, calculated using points for the July 1 rate setting of that fiscal year, reduce the points to zero until the next point calculation. If a facility's recalculated points are below the 25$^{th}$ percentile for that fiscal year, the facility shall receive 0 points for the remainder of that fiscal year.
4) A nursing facility's quality score shall be recalculated for the second half of the state fiscal year based on the most recent four quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as the care compare, in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins. The metrics specified on the facility's occupancy rate shall not be recalculated. In redetermining the quality payment for each facility based on the recalculated points, the department shall use the same per point value determined for the quality payment at the start of the fiscal year.

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

New providers shall receive the median quality points for the fiscal year in which the new facility obtains an initial provider agreement and the immediately following fiscal year. Entering providers from a change of operator shall not receive a quality add-on for a minimum of six (6) months.

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**Fiscal Year Amounts**

The total amount to be spent on quality incentive payments for a state fiscal year 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) Add sixty per cent of the per diem amount by which the nursing facility's rate for direct care costs determined for the fiscal year changed as a result of the rebasing.
   d) Multiply the amount determined by adding paragraphs a), b), and c) 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 d) 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 $125 million.

***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 with an effective date of July 1, 2023 or later shall not receive a quality incentive payment for a minimum of six (6) months after 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 $16.44 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 and the following state fiscal year, a nursing facility shall receive a quality incentive payment equal to the median of all nursing facilities.

*Low Case-Mix Residents*

The per diem rate for nursing facility services provided to low case-mix residents shall be a flat rate instead of the facility-specific total per diem rate. Low case-mix residents are those residents who are assigned to the PA1 and PA2 case-mix groups, which are assigned the two lowest case-mix groups, excluding any group used for residents with incomplete assessment data.

Beginning in October 2019, payment for low resource utilization residents shall be a flat rate of $115.00 per Medicaid day, as set by the Ohio General Assembly.