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State/Territory Name: OH

State Plan Amendment (SPA) #: 24-0015

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

December 5, 2024

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

RE: TN 24-0015

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-D, OH 24-0015, which was submitted to CMS on September 27, 2024. This plan amendment updates the Intermediate Care Facility for Individuals with Intellectual Disabilities Peer Group 5 Provider Rate.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of September 17, 2024. We are enclosing the approved CMS-179 and a copy of the new state 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: 24-0015

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
9/17/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.150; 447 Subpart C; 483 Subpart I

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 2, Page 21

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Supp 2, Page 21 (TN 22-030)

(Attachment 4.19-D, Supp 2, Page 22 (TN 22-030) (REMOVE)

9. SUBJECT OF AMENDMENT

Payment for Services: ICF-IID Peer Group 5 New Provider Rate

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 27, 2024

15. RETURN TO

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

FOR CMS USE ONLY

16. DATE RECEIVED
9/27/2024

17. DATE APPROVED
December 5, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
9/17/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

New Facility in Peer Group 1, 2, 3, 4, or 5

The initial rate for an ICF-IID including a facility that replaces one or more existing facilities shall be calculated as follows:

1) The direct care rate component shall be calculated as follows:
    a. If there is no cost or resident assessment data available, the rate shall be the median cost per case-mix unit calculated for standard rates as calculated in the direct care section of this Attachment multiplied by the median annual average case-mix score for the peer group for that period and by the rate of inflation estimated for standard rates.
    b. If the facility is a replacement facility and the facility or facilities being replaced are in operation immediately before the replacement facility opens, the rate shall be the same as the rate for the replaced facility or facilities, proportionate to the number of beds in each replaced facility.
2) The rate for indirect care costs shall be the maximum rate for the facility's peer group as calculated for the standard rates.
3) The rate for capital costs shall be the median of all standard capital rates as calculated in the capital section of this Attachment
4) The rate for other protected costs shall be 115% of the median rate for ICFs-IID for the standard rates as calculated in the other protected section of this Attachment, and shall include the franchise permit fee rate if the beds were subject to the franchise permit fee during the fiscal year.
5) The rate for the direct support personnel payment shall be the median rate value of the direct support personnel payment rates calculated in that section of this Attachment.
6) The rates calculated above will be adjusted effective the first day of July, to reflect new rate calculations for standard rates.