Table of Contents

State/Territory Name: OH

State Plan Amendment (SPA) #: 23-0032

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form
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

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

Financial Management Group

January 29, 2024

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

RE: Ohio State Plan Amendment (SPA) 23-0032

Dear Ms. Corcoran:

We have reviewed the proposed amendment to Attachments 4.19-D of your Medicaid State plan submitted under transmittal number 23-0032 titled "Payment for Services: Nursing Facility Services Case Mix Reimbursement Changes."

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 October 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,

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: 2 3 — 0 0 3 2

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
October 1, 2023

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

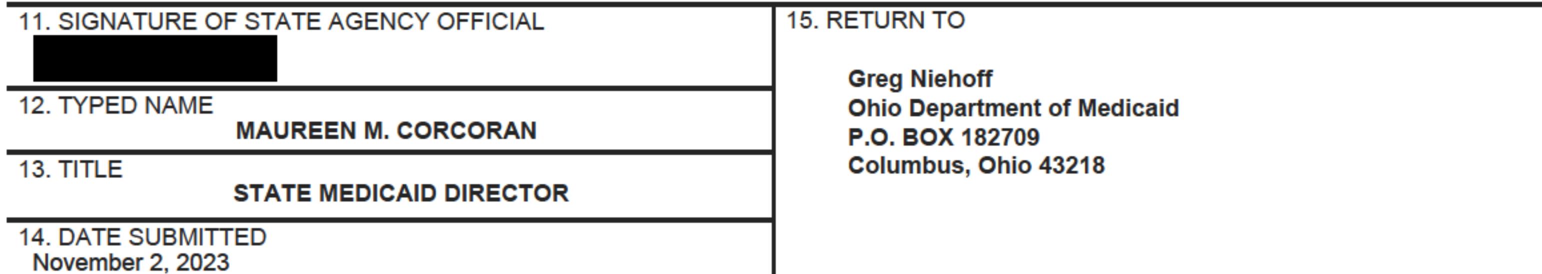
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Supp 1, Sec 001.8.1, page 1 of 1
Attachment 4.19-D, Supp 1, Sec 001.8.3, page 2 of 2
Attachment 4.19-D, Supp 1, Sec 001.8.4, page 1 of 1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Atch 4.19-D, Supp 1, Sec 001.8.1, page 1 of 1 (TN 16-012)
Atch 4.19-D, Supp 1, Sec 001.8.3, page 2 of 2 (TN 16-012)
Atch 4.19-D, Supp 1, Sec 001.8.4, page 1 of 1 (TN 16-012)

9. SUBJECT OF AMENDMENT

Payment for Services: Nursing Facility Services Case Mix Reimbursement Changes

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

12. TYPED NAME
MAUREEN M. CORCORAN

13. TITLE
STATE MEDICAID DIRECTOR

14. DATE SUBMITTED
November 2, 2023

15. RETURN TO

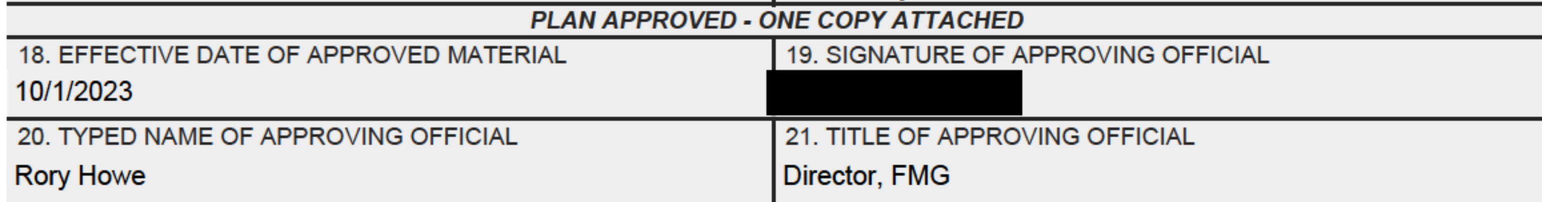
Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
11/2/2023

17. DATE APPROVED
January 29, 2024

PLAN APPROVED - ONE COPY ATTACHED



18. EFFECTIVE DATE OF APPROVED MATERIAL
10/1/2023

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

1/19/2024 - State updated block 6 to reference federal fiscal years 2024 and 2025

Case Mix Payment System

Minimum Data Set Version 3.0 (MDS 3.0) Resident Assessment Instrument

Each facility's rate for direct care costs is based on a case mix payment system. The case mix payment system begins with the Minimum Data Set version 3.0 (MDS 3.0), the resident assessment instrument used in Ohio for implementing standardized assessments and for facilitating care management in nursing facilities. The MDS 3.0 is used in Ohio to comply with regulations specified in 42 C.F.R. 483.20 that require nursing facilities to provide comprehensive, accurate, standardized, reproducible assessments of each long term care facility resident's functional capacity, including assessments of medical conditions. The MDS 3.0 also includes Ohio-specific data elements designated as Section S.

All nursing facilities must submit encoded, accurate, and complete MDS 3.0 data for all residents of Medicaid certified beds, regardless of pay source or anticipated length of stay. Data must be encoded in accordance with 42 C.F.R. 483.20 and with federal MDS 3.0 data submission specifications.

MDS 3.0 data submitted by nursing facilities is used to calculate quarterly, semiannual, and annual case mix scores, which in turn are used to calculate the direct care component of each nursing facility's per diem rate. During state fiscal years 2024 and 2025, nursing facilities may submit the Optional State Assessment (OSA) for purposes of calculating the quarterly, semiannual, and annual case mix scores or may freeze for the biennium their direct care rate beginning January 1, 2024, based on March 2023 quarterly case mix scores. Facilities have until October 1, 2023 to select their choice of methodology. The OSA will be used for those facilities that did not make a selection by the October date.

September reporting quarters. If a facility does not have a quarterly facility average Medicaid case mix score for both the June and September reporting quarters, the median annual facility average case mix score for the nursing facility's peer group shall be assigned as the semiannual facility average Medicaid case mix score.

The annual facility average case mix score is calculated as follows:

1) Add all qualifying case mix scores.
2) Divide the sum of the qualifying case mix scores by the total number of quarters of qualifying scores.

Qualifying case mix scores are scores for facilities that have at least two quarterly facility average total case mix scores, and that also submitted resident assessment data timely, accurately, and sufficiently. If the department assigned a nursing facility a quarterly facility average total case mix score but the facility did not submit resident assessment data timely, accurately, or sufficiently, the assigned score is not used to calculate the facility's annual average case mix score.
In addition, for any score that was adjusted, the adjusted score is substituted according to the following hierarchy:

1) Adjusted quarterly facility average total case mix scores established by a rate reconsideration decision resulting from an exception review of resident assessment information conducted according to Section 001.8.4 of Attachment 4.19-D, Supplement 1 before the effective date of the rate.
2) Adjusted quarterly facility average total case mix scores as a result of exception review findings from an exception review conducted according to Section 001.8.4 of Attachment 4.19-D, Supplement 1.

During state fiscal years 2024 and 2025 the department shall determine a nursing facility's assessment RUGs score using the Optional State Assessments (OSAs) unless the nursing facility elected to freeze their case mix score for the biennium. Facilities have until October 1, 2023 to select their choice of methodology. The OSA will be used for those facilities that did not make a selection by the October date.

Exception Reviews
An exception review is a review of minimum data set (MDS) resident assessment data submitted by a nursing facility provider. Exception reviews are conducted by registered nurses or other appropriate licensed or certified health professionals as determined by the Department of Medicaid who are employed by or under contract with the department to identify any patterns or trends related to resident assessments that could result in inaccurate case mix scores. Facilities may be selected for an exception review based on the findings of a Medicaid certification survey conducted by the Department of Health, a risk analysis, or prior performance of the nursing facility.

If an exception review is conducted before the effective date of a nursing facility's rate for direct care costs, and the exception review results in findings that exceed tolerance levels specified by the department and indicate the facility received a higher rate than it was entitled to receive, the department will use the exception review findings to calculate or recalculate individual resident case mix scores, and to calculate or recalculate the nursing facility's quarterly facility average total case mix scores, quarterly and semiannual facility average Medicaid case mix scores, and annual facility average case mix scores. The department will use the nursing facility's quarterly facility average total case mix scores, quarterly and semiannual facility average Medicaid case mix scores, and annual facility average case mix scores based on exception review findings to calculate or recalculate the facility's rate for direct care costs for the appropriate six month period.