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State/Territory Name: OH

State Plan Amendment (SPA) #:14-0024

This file contains the following documents in the order listed:

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

May 11, 2016

John B. McCarthy, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 14-024

Dear Mr. McCarthy:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA):

Transmittal #14-024
- Medicaid Professional Fee Schedule Updates
- Effective Date: December 31, 2014

If you have any questions regarding this SPA, please have a member of your staff contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sarah Curtin, ODM
Carolyn Humphrey, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **14 – 024** Revised

2. STATE **OHIO**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 31, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $3,122,385
b. FFY 2016 $4,144,570

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Item 3, Page 1 of 1 Revised
Attachment 4.19-B, Item 5-a, Page 1 of 7 Revised
Attachment 4.19-B, Item 6-a, Page 1 of 2 Revised
Attachment 4.19-B, Item 6-d-(5), Page 1 of 1 Revised
Attachment 4.19-B, Item 6-d-(6), Page 2 of 5 Revised
Attachment 4.19-B, Item 6-d-(6), Page 4 of 5 Revised
Attachment 4.19-B, Item 7-c, Page 1 of 1 Revised
Attachment 4.19-B, Item 9-a, Page 1 of 1 Revised
Attachment 4.19-B, Item 11-a, Page 1 of 1 Revised
Attachment 4.19-B, Item 23, Page 1 of 3 Revised

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Item 3, Page 1 of 1 (TN 14-017)
Attachment 4.19-B, Item 5-a, Page 1 of 7 (TN 14-005)
Attachment 4.19-B, Item 6-a, Page 1 of 2 (TN 13-036)
Attachment 4.19-B, Item 6-d-(5), Page 1 of 1 (TN 14-005)
Attachment 4.19-B, Item 6-d-(6), Page 2 of 5 (TN 14-005)
Attachment 4.19-B, Item 6-d-(6), Page 4 of 5 (TN 14-005)
Attachment 4.19-B, Item 7-c, Page 1 of 1 (TN 13-023)
Attachment 4.19-B, Item 9-a, Page 1 of 1 (TN 14-005)
Attachment 4.19-B, Item 11-a, Page 1 of 1 (TN 14-018)
Attachment 4.19-B, Item 23, Page 1 of 3 (TN 14-005)

10. SUBJECT OF AMENDMENT:
Medicaid Professional Fee Schedules updates December 31, 2014

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: **JOHN B. McCARTHY**

14. TITLE: **STATE MEDICAID DIRECTOR**

15. DATE SUBMITTED: 12/29/2014

16. RETURN TO:

Carolyn Humphrey
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 29, 2014

18. DATE APPROVED:
May 11, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
December 31, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Ruth A. Hughes

22. TITLE:
Associate Regional Administrator

23. REMARKS:

3. Other laboratory and x-ray services.

Other laboratory and x-ray services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.30.

Payment for Other laboratory and x-ray services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service **that is not to exceed the Medicare rate on a per-test basis**. The Medicaid maximum is the amount listed on the Department's other laboratory and x-ray services fee schedule.

A payment reduction provision applies when more than one advanced imaging procedure is performed by the same provider or provider group for an individual patient in the same session. Payment is made for the primary procedure at 100%; payment for each additional technical component is 50%; payment for each additional professional component is 75%. This payment reduction provision takes effect on July 31, 2014.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's laboratory and x-ray services fee schedule rate was set as of December 31, 2014 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate, or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the state plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Clinical Diagnostic Lab (CDL) rates attestation

The state attests that it complies with 1903(i)(7) of the Social Security Act and limits Medicaid payments for clinical diagnostic lab services to the amount paid by Medicare for those services on a per test basis.

5. a. Physicians' services.

Physicians' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.50.

Payment for Physicians' services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's Physicians' services fee schedule.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's physicians' services fee schedule rate was set as of December 31, 2014 and is effective for services provided on or after that date. The site differential payment is effective as of January 1, 2014 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

Non-covered services are identified on the state developed Medicaid fee schedule medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates by "NC" as the current price.

The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40 percent of the Medicaid physician visits in the county of location and 10 percent of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40 percent of that fee.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Podiatrists' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.60.

Payment for Podiatrists' services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's Podiatrists' services fee schedule.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's podiatrists' services fee schedule rate was set on December 31, 2014, for services provided on or after that date. The site differential payment is effective as of January 1, 2014.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

d. Other practitioners' services
(5) Physician assistants' services

Physician assistants' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.60.

Payment for Physician assistants' services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's Physician assistants' services fee schedule.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's physician assistants' fee schedule rate was set as of December 31, 2014 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

The following payment scenarios applicable to physicians also apply to physician assistants:

The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40 percent of the Medicaid physician visits in the county of location and 10 percent of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40 percent of that fee.

The Department will reimburse for services provided by a physician assistant the lesser of the billed charge or eighty-five per cent of the Medicaid maximum, utilizing a modifier that indicates the provider and services are subject to an adjusted rate, unless the service is the type usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations). The Department will reimburse for services provided by a physician assistant either the lesser of the billed charge or one hundred per cent of the Medicaid maximum.

B. Clinical Nurse Specialists' (CNS) services:

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's fee schedule.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's clinical nurse specialists' fee schedule rate was set as of December 31, 2014 and is effective for services provided on or after that date. The site differential payment is effective as of January 1, 2014 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

The maximum reimbursement for CNSs' services is the lesser of the provider's billed charge or the percentage listed below, whichever is less:

eighty-five per cent of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the Medicaid maximum when services are provided in any non-hospital place of service.

For Rural Health Clinic (RHC)-based, Federally Qualified Health Center (FQHC)-based and Outpatient Health Facility (OHF)-based practices, reimbursement for services is the Medicaid maximum set forth in Section III of Attachment 4.19-B, Item 2c.

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

C. Certified Nurse Practitioners' (CNP) services, other than certified pediatric or family nurse practitioners' services

Except as otherwise noted in the state plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's fee schedule.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's certified nurse practitioners' fee schedule rate was set as of December 31, 2104 and is effective for services provided on or after that date. The site differential payment is effective as of January 1, 2014 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

The maximum reimbursement for CNPs' services is the lesser of the provider's billed charge or the percentage listed below, whichever is less:

eighty-five per cent of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the Medicaid maximum when services are provided in any non-hospital place of service.

For Rural Health Clinic (RHC)-based, Federally Qualified Health Center (FQHC)-based and Outpatient Health Facility (OHF)-based practices, reimbursement for services is the Medicaid maximum set forth in Section III of Attachment 4.19-B, Item 2c.

7. Home health services, continued.

c. Medical supplies, equipment, and appliances suitable for use in the home.

Payment for enteral nutrition products is the lesser of the billed charge or an amount based on the Medicaid maximum for the product. The Medicaid maximum is the amount listed on the Department's Durable Medical Equipment fee schedule. Where no Medicaid maximum is specified, payment is the average wholesale price (AWP) minus 23 per cent.

Payment for blood glucose monitors, test strips, lancets, lancing devices, needles including pen needles, calibration solution/chips, and syringes with a needle less than or equal to 1 milliliter will be based on wholesale acquisition cost (WAC) plus seven percent. In the event that WAC cannot be determined, reimbursement will be AWP minus 14.4 percent. The Medicaid maximum is the amount listed on the Department's Pharmacy fee schedule.

For all other items, payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service or item. The Medicaid maximum is the amount listed on the Department's Durable Medical Equipment fee schedule. Where no Medicaid maximum is specified, payment is 72 per cent of the list price or, if no list price is available, 147 per cent of the invoice price.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's Medical supplies, equipment, and appliances fee schedule was set as of December 31, 2014 and is effective for services provided on or after that date. The agency's diabetic testing and injection supplies fee schedule (under the Pharmacy fee schedule) was set as of July 1, 2013, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

9. Clinic services.

a. Free-standing ambulatory health care clinics (AHCCs).

AHCCs' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.90.

Dialysis
The State uses the Medicare PPS rate as the basis for establishing Medicaid payment to dialysis clinics for dialysis services. The 2003 Medicare PPS rate was used to establish the initial Medicaid rate. The State divides the Medicare monthly PPS rate by 4 to determine the weekly rate and divides the weekly rate by 3 to establish treatment rate.

Payment for all other AHCCs' services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's AHCCs' services fee schedule.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's Clinic services fee schedule was set as December 31, 2014 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

11. Physical therapy and related services.

a. Physical therapy.

Physical therapy services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for physical therapy services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision takes effect on January 1, 2014.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's physical therapy fee schedule rate was set as of December 31, 2014 and is effective for services provided on or after that date.

Except as otherwise noted in the state plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Payment for physical therapy services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG-exempt.

Payment for physical therapy services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

For residents of nursing facilities (NFs), physical therapy services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for physical therapy services provided to residents of NFs is included in the facility per diem.

23. Certified pediatric and family nurse practitioners' services.

Certified pediatric and family nurse practitioners' services under this section are covered by Ohio Medicaid in accordance with 42 CFR §§ 440. 166 and 441.22.

Payment for certified pediatric and family nurse practitioners' services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's certified pediatric and family nurse practitioners' services fee schedule.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's certified pediatric and family nurse practitioners' services fee schedule rate was set as of December 31, 2014 and is effective for services provided on or after that date. The site differential payment is effective as of January 1, 2014 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

The maximum reimbursement for certified pediatric and family nurse practitioners' services is the lesser of the provider's billed charge or the percentage listed below, whichever is less:

eighty-five per cent of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the Medicaid maximum when services are provided in any non-hospital place of service.

For Rural Health Clinic (RHC)-based, Federally Qualified Health Center (FQHC)-based and Outpatient Health Facility (OHF)-based practices, reimbursement for services is the Medicaid maximum set forth in Section III of Attachment 4.19-B, Item 2c.