Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

September 27, 2012

John McCarthy, Medicaid Director
Office of Ohio Health Plans
Ohio Department of Job and Family Services (ODJFS)
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 09-035

Dear Mr. McCarthy:

This letter is being sent as a companion to CMS approval of Ohio State Plan Amendment (SPA) 09-035, which was submitted on December 29, 2009 by the Ohio Department of Job and Family Services (ODJFS, hereafter referenced as "the State"). This SPA authorizes rate reductions for community providers equating to 3 percent in the aggregate and reductions in the adult dental benefit and to the monthly allowance of certain incontinence garments for adults, effective January 1, 2010.

The items summarized in this document comprise our questions and comments regarding the corresponding pages for OH SPA 09-035. Some of these items are duplicates of companion Request for Additional Information (RAI) items originally issued to the State on March 31, 2010. Because the State requested to address corresponding page items apart from OH SPA 09-035, CMS and the State did not discuss them during the second-clock review and they are provided here for continuity.

As set forth in 42 CFR 430.10, the State plan is a "comprehensive written statement" describing a state's Medicaid program, and, as such, it must contain all information necessary to serve as a basis for Federal financial participation (FFP) in the State program. During our review of OH SPA 09-035, we determined that the following require clarification and/or amendment to comply with 42 CFR 430.10, in addition to other regulations, as cited.

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Attachment 3.1-A Pre-print Page 1, Item 3, Page 1 of 1 – Other Laboratory and X-Ray Services (TN# 92-020)

1. In the first paragraph, the State indicates that, "laboratory services are covered only if the service is medically necessary or is medically indicated…" As CMS only reimburses for medically necessary services per 42 CFR 440.230(d), please remove the phrase "or is medically indicated." For clarity, we suggest the first part of sentence read: "Laboratory services are covered only if the service is medically necessary or when provided in conjunction with a covered medically necessary preventive health service;…"

Attachment Item 5-a – Physician (Page 1: TN#90-38; Page 2: TN#91-02)

2. *Attachment 3.1-A, Pre-print page 2, Item 5, Page 1 of 3 – Physicians Services:* In the third paragraph on this page, the State indicates that it does not cover "abortions, hysterectomies, and sterilization not meeting the requirements in 42 CFR 440.200 through 441.258." Please see below:

    a. Abortions: CMS recommends that the State indicate in the State plan that it covers abortion services consistent with the provisions of the Hyde Amendment.

    b. Sterilizations: This is a family planning service benefit. It should be removed from the physician services section of the State plan. If the State would like to keep the sterilization language in the State plan, it needs to be moved to the family planning services section of the plan; and the State plan language for sterilizations should be updated to indicate that it comports with 42 CFR 441.257 regarding informed consent. Note that the sterilization language does not need to be specifically indicated in section 4(c) because it is assumed that sterilizations are covered as part of the family services benefit per 440.40(c).

    c. Hysterectomies: The language pertaining to hysterectomies is unclear. Please clarify. If the State's intent is to address sterilization by hysterectomy (which is a family planning service), the guidelines pertaining to sterilizations as indicated above would apply.

3. *Attachment 3.1-A, Pre-print page 2, Item 5, Page 1 of 3 – Physicians Services:* In the eleventh paragraph on this same page, the State indicates that it does not cover "services determined by another third-party…or Medicare as not necessary." Please remove this language, as the State cannot base coverage of service on the medical necessity determination from a third party payor or Medicare. The Medicaid program must make its own medical necessity determination regarding services provided to Medicaid beneficiaries.

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Attachment Item 5-a – Physician (Page 1: TN#90-38; Page 2: TN#91-02) (Continued)

4. *Attachment 3.1-A, Pre-print page 2, Item 5, Page 1 of 3 – Physicians Services:* In the last paragraph on this page, the State indicates that it does not cover "special services and reports." This statement is very broad. Please explain the services and reports to which this statement applies.

5. *Attachment 3.1-A, Pre-print page 2, Item 5, Page 2 of 3 – Physicians Services:* Please confirm our understanding that this is a utilization control procedure, and not a hard limit to which the recipient would be subjected. It appears that this description is the State's utilization control procedures which belong in the State provider/services manual, not in the State plan. If this is a utilization control procedure, please remove the two paragraphs and three bullets in uppercase, underlined text that describes the physician visits in an outpatient setting. If this is a hard limit, we may ask additional questions on sufficiency.

Attachment 3.1-A, Item 6, Page 4 of 6 – Medical Care and Other Types… (TN# 08-012)

6. Pursuant to information provided by the State on February 18, 2010, CMS understands that mechanotherapist services are provided by one licensed provider in the State of Ohio. CMS understands that the State will be removing the current language (including the reference to State Plan Item 11) and replacing it with the following language per 42 CFR 440.60: "Mechanotherapists are licensed providers who provide services within the scope of practice under State law."

Attachment 3.1-A, Item 7a-d, Page 1 – Home Health (TN# 06-012)

Home health nursing and home health aide services are mandatory. The current Home health plan page, with TN #06-012, note "Fourteen hours of nursing and/or aide services per week can be provided through the home health benefit."

The draft home health pages that were discussed with the State for OH 09-035 (but not included in the final package) note that beneficiaries are limited to "no more than a combined total of eight hours per day of intermittent or part-time nursing services, home health aide services, and physical therapy, occupational therapy, or speech pathology and audiology services." "No more than a combined total of 14 hours per week or intermittent or part-time nursing services and home health aide services." The plan goes on to describe an individual can access the above combined services "for up to a combined total of 28 hours per week for up to 60 consecutive days upon discharge from a covered inpatient hospital stay of three or more days…"

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Attachment 3.1-A, Item 7a-d, Page 1 – Home Health (TN# 06-012) (Continued)

7. Please provide language in the State plan explaining how additional hours, over the 14 hours per week and 28 hours per week limits, are provided for adult beneficiaries who are determined to meet the medical necessity criteria for these services (e.g. pre-authorization) or provide an assurance that the hour caps on the services will meet the beneficiaries needs.

8. Reducing the amount of one service because of the use of another service does not comply with the comparability requirement found at 42 CFR 440.240. Please remove the cumulative cap from each SPA and provide separate limitations for each service.

    a. For item 7-d, please explain how beneficiaries would receive therapy services, should they meet the 8 hours limit with other mandatory services (nursing/home health aide) and vice versa.

9. What is the impetus/reason for these limitations?

    a. If the reason is budgetary, please provide the assumptions used to support the savings, if not already provided.

    b. If the reason for the limitation is duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes have you tried or considered to address this matter?

10. Do the limitations apply to services performed through managed care contracts, fee-for-service (FFS) or both? If applied in managed care, do the capitation rates take into account the limitations?

11. Please describe what will or is likely to occur to beneficiaries impacted by the limitations. Based on a medical determination of medical necessity, can additional services be provided? Is there an exception or prior authorization process for beneficiaries that require services beyond the limitations?

12. If the limit cannot be exceeded, when based on a determination of medical necessity:

    a. How will those affected by the limitation obtain the medical services they need beyond the stated limits?

    b. Will beneficiaries be billed and expected to pay for any care that may not be covered? Or, instead will the provider or practitioner be expected to absorb the costs of the provided services?

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Attachment 3.1-A, Item 7a-d, Page 1 – Home Health (TN# 06-012) (Continued)

13. How will the limitation be tracked?

14. Will both providers and beneficiaries be informed in advance so they know they have reached the limit? Please summarize the process.

15. How will the State be implementing/imposing the limitation when a submitted claim exceeds the limitation? Will the State be doing retrospective review of claims? If so, then please describe the process/purpose for such review. How will this impact the provider/beneficiary if the claim is denied? Is this a sampling of the population or reviewing each individual?

16. Based on the proposed limit indicated and using claims data within the last 12 months, what percentage of Medicaid beneficiaries are fully served (i.e., receive all the services they require) under the limit? Please provide this information for the following eligibility groups:

    a. Aged, Blind and Disabled

    b. Non-Dually Eligible Adults (for analyses of primary services for which Medicare would be primary payer)

    c. Dually Eligible

    d. Pregnant Women

    e. Parents/Caretakers /Other Non-Disabled Adults

Attachment 3.1-A, Item 7c, Page 3 – Home Health (TN# 06-012)

17. Pursuant to 6407(d) of the Affordable Care Act, please add face-to-face encounter language pertaining to medical supplies and equipment. CMS is available, at the State's request, to provide guidance regarding this language. CMS understands that the State has not yet implemented provisions related to the face-to-face encounters for medical supplies and equipment.

18. Please provide a timeframe for the review of a plan of care by a physician.

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Attachment 3.1-A, Item 7c, Page 3 – Home Health (TN# 06-012) (Continued)

19. Please remove the cited website for limitations from this section and instead add specific language that is in accordance with CMS guidance regarding the coverage of medical equipment (ME). This information is summarized in the CMS (then HCFA) September 4, 1998 SMD letter following the DeSario v. Thomas ruling in the United States Court of Appeals for the Second Circuit. This State plan language should ensure that the following conditions are met with respect to an individual applicant's request for ME:

- The process is timely and employs reasonable and specific criteria by which an individual item of ME will be judged for coverage under the State's home health services benefit. These criteria must be sufficiently specific to permit a determination of whether an item of ME that does not appear on a State's pre-approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness, or condition.

- The State's process and criteria, as well as the State's list of pre-approved items, are made available to beneficiaries and the public.

- Beneficiaries are informed of their right, under 42 CFR, Part 431, Subpart E, to a fair hearing to determine whether an adverse decision is contrary to the law cited above.

Attachment 3.1-A, Item 7d, Page 4 – Home Health (TN# 06-012)

20. Please add language to the State plan page that provider's qualifications are in accordance with 42 CFR 440.110.

Attachment 3.1-A, Item 23 – Certified Pediatric and Family Nurse Practitioner Services (TN# 97-015)

21. This section states that: "Limitations to certified pediatric and family nurse practitioner services are the same as those listed for physician services and are found in Attachment 3.1-A, Item 5." Rather than reference another part of the State plan for limitations, the State should indicate the limitations in the certified pediatric and family nurse practitioner services section.

22. The State has indicated that the limitations for physician services and certified pediatric and family nurse practitioner services are the same. Depending on the information the State provides regarding whether the limitations are a utilization control procedure, or a hard cap to recipient care, we may ask additional questions on sufficiency.

Attachment 3.1-A, Item 24-A, Transportation (TN# 90-045)

During our review of OH 09-010, we commented that the State does not comprehensively describe transportation.

23. *Page 1:* Please revise this language. CMS suggests the following language, "When the beneficiary has no other means of transportation to access covered medical services the State will arrange the least costly mode of transportation that is appropriate for the beneficiaries' physical and or mental condition."

24. *Page 9:* The State has checked that transportation is provided with limitations, however, there is not a description of limitations in the State plan language. The State must provide State plan language to explain the limitations on the provision of transportation e.g., prior authorization, condition restrictions on the use of an ambulance, other limitations, etc.

Attachment 3.1-D, Transportation (TN# 93-38)

Attachment 3.1-D is titled "Assurance of Transportation" and is used to describe in full how transportation will be provided. States are required to describe the methodology for assuring NEMT on this page.

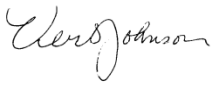
25. Ohio should state in Attachment 3.1-D that it will provide the least costly and most appropriate mode of transportation for each beneficiary's physical/mental condition and what modes of transportation will be used. The State should also indicate under what circumstances the NF will provide NEMT.

26. The current 3.1-D page reads, "…recipients who are not residents of a nursing facility and who do not require ambulance services may request assistance through the local County Department of Jobs and Family Services in securing transportation..." Please revise the plan language to describe, in greater detail, the methodology used by local County Departments of Jobs and Family Services to assure NEMT.

The State has 90 days from the date of this letter to respond to this letter. Within that period, the State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance.

Please contact Heather Brown-Palsgrove, of my staff, at (312) 886-2417 or heather.brown-palsgrove@cms.hhs.gov if you have any questions.

Sincerely,



Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Debbie Saxe, ODJFS
Lynne Lyon, ODJFS
Andy Jones, ODJFS
Becky Jackson, ODJFS