Table of Contents

State/Territory Name: OH

State Plan Amendment (SPA) #: 15-0006

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

July 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 15-006

Dear Mr. McCarthy:

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

Transmittal #15-006 - Payment for services: Professional fee schedule updates
- Effective Date: January 1, 2015

If you have any questions about this SPA, please 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: Carolyn Humphrey, ODM
Sarah Curtin, 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: **15-006** 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
January 1, 2015

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 $0
b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Item 3, Page 1 of 1 Revised	Attachment 4.19-B, Item 3, Page 1 of 1 (TN 14-024)
Attachment 4.19-B, Item 5-a, Page 1 of 7 Revised	Attachment 4.19-B, Item 5-a, Page 1 of 7 (TN 14-024)
Attachment 4.19-B, Item 5-a, Page 7 of 7 Revised	Attachment 4.19-B, Item 5-a, Page 7 of 7 (TN 13-036)
Attachment 4.19-B, Item 6-a, Page 1 of 2 Revised	Attachment 4.19-B, Item 6-a, Page 1 of 2 (TN 14-024)
Attachment 4.19-B, Item 6-d-(5), Page 1 of 1 Revised	Attachment 4.19-B, Item 6-d-(5), Page 1 of 1 (TN 14-024)
Attachment 4.19-B, Item 6-d-(6), Page 2 of 5 Revised	Attachment 4.19-B, Item 6-d-(6), Page 2 of 5 (TN 14-024)
Attachment 4.19-B, Item 6-d-(6), Page 4 of 5 Revised	Attachment 4.19-B, Item 6-d-(6), Page 4 of 5 (TN 14-024)
Attachment 4.19-B, Item 7-c, Page 1 of 1 Revised	Attachment 4.19-B, Item 7-c, Page 1 of 1 (TN 14-024)
Attachment 4.19-B, Item 9-a, Page 1 of 1 Revised	Attachment 4.19-B, Item 9-a, Page 1 of 1 (TN 14-024)
Attachment 4.19-B, Item 10, Page 1 of 1 Revised	Attachment 4.19-B, Item 10, Page 1 of 1 (TN 14-005)
Attachment 4.19-B, Item 13-c, Page 1 of 1 Revised	Attachment 4.19-B, Item 13-c, Page 1 of 1 (TN 13-013)
Attachment 4.19-B, Item 17, Page 1 of 3 Revised	Attachment 4.19-B, Item 17, Page 1 of 3 (TN 14-005)
Attachment 4.19-B, Item 23, Page 1 of 3 Revised	Attachment 4.19-B, Item 23, Page 1 of 3 (TN 14-024)

10. SUBJECT OF AMENDMENT: Payment for services: Professional Fee Schedules Update

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:

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

14. TITLE: **STATE MEDICAID DIRECTOR**

15. DATE SUBMITTED: 03/31/2015

16. RETURN TO:
Carolyn Humphrey
Ohio Department of Medicaid
P.O. Box 182709
Columbus, Ohio 43218

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 31, 2015

18. DATE APPROVED: July 11, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

Instructions on Back

3. Other laboratory and x-ray services.

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. **Payment for other laboratory services 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 made at 50%, and payment for each additional professional component is made at 75%. This payment reduction provision takes effect on July 31, 2014.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's other laboratory and x-ray services fee schedule was set as of January 1, 2015 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services 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 section 1903(i)(7) of the Social Security Act and limits Medicaid payments for clinical diagnostic lab services to the amounts paid by Medicare for those services on a per test basis (or per billing code basis for a bundled/panel of tests).

5. a. Physicians' services.

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.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's physicians' services fee schedule was set as of January 1, 2015 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 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% of the Medicaid physician visits in the county of location and 10% 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% of that fee.

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. (Continued)

Optometrists' Services

Payment for Optometrists' 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 Optometrists' services fee schedule.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's physicians' (including optometrists') services fee schedule was set as of January 1, 2015 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.

Optometrists' services are subject to a co-payment as referenced in Attachment 4.18-A of the State Plan.

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.

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.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's podiatrists' services fee schedule was set on January 1, 2015, for services provided on or after that date. The site differential payment is effective as of January 1, 2014.

By-report services 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

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.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's physician assistants' fee schedule was set as of January 1, 2015 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services 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% of the Medicaid physician visits in the county of location and 10% 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% 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).

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.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's clinical nurse specialists' fee schedule was set as of January 1, 2015 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 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:

85% of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

100% of the Medicaid maximum when services are provided in any non-hospital place of service.

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.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's certified nurse practitioners' fee schedule was set as of January 1, 2105 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 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:

85% of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

100% of the Medicaid maximum when services are provided in any non-hospital place of service.

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%.

      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%. 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% of the list price or, if no list price is available, 147% of the invoice price.

      For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

      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 January 1, 2015 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).

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 the 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.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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 January 1, 2015 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services 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.

10. Dental services.

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

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's dental services fee schedule was set as of January 1, 2015 and is effective for services provided on or after that date.

The following payment scenarios also exist:

By-report services 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.

Selected dental services are subject to a co-payment as specified in Attachment 4.18-A of the State plan.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

   c. Preventive services.

   Payment for preventive 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 Preventive services fee schedule.

   For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

   The agency's fee schedule was set as of January 1, 2015, 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.

17. Nurse-midwife services.

Payment for Nurse-midwife 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 Nurse-midwife services fee schedule.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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

The agency's nurse-midwife services fee schedule was set as of January 1, 2015 and is effective for services provided on or after that date. The site differential payment was set 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 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 nurse-midwife 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.

23. Certified pediatric and family nurse practitioners' services.

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.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at 80% of the Medicare allowed amount.

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 was set as of January 1, 2015 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 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.