Background

Facility-specific nursing home rates are established prospectively using prices calculated using the base year cost report Each rate is the sum of the direct care rate component, the ancillary and support services price, the capital price, the tax rate component, the franchise permit fee rate component and the quality incentive payment.

Cost reports reflect allowable costs (costs determined by the Department of Job and Family Services to be reasonable and do not include fines paid). Unless otherwise specified, allowable costs are determined in accordance with the following, as currently issued and updated, in the following priority:

1) Title 42 Code of Federal Regulations (CFR) Chapter IV
2) The provider reimbursement manual (CMS Publication 15-1)
3) Generally accepted accounting principles.

A reasonable cost is one that is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs and that do not exceed what a prudent buyer pays for a given item or service. The costs of goods, services and facilities furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party.

Eligibility for Payment for Nursing Facility Services

In order to be eligible for Medicaid payments the operator of a nursing facility shall enter into a provider agreement with the department, apply for and maintain a valid license to operate if so required by law, and comply with all applicable state and federal laws and rules. The operator of a nursing facility that chooses to be a Medicaid provider must maintain Medicare certification for all beds participating in the Medicaid program.

Relation to Other Services

The nursing facility rate is a comprehensive rate including many services otherwise provided through the Medicaid program on a fee for service basis. The following services are included in the nursing facility per diem and are not available to residents of a nursing facility on a fee for service basis:

1) Personal hygiene services provided by facility staff or contracted personnel;
2) The purchase and administration of tuberculin tests;
3) Drawing specimens and forwarding specimens to a laboratory;
4) Needed medical and program supplies, defined as items with a very limited life expectancy (e.g., atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits);
5) Needed medical equipment, defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility (e.g., hospital beds, wheelchairs, and intermittent positive-pressure breathing machines);
6) Contents of oxygen cylinders or tanks, including liquid oxygen, oxygen producing machines (concentrators), and equipment associated with oxygen administration (e.g., carts, regulators/humidifiers, cannulas, masks and demurrage);
7) Over the counter drugs and nutritional supplements;
8) Physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants;
9) Services provided by a licensed psychologist;
10) Respiratory therapy services, including physician ordered administration of aerosol therapy rendered by a licensed respiratory care professional;
11) Transportation of residents by ambulance, ambulette or other means, other than transport on the date of discharge and hospital to hospital transfers.

The following services are not included in the nursing facility per diem and are available to residents of a nursing facility on a fee for service basis:

1) Covered dental services provided by licensed dentists;
2) Laboratory and x-ray procedures covered under the Medicaid program;
3) Ventilators;
4) Prostheses and othoses;
5) Pharmaceuticals, subject to the limitations found in Attachment 4.19B, subject to the following conditions.
    a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient;
    b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years;
    c) A receipt for drugs delivered to a NF must be signed by the facility representative at the time of delivery; a copy must me maintained by the pharmacy.
6) Psychologist services provided by a community mental health center;

7) Physician services, including all covered diagnostic and treatment services in accordance with Attachment 4.19B, all medically necessary physician visits in accordance with Attachment 4.19B, and required physician visits billed in accordance with Attachment 4.19B.

8) Podiatry services in accordance with Attachment 4.19B. Payment by ODJFS is limited to one visit per month for NF residents.

9) Vision care services in accordance with Attachment 4.19B.

Peer Groups

Peer groups are used to establish the direct care, ancillary and support and capital rate components for nursing facility rates. Providers are assigned to peer groups based on the provider's geographical location and the number of licensed beds reported on the provider's annual cost report for the calendar year preceding the fiscal year for which the rate is established. For a provider new to the Medicaid program, the initial number of licensed beds documented in the provider agreement shall be used; subsequently the number of beds reported on the provider's annual cost report will be used. In the case of a change of operator, the entering operator shall be assigned to the peer group that had been assigned to the exiting operator on the day immediately preceding the date on which the change of operator occurred; subsequently the number of licensed beds reported on the annual cost report shall be used. No adjustment will be made to the provider's placement in a peer group due to a change in bed size until the first day of the next fiscal year.

Direct Care

Three peer groups are used to establish the direct care component for nursing facility rates. Peer Group 1 consists of facilities located in Brown, Butler, Clermont, Clinton, Hamilton and Warren counties. Peer Group 2 consists of facilities located in Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union and Wood counties. Peer Group 3 consists of facilities located in Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties.

Ancillary and Support and Capital

Six peer groups are used to establish the ancillary and support and capital components for nursing facility rates. Peer Group 1 consists of facilities with fewer than 100 beds located in Brown, Butler, Clermont, Clinton, Hamilton and Warren counties. Peer Group 2 consists of facilities in those counties with 100 or more beds.

Peer Group 3 consists of facilities with fewer than 100 beds located in Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union and Wood counties. Peer Group 4 consists of facilities in those counties with 100 or more beds.

Peer Group 5 consists of facilities located in Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties. Peer Group 6 consists of facilities in those counties with 100 or more beds.

Direct Care

Costs Included in Direct Care

Direct care costs are reasonable costs incurred for the following:

1) Registered nurses, licensed practical nurses and nurse aides employed by the facility;
2) Direct care staff, administrative nursing staff, medical directors, respiratory therapists, and other persons holding degrees qualifying them to provide therapy;
3) Purchased nursing services;
4) Quality assurance;
5) Consulting and management fees related to direct care;
6) Allocated direct care home office costs;
7) Habilitation staff, other than habilitation supervisors;
8) Medical Supplies, habilitation supplies and universal precaution supplies;
9) Oxygen;
10) Over the counter pharmacy products;
11) Behavioral and mental health services;
12) Physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, and audiologists
13) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in direct care;
14) Other direct care resources.

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) Calculate the direct care cost per diem for each provider by dividing the direct care costs the provider reported on the base year 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 twenty-fifth 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) Multiply the CPCMU of the provider at the twenty-fifth percentile by 102%.
6) Multiple the result in the step above by the rate of inflation for the eighteen month period beginning on the first day of July in the base year and ending on the last day of December in the following calendar year. Inflation is measured using the employment cost index for total compensation, health services component, published by the United States Bureau of Labor Statistics, as the index existed on July 1, 2005. When a new base year is selected, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States Bureau of Labor Statistics will be used.
7) Increase the result in the previous step by one dollar and eighty-eight cents.
8) Multiply the result in the previous step by 105.08% to calculate the peer group price.

Calculating the Direct Care Rate

A facility specific direct care rate component is calculated by multiplying the peer group price by a facility specific semi-annual case mix score. For rates effective on the first day of July 2011 the fiscal year, the price is multiplied by the semi-annual Medicaid case mix score for the quarters ended June 30, 2010 and October 31, 2010. Subsequently, rates are adjusted for changes in acuity effective July 1 and January 1 of the fiscal year. The July 1 acuity adjustment will be made using the semi-annual Medicaid case mix scores for the preceding quarters ended December 31 and March 31. The January 1 acuity adjustment will be made using semi-annual Medicaid case mix scores for the preceding quarters ended June 30 and September 30.

Ancillary and Support

Costs Included In Ancillary and Support

Ancillary and support costs are reasonable costs incurred by a nursing facility that are not direct care costs, capital costs, or tax costs. They include, but are not limited to, costs incurred for the following:

1) Activities;
2) Social services;
3) Pharmacy consultants;
4) Habilitation supervisors, qualified mental retardation professionals, and program directors.
5) Program and incontinence supplies;
6) Food, enterals, dietary supplies, and dietary personnel;
7) Laundry and housekeeping;
8) Security;
9) Administration, bookkeeping, purchasing department, human resources, and communication;
10) Medical equipment, minor equipment, and wheelchairs;
11) Utilities;
12) Liability and property insurance;
13) Travel;
14) Dues, license fees, and subscriptions;
15) Home office costs not otherwise allocated;
16) Legal and accounting services;
17) Resident transportation;
18) Maintenance and repairs; maintenance and repairs are necessary and proper to maintain an asset in a normally efficient working condition and do not extend the useful life f the asset two years or more. Maintenance and repairs include, but are not limited to ordinary repairs such as painting and wallpapering.
19) Help wanted and informational advertising;
20) Start up costs and organizational expenses;
21) Other interest;
22) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in ancillary and support;

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 and 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 facility removes from its Medicaid certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.
3) Determine the ancillary and support per diem of the provider at the twenty-fifth 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) Multiple the result in the step above by the rate of inflation for the eighteen month period beginning on the first day of July in the base year and ending on the last day of December in the following calendar year. Inflation is measured using the consumer price index for all items for all urban consumers for the north central region, published by the United States Bureau of Labor Statistics, as the index existed on July 1, 2005. When a new base year is selected, the consumer price index for all items for all urban consumers for the midwest region, published by the United States Bureau of Labor Statistics will be used.
5) Multiply the result in the previous step by 105.08% to calculate the peer group price.
6) The provider's ancillary and support rate component is equal to the ancillary and support price for the peer group.

Capital

Costs Included in Capital

Capital costs are reasonable costs incurred for depreciation, amortization and interest on any capital assets that cost $500 or more per item, including the following:

1) Buildings and building improvements;
2) Equipment;
3) Transportation equipment
4) Land improvements;
5) Leasehold improvements;
6) Financing costs.

Depreciation, amortization and interest for capital assets costing less than $500 per item may be considered capital costs in accordance with the provider's practice. Depreciation for costs paid or reimbursed by a government agency shall not be included in cost reports unless that part of the payment is used to reimburse the government agency. Amortization of the cost of acquiring operating rights for the relocated beds is not an allowable cost.

Capital costs also include rent and lease expense for land building and equipment. Allowable lease expense is determined as follows:

(1) For a lease of a facility that was effective on May 27, 1992, the entire lease expense is an allowable expense.

(2) For a renewal of a lease of a facility that was effective on May 27, 1992 that is pursuant to a renewal option in existence on May 27, 1992, the entire lease expense is an allowable expense.

(3) For a renewal of a lease between the same parties and for the same lease payment as a lease in effect on May 27, 1992, the entire lease expense is an allowable expense.

(4) For a lease of a facility in existence on May 27, 1992 but not operated under a lease on that date, the allowable lease expense is the lesser of the annual lease expense or depreciation and interest calculated using the lessor's historical capital asset cost basis adjusted for one half of the change in the consumer price index for all items for all urban consumers as published by the United State Bureau of Labor Statistics during the time the lessor held each asset until the beginning of the lease. Interest will be imputed at the lessor of the prime rate plus two percent or ten percent.

(5) For a lease of a facility with a date of licensure on or after May 27, 1992 that is initially operated under a lease, the entire lease expense is an allowable capital cost if there was a substantial commitment of money for construction of the facility after December 22, 1992 and before July 1, 1993.

(6) For a lease of a facility with a date of licensure on or after May 27, 1992 that is initially operated under a lease, if there was not a substantial commitment of money for construction of the facility after December 22, 1992 and before July 1, 1993, the allowable lease expense is the lesser of the annual lease expense or the sum of the following:

   (a) Depreciation calculated at the inception of the lease using the lessor's capital asset cost basis; and

(b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or imputed interest calculated using 70% of the lessor's capital asset cost basis.

(7) For the lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, the allowable capital costs are the lesser of the annual lease expense or depreciation and interest calculated using the lessor's historical capital asset cost basis adjusted for one half of the change in the consumer price index for all items for all urban consumers as published by the United State Bureau of Labor Statistics during the time the lessor held each asset until the beginning of the lease. Interest will be imputed at the lessor of the prime rate plus two percent or ten percent.

(8) For a subsequent lease of a facility that was operated under a lease on May 27, 1992, allowable capital costs are the lesser of the annual lease expense or the annual old lease payment. If the old lease was in effect for at least ten years, the old lease payment will be adjusted by one half of the change in the consumer price index for all items for all urban consumers, as published by the United States Bureau of Labor Statistics, from the beginning of the old lease to the beginning of the new lease.

(9) For a subsequent lease of a facility not in existence or not operated under a lease on May 27, 1992, allowable capital costs equal the lesser of the annual lease expense or the allowable capital costs under the old lease. If the old lease was in effect for at least ten years, the old lease payment will be adjusted by one half of the change in the consumer price index for all items for all urban consumers, as published by the United States Bureau of Labor Statistics, from the beginning of the old lease to the beginning of the new lease.

(10) A revision of a lease does not change the allowable capital costs under a lease.

(11) The allowable capital costs for a lease to a related party equal the lesser of the annual lease expense or the reasonable cost to the lessor.

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) Calculate the capital cost per diem for each provider by dividing the capital costs the provider reported on the base year 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 twenty-fifth percentile in each peer group.
4) Multiply the result in the previous step by 105.08% to calculate the peer group price.
5) The provider's capital rate component equals the capital price for the provider's peer group.

Capital Cost Basis

The capital cost basis of nursing facility assets is determined as follows:

(1) For facilities with dates of licensure on of before June 30, 1993 that have not undergone a change of operator since that date, the capital cost basis equals the actual allowable cost basis listed on the facility's cost report.

(2) For facilities with dates of licensure after June 30, 1993, the capital cost basis is determined in accordance with the principles of the Medicare program.

(3) If a provider transfers an interest in the facility to a related party, there is no increase in the cost basis of the asset unless the related party is a relative of the owner, the provider making the transfer retains no interest in the facility, and the Department of Job and Family Services determines that the transfer is an arm's length transaction.

(4) If a facility undergoes a change of operator after June 30, 1993 and the transfer is not to a related party, the basis of the asset is adjusted by one half the change in the consumer price index for all items for all urban consumers as published by the United States Bureau of Labor Statistic during the time the transferor held the asset.

Depreciation

All assets are depreciated using the straight-line method of depreciation. Buildings are depreciated over forty years or a different period approved by the department. Components and equipment shall be depreciated over a period consistent with the guidelines of the American Hospital Association or a different period approved by the department. If additional guidance is needed, the Internal Revenue Service Publication 946 "How to Depreciate Property" shall be used to determine the useful life of that capital assets.

No depreciation is recognized in the month that an asset is placed into service. A full month's depreciation expense is recognized in the month following the month the asset is placed into service. In the month an asset is disposed and it is not a change in ownership, depreciation equal to the difference between the historical cost and accumulated depreciation is recognized.

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. The result is multiplied by 105.08%.

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.

Franchise Permit Fee

In state fiscal year 2012, the franchise permit fee rate component is $11.47. The franchise permit fee rate component is eliminated for state fiscal year 2013 and thereafter.

Quality Incentive Payment

Quality Measures

The rate for each facility includes a quality incentive payment calculated based on the following measures:

1) The facility had no health deficiencies on the facility's most recent standard survey;
2) The facility had no health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards established under Title XIX, on the facility's most recent standard survey;
3) The facility's resident satisfaction survey score is above the statewide average. (This measure is used if a resident satisfaction survey was conducted by the Ohio Department of Aging in the calendar year preceding the fiscal year.)
4) The facility's resident satisfaction survey score is above the statewide average. (This measure is used if a resident satisfaction survey was conducted by the Ohio Department of Aging in the calendar year preceding the fiscal year.)
5) The number of hours the facility employs nurses is above the statewide average.
6) The facility's employee retention rate is above the average for the facility's direct care peer group.
7) The facility's occupancy rate is above the statewide average.
8) The facility's case mix score is above the statewide average.
9) The facility's Medicaid utilization rate is above the statewide average.

One point will be awarded for the first eight measures and three points will be awarded for the ninth measure.

Calculation of the Quality Incentive Payment

The quality incentive payment component of each provider's rate shall be the product of the number of points earned by the provider and the value per point. The value per point is calculated as follows:

1) Calculate the total dollars for the quality incentive payment by multiplying $3.03 by the total number of Medicaid days reported on cost reports for the calendar year preceding the fiscal year.
2) Calculate the total number of point days for each facility by multiplying the number of points the facility earned by the number of Medicaid days reported on the facility's cost report.
3) Calculate the total point days by adding the point days for all facilities.
4) Divide the total dollars for the quality incentive payment by the total point days to calculate the value per point.

Modified Stop Loss

State fiscal year 2012 is the final year of the transition to full implementation of the reimbursement methodology. For that year, a stop loss provision will limit the decrease in a provider's rate if the rate determined for the provider for fiscal year 2012 is less than 90% of the rate the provider was paid on June 30, 2011. For those providers, the amount of the decrease in their rate that exceeds 10% will be reduced by 50%.

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.

JUN 18 2012

TN 11-022 Approval Date _____
Supersedes
TN NEW Effective Date 07/01/11

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 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 median tax rate component for the facility's ancillary and support peer group.
5) The quality incentive payment equals the mean quality incentive payment made to nursing facilities.

Added and Replaced Beds

If a nursing facility adds or replaces one or more Medicaid certified beds, the rate for the added or replaced bed equals the rate for the nursing facility's existing bed.

Outlier

An outlier is a facility or unit in a facility serving residents with diagnoses or special care needs that require direct care resources not measured adequately by the MDS 3.0 or who serve residents with special care needs otherwise qualifying for consideration. An outlier rate is a contracted rate and may differ from a standard rate as follows:

1) The direct care rate component may be increased of deemed necessary based on analysis of historical direct care costs if the provider had previously been a Medicaid provider, a comparison of direct care costs and staffing ratios of facilities caring for individuals with similar needs, a comparison of payment rates paid by private insurers or other states, and an analysis of the impact on historical costs if there are plans to change the patient mix.
2) The ancillary and support rate component may be increased due to increased expenses deemed necessary by ODJFS for treatment of individuals requiring outlier services.
3) The capital rate component may be adjusted to reflect costs of specialized high cost equipment or their capital expenditures necessary for treatment of individuals requiring outlier services.

Individuals must receive prior approval for outlier services.

Base Year
The initial base year, first used for rates in state fiscal year 2007, is calendar year 2003.

Medicaid Maximum Allowable Reimbursement Rate

(For Medicare Part A cost-sharing provisions, see Appendix to Item 3 of Supplement 1 to Attachment 4.19-B, page 1 of 1)

The Medicaid maximum allowable reimbursement rate is 109% of the nursing facility's Medicaid per diem. Effective January 1, 2012 and thereafter, the Medicaid maximum allowable reimbursement is 100% of the nursing facility's Medicaid per diem.

Leave Days

The Department of Job and Family Services will make payments to reserve a bed for a recipient during temporary absence for hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the facility when the resident's plan of care provides for the absence for up to thirty days in a calendar year. During calendar year 2011, the payment will equal fifty percent of the nursing facility's per diem. During calendar year 2012 and thereafter, the payment will equal fifty percent of the nursing facility's per diem if the nursing facility's occupancy exceeded ninety-five percent in the preceding calendar year and eighteen percent of the nursing facility's per diem if the nursing facility's occupancy did not exceed ninety-five percent in the preceding calendar year.

Nursing facility payment for Medicare part A cost sharing.

For qualified Medicare beneficiaries (QMB) including QMB plus and Medicaid consumers admitted to a nursing facility as a Medicare part A benefit, the Ohio Department of Job and Family Services (ODJFS) will pay as cost sharing for nursing facility services the lesser of:

The coinsurance amount as provided by the Medicare part A plan; or

The Medicaid maximum allowable amount for the identified service or services minus the Medicare part A plan's payment to a nursing facility for the same service or services. If the Medicare part A plan's payment to a nursing facility for a service or services identified is greater than the Medicaid maximum allowable amount, ODJFS will pay nothing for the same identified service or services.

OS Notification

State/Title/Plan Number:	**Ohio 11-022**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**June 20, 2012**
Fiscal Impact:	**FY 2011 $(29,664,000)** **FY 2012 $(91,462,000)**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: **Effective for services on or after July 1, 2011, this amendment revises methodology for making payments for nursing facility (NF) services. Specifically, this amendment reduces reimbursement for NF services; modifies reimbursement for coinsurance claims for NF services received by dually eligible consumers; modifies payment for leave days. Funding the non-Federal share of these payments comes from State appropriations and provider tax. The State met public process requirements. There are no issues with the UPL. The proposed plan changes to leave days reimbursement methodology in Attachment 4.19-C has been cleared by Dan Timmel. The proposed plan changes, to reimbursement for coinsurance claims for NF services by dually eligible consumers, has been cleared by Cathy Sturgill and Nancy Dieter. The State provided satisfactory responses to the access questions.**

The State believes that, despite the reduction in reimbursement, the rates still comply with requirements of 1902(a)(30) . Ohio Medicaid's nursing facility program includes more than 900 facilities averaging occupancy of approximately 85%. After considering rates in other Medicaid programs, rates paid by other payers, and the concentration of nursing facility beds in Ohio, the State determined that sufficient access would remain after the changes in the rate methodology. To date, there has not been a significant number of facility closures. In most cases, when a facility closes, the beds have remained in the system at other facilities.

The State sought stakeholder input, which generally came from the provider community who expressed concerns about the amount of the changes, the lack of

flexibility in Ohio's regulatory structure and the impact on quality of care. In response to their concerns a package of regulatory changes intended to provide additional flexibility in the operation of nursing facilities in Ohio and to streamline the administration of Ohio's nursing home program were included. In addition, modifications to the original proposal included a modified stop loss provision for FY12 to assist facilities who would realize the largest decrease in their rate in the final transition to pricing and a one year delay in shifting to a larger percentage of the rate being linked to performance to allow providers time to modify their business practices.

The State estimates the Federal budget impact as a result of this amendment to be a decrease of $29,664,000 for FFY 2011 and a decrease of $91,462,000 for FFY 2012. These reductions represent approximately 1.12% and 3.74% of total NF expenditures for FFY 2011 and FFY 2012 respectively. There are no supplemental payments to NFs that would offset this reduction.

Other Considerations: **This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.**

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact: **Todd McMillion (608) 441-5344**
National Institutional Reimbursement Team