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State/Territory Name: OH

State Plan Amendment (SPA) #: 15-0017

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



October 19, 2016

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

RE: TN 15-017

Dear Mr. McCarthy:

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

Transmittal #15-017 - Coverage & Payment: Lead Investigation Services
 - Effective Date: December 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.

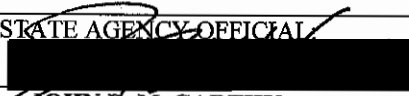
Sincerely,

/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		1. TRANSMITTAL NUMBER: 15-017 Revised	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		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 01, 2015	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 2 CFR 225, Appendix E 42 CFR 440.130(a)		7. FEDERAL BUDGET IMPACT: a. FFY 2016 \$339.3 thousands b. FFY 2017 \$498.56 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 13-a, page 1 of 1 Attachment 4.19-B, Item 13-a, pages 1 and 2 of 3 Attachment 4.19-B, Item 13-a, page 3 of 3 (New)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-A, Item 13-a, page 1 of 1 (TN 09-011) Attachment 4.19-B, Item 13-a, pages 1 and 2 of 2 (TN 09-011)	
10. SUBJECT OF AMENDMENT: Payment for Services: Lead Investigation Rate			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The State Medicaid Director is the Governor's designee	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: JOHN B. McCARTHY		Carolyn Humphrey Ohio Department of Medicaid P.O. BOX 182709 Columbus, Ohio 43218	
14. TITLE: STATE MEDICAID DIRECTOR			
15. DATE SUBMITTED: December 11, 2015			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: December 11, 2015		18. DATE APPROVED: October 19, 2016	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: December 1, 2015		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Ruth A. Hughes		22. TITLE: Associate Regional Administrator	
23. REMARKS:			

Instructions on Back

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

a. Diagnostic services

Diagnostic services are covered by Ohio Medicaid in accordance with 42 CFR 440.130(a) and State law.

Beneficiaries younger than twenty-one can access diagnostic services without limitation when such services are medically necessary.

Services determined by the State as not medically necessary will not be covered.

Diagnostic services are limited to lead investigation to determine the source of lead poisoning for a child who is diagnosed with an elevated blood lead level as defined by the Centers for Disease Control and Prevention (CDC). The investigation will be conducted in the child's home or primary residence. A maximum of two sites may be investigated. Lead investigations beyond the child's home or primary residence, such as in community settings, schools, or other residences, are not reimbursable.

Provider limitations:

Investigations shall be performed by Public Health Lead Investigators, who are authorized and defined by State law.

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

One-time lead investigations to determine the source of lead poisoning:

A public health lead investigation consists of one or more of the following components, depending on the specific circumstances relevant to each child:

- Completion of a comprehensive on-site questionnaire;
- Interview of the parent, guardian or other appropriate adult;
- Gathering of information about habits of the child; and
- Identifying potential lead sources in the child's home or primary residence.

Rate(s):

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

Medicaid reimbursement includes payment for collection of specimens, assessment of the home or primary residence of a child identified as having an elevated blood lead level, and on-site testing. The State will only pay for those components of the one-time lead investigation that are performed. The State will not pay for external laboratory testing.

Payment for one-time lead investigations to determine the source of lead poisoning:

The State reimburses the Ohio Department of Health (ODH) for the cost of conducting a one-time lead investigation to determine the source of lead poisoning, utilizing a cost settlement and reconciliation payment methodology, in accordance with 2 CFR 200 Subpart E - Cost Principles. The State will reimburse ODH for the lead investigation at a unit rate of \$1,289.00 per investigation, and will settle to actual cost. The unit rate was derived by using actual provider cost data related to salary, travel and equipment for state fiscal year 2014. The analysis showed that the proposed rate was within a reasonable range when compared to both the average and median unit cost, with some falling below and some falling above. The State will continue to reimburse ODH based on established statewide rates, and ODH will complete a cost report at the conclusion of each quarter.

TN: 15-017

Supersedes:

TN: 09-011

Approval Date: 10/19/16

Effective Date: 12/01/2015

The reimbursement methodology is as follows:

Claims Payment Process:

The Ohio Department of Health submits claims to the single state agency listed in section 1.1(a) of the state plan. The single state agency processes the claims and reimburses the Ohio Department of Health at 100%.

Direct Medical Services Payment Methodology:

The cost settlement methodology will consist of a CMS-approved cost report and reconciliation to actual allowable cost, entitled “Ohio Department of Medicaid Lead Investigations Cost Report”.

The following will be required to determine the Medicaid-allowable direct and indirect costs of providing direct medical services to individuals who are Medicaid eligible and receive Lead Investigation services:

Direct costs for medical service include payroll costs and other costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services of personnel providing direct medical services.

Other direct costs include non-personnel costs directly related to the delivery of medical services, such as purchased services, capital outlay, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs.

Total direct costs for direct medical services are reduced on the cost report by any restricted public health service grant payments as defined in 2 CFR 200 Subpart E resulting in adjusted direct costs for direct medical services.

Indirect costs are calculated using the actual direct payroll cost of individuals who perform direct medical services times the federally approved indirect cost rate. The federally approved indirect cost rate does not include any costs otherwise included in the cost report.

Total indirect costs do not include any restricted public health service grant payments as defined in 2 CFR 200 Subpart E resulting in adjusted indirect costs.

An actual time report is used to determine the percentage of time spent by medical service personnel on Medicaid covered services, administrative duties, and non-reimbursable activities in compliance with applicable rules and regulations.

The total service rate is calculated by dividing the total allowable cost by the total number of services performed during the cost report period. The total service rate is compared to the interim rate for cost reconciliation purposed.

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Certification of Expenditures:

On an annual basis, the Ohio Department of Health (ODH) will certify through its cost report its total actual, incurred Medicaid allowable costs.

Annual Cost Report Process:

For Medicaid covered services, ODH shall file an annual cost report as directed by the Ohio Department of Medicaid (ODM) in accordance with 42 CFR 413 Subpart B and 42 CFR 447.202.

The primary purposes of the governmental cost report are to document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid covered services using a CMS-approved cost allocation methodology and cost report, and to reconcile annual interim payments to total CMS-approved, Medicaid allowable costs using a CMS-approved cost allocation methodology and cost report.

The Cost Reconciliation Process:

The cost reconciliation process must be completed within twelve months of the receipt of the cost report. The total Medicaid-allowable costs are determined based in accordance with 42 CFR 413 Subpart B and the CMS Provider Reimbursement Manual methodology and are compared to the ODH Medicaid interim payments delivered during the reporting period as documented in the Medicaid Information Technology System (MITS), resulting in a cost reconciliation.

The Cost Settlement Process:

If a provider's interim payments exceed the provider's certified cost for Medicaid services furnished by ODH to Medicaid recipients, the provider will remit the excess federal share of the overpayment at the time the cost report is submitted. The federal share will be returned via the CMS-64 Report.

If the certified cost of ODH's provider exceeds the interim payments, ODM will pay the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

TN: 15-017

Supersedes:

TN: NewApproval Date: 10/19/16Effective Date: 12/01/2015