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State/Territory Name: OH

State Plan Amendment (SPA) #: 16-012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

OCT 14 2016

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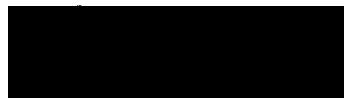Columbus, Ohio 43218

RE: Ohio State Plan Amendment (SPA) 16-012

Dear Mr. McCarthy:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-012. Effective March 1, 2016, this SPA modifies provisions in Attachment 4.19-D, Supplement 1 to align with recent legislation adopted under Amended Substitute House Bill 64 of the 13151 Ohio General Assembly to implement the RUG IV system in nursing facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 16-012 is approved effective March 1, 2016. We are enclosing the HCFA-179 and the amended plan pages.
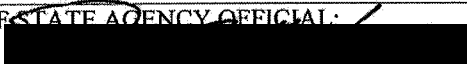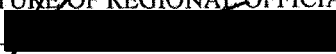
If you have any questions, please contact Fred Sebree at (217) 492-4122 or Fredrick.sebree@cms.hhs.gov.

Sincerely,

Kristin Fan
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: **16-012**	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
	March 1, 2016	

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:
Section 1902(a)(13)(A) of the Social Security Act
Section 1902(a)(30)(A) of the Social Security Act
42 C.F.R.Part 447.205
42 C.F.R.Part 483.20
	7. FEDERAL BUDGET IMPACT:
	  a. FFY 2016 $10,000 thousands
	  b. FFY 2017 $40,200 thousands

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Supplement 1: Section 001.8.1, page 1 of 1 **NEW** Section 001.8.2, pages 1-2 of 2 **NEW** Section 001.8.2 Appendix A, page 1-2 of 2 **NEW** Section 001.8.3, pages 1-2 of 2 **NEW** Section 001.8.4, page 1 of 1 **NEW** Section 001.8.4 Appendix A, pages 1-2 of 2 **NEW** Section 001.8.4 Appendix B, pages 1-4 of 4 **NEW**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, Supplement 1: Section 309.30.25.000, pages 1-3 of 3 (TN 10-001) **DELETE** Section 5111.231.001, pages 1-6 of 6 (TN 10-002) **DELETE** Section 5111.232.000, pages 1-4 of 4 (TN 09-024) **DELETE** Section 5111.232.001, pages 1-8 of 8 (TN 10-002) **DELETE** Section 5111.232.001 Appx. A, pages 1-38 of 38 (TN 10-002) **DELETE** Section 5111.232.001 Appx. B, pages 1-27 of 27 (TN 10-002) **DELETE** Section 5111.232.001 Appx. C, pages 1-8 of 8 (TN 10-002) **DELETE** Section 5111.232.001 Appx. D, pages 1-33 of 33 (TN 10-002) **DELETE** Section 5111.232.001 Appx. E, pages 1-33 of 33 (TN 10-002) **DELETE** Section 5111.232.002, pages 1-24 of 24 (TN 10-002) **DELETE** Section 5111.232.002 Appx. A, pages 1-2 of 2 (TN 10-002) **DELETE** Section 5111.232.002 Appx. B, page 1 of 1 (TN 10-002) **DELETE** Section 5111.232.002 Appx. C, page 1 of 1 (TN 10-002) **DELETE** Section 5111.232.002 Appx. D page 1 of 1 (TN 10-002) **DELETE** Section 5111.232.002 Appx. E, page 1 of 1 (TN 10-002) **DELETE** Section 5111.27.002, pages 1-8-of 8 (TN 10-002) **DELETE** Section 5111.27.002 Appx. A, pages 1-3 of 3 (TN 07-004) **DELETE** Section 5111.27.002 Appx. B, pages 1-4 of 4 (TN 07-004) **DELETE**

10. SUBJECT OF AMENDMENT: Payment for services: Nursing facility services – Case Mix Payment System

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:	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: March 31, 2016	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED:	18. DATE APPROVED: **OCT 14 2016**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **MAR 01 2016**	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

FORM CMS-179 (07-92)

Case Mix Payment System

Minimum Data Set Version 3.0 (MDS 3.0) Resident Assessment Instrument
Each facility's rate for direct care costs is based on a case mix payment system. The case mix payment system begins with the Minimum Data Set version 3.0 (MDS 3.0), the resident assessment instrument used in Ohio for implementing standardized assessments and for facilitating care management in nursing facilities. The MDS 3.0 is used in Ohio to comply with regulations specified in 42 C.F.R. 483.20 that require nursing facilities to provide comprehensive, accurate, standardized, reproducible assessments of each long term care facility resident's functional capacity, including assessments of medical conditions. The MDS 3.0 also includes Ohio-specific data elements designated as Section S.

All nursing facilities must submit encoded, accurate, and complete MDS 3.0 data for all residents of Medicaid certified beds, regardless of pay source or anticipated length of stay. Data must be encoded in accordance with 42 C.F.R. 483.20 and with federal MDS 3.0 data submission specifications.

MDS 3.0 data submitted by nursing facilities is used to calculate quarterly, semiannual, and annual case mix scores, which in turn are used to calculate the direct care component of each nursing facility's per diem rate.

Resource Utilization Groups (RUG) Classification System
The Ohio case mix payment system uses the resource utilization groups (RUG) classification system, which is a methodology for grouping nursing facility residents into case mix groups in a way that is clinically meaningful, and uses criteria that sufficiently differentiates one group from another. Ohio uses the following versions of the RUG classification system:

1)   For rates paid for services provided before July 1, 2016, version III (RUG III). Based on the items in the MDS 3.0, if a resident meets the criteria for placement in more than one group, the resident will be placed in a group within the highest major category of resident types according to the hierarchy unless the activities of daily living (ADL) index score is not met for placement within the highest major category of resident types. In descending order, the hierarchy of RUG III major categories using the forty-five grouper model as used in Ohio is as follows:
   a)   Extensive services.
   b)   Special rehabilitation
   c)   Special care.
   d)   Clinically complex.
   e)   Impaired cognition.
   f)   Behavior problems.
   g)   Reduced physical function.

2)   For rates paid for services provided July 1, 2016 and thereafter, version IV (RUG IV). Based on items in the MDS 3.0, if a resident meets the criteria for placement in more than one group, the resident will be placed in a group according to the hierarchy. In descending order, the hierarchy of RUG IV major categories using the forty-eight, fifty-seven, or sixty-six grouper model is as follows:
   a)   Rehabilitation plus extensive services (sixty-six grouper model only).
   b)   Rehabilitation.
   c)   Extensive services.
   d)   Special care high.
   e)   Special care low.
   f)   Clinically complex.
   g)   Behavioral symptoms and cognitive performance.
   h)   Reduced physical function.

Each of the RUG groups is assigned a relative resource weight. The relative resource weight indicates the relative amount of staff time required on average for workers in the registered nurse (RN), licensed practical nurse (LPN), and nurse aide (NA) worker classifications to deliver care to residents in a particular RUG group. Relative resource weights are calculated as follows using the average minutes per worker classification per RUG group provided by the United States Department of Health and Human Services (HHS), and the most recent available three-year averages of RN, LPN, and NA wages in Ohio Medicaid certified nursing facilities as reported on the Ohio Medicaid annual cost report:

1)   By setting the NA wage weight at one, wage weights for RNs and LPNs are calculated by dividing the NA wage into the RN or LPN wage.

2)   To calculate the total weighted minutes for each RUG group, the wage weight for each worker classification is multiplied by the average number of minutes that classification of workers spends caring for a resident in the RUG group, and then the products for each RUG group are summed.

3)   Relative resource weights are calculated by dividing the lowest group's total weighted minutes into each group's total weighted minutes. Weight calculations are rounded to the fourth decimal place. The RUG group with the lowest total weighted minutes receives a relative resource weight of 1.0000.

Residents whose MDS 3.0 forms contain missing or out-of-range responses to data elements used to determine the RUG classification shall be assigned to a default group. The lowest relative resource weight for the RUG groups (1.0000) is used as the weight for the default group.

APPENDIX A

RUG CLASSIFICATION SYSTEM
RELATIVE RESOURCE WEIGHTS

	RUG III CLASS - 45 GROUPER	RELATIVE WEIGHT
1	SE3	3.6037
2	SE2	2.9532
3	SE1	2.5253
4	RUC	2.7812
5	RUB	2.0327
6	RUA	1.6546
7	RVC	2.4192
8	RVB	2.2206
9	RVA	1.7320
10	RHC	2.6820
11	RHB	2.2565
12	RHA	1.8480
13	RMC	2.8835
14	RMB	2.3328
15	RMA	2.0480
16	RLB	2.4124
17	RLA	1.7119
18	SSC	2.4449
19	SSB	2.2715
20	SSA	2.1546
21	CC2	2.4231
22	CC1	2.1474
23	CB2	1.9681
24	CB1	1.8232
25	CA2	1.7925
26	CA1	1.6009
27	IB2	1.5112
28	IB1	1.4600
29	IA2	1.2366
30	IA1	1.1481
31	BB2	1.4861
32	BB1	1.4116
33	BA2	1.2090
34	BA1	1.0259
35	PE2	1.7400
36	PE1	1.6983
37	PD2	1.5821
38	PD1	1.5509
39	PC2	1.4489
40	PC1	1.3925
41	PB2	1.1054
42	PB1	1.0892
43	PA2	1.0503
44	PA1	1.0000
45	BC1	1.0000

	RUG IV CLASS - 48 GROUPER	RELATIVE WEIGHT
1	ES3	6.5333
2	ES2	4.9111
3	ES1	4.6889
4	RAE	3.6667
5	RAD	3.4889
6	RAC	2.9778
7	RAB	2.4222
8	RAA	1.7778
9	HE2	4.2444
10	HE1	3.3111
11	HD2	3.7333
12	HD1	2.9778
13	HC2	3.4444
14	HC1	2.7333
15	HB2	3.3111
16	HB1	2.6889
17	LE2	3.6000
18	LE1	2.8222
19	LD2	3.4444
20	LD1	2.7333
21	LC2	2.8444
22	LC1	2.2667
23	LB2	2.6667
24	LB1	2.1111
25	CE2	3.0667
26	CE1	2.7556
27	CD2	2.8889
28	CD1	2.5778
29	CC2	2.4000
30	CC1	2.1333
31	CB2	2.0889
32	CB1	1.8889
33	CA2	1.6222
34	CA1	1.4222
35	BB2	1.8222
36	BB1	1.6667
37	BA2	1.2889
38	BA1	1.2000
39	PE2	2.8000
40	PE1	2.6000
41	PD2	2.5778
42	PD1	2.3778
43	PC2	2.0667
44	PC1	1.8889
45	PB2	1.5556
46	PB1	1.4444
47	PA2	1.1111
48	PA1	1.0000

RUG CLASSIFICATION SYSTEM
RELATIVE RESOURCE WEIGHTS

	RUG IV CLASS - 57 GROUPER	RELATIVE WEIGHT
1	RUC	3.9556
2	RUB	3.8667
3	RUA	2.4000
4	RVC	3.7333
5	RVB	2.8667
6	RVA	2.7111
7	RHC	3.7111
8	RHB	2.9556
9	RHA	2.2444
10	RMC	3.6222
11	RMB	3.2667
12	RMA	2.0667
13	RLB	3.6667
14	RLA	1.8000
15	ES3	6.4889
16	ES2	4.9111
17	ES1	4.0667
18	HE2	4.2444
19	HE1	3.3111
20	HD2	3.7333
21	HD1	2.9778
22	HC2	3.4444
23	HC1	2.7333
24	HB2	3.3111
25	HB1	2.6889
26	LE2	3.6000
27	LE1	2.8222
28	LD2	3.4444
29	LD1	2.7333
30	LC2	2.8444
31	LC1	2.2667
32	LB2	2.6667
33	LB1	2.1111
34	CE2	3.0667
35	CE1	2.7556
36	CD2	2.8889
37	CD1	2.5778
38	CC2	2.4000
39	CC1	2.1333
40	CB2	2.0889
41	CB1	1.8889
42	CA2	1.6222
43	CA1	1.4222
44	BB2	1.8222
45	BB1	1.6667
46	BA2	1.2889
47	BA1	1.2000
48	PE2	2.8000
49	PE1	2.6000
50	PD2	2.5778
51	PD1	2.3778
52	PC2	2.0667
53	PC1	1.8889
54	PB2	1.5556
55	PB1	1.4444
56	PA2	1.1111
57	PA1	1.0000

	RUG IV CLASS - 66 GROUPER	RELATIVE WEIGHT
1	RUX	6.6444
2	RUL	6.2667
3	RVX	6.6222
4	RVL	5.3556
5	RHX	6.2000
6	RHL	5.1778
7	RMX	5.9556
8	RML	5.0889
9	RLX	5.4000
10	RUC	3.8667
11	RUB	3.7778
12	RUA	2.4000
13	RVC	3.7111
14	RVB	2.7333
15	RVA	2.6889
16	RHC	3.5333
17	RHB	2.8889
18	RHA	2.2444
19	RMC	3.3556
20	RMB	2.9778
21	RMA	2.0667
22	RLB	3.6667
23	RLA	1.8000
24	ES3	6.4889
25	ES2	4.9111
26	ES1	4.0667
27	HE2	4.2444
28	HE1	3.3111
29	HD2	3.7333
30	HD1	2.9778
31	HC2	3.4444
32	HC1	2.7333
33	HB2	3.3111
34	HB1	2.6889
35	LE2	3.6000
36	LE1	2.8222
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38	LD1	2.7333
39	LC2	2.8444
40	LC1	2.2667
41	LB2	2.6667
42	LB1	2.1111
43	CE2	3.0667
44	CE1	2.7556
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46	CD1	2.5778
47	CC2	2.4000
48	CC1	2.1111
49	CB2	2.0889
50	CB1	1.8889
51	CA2	1.6222
52	CA1	1.4222
53	BB2	1.8222
54	BB1	1.6667
55	BA2	1.2889
56	BA1	1.2000
57	PE2	2.8000
58	PE1	2.6000
59	PD2	2.5778
60	PD1	2.3778
61	PC2	2.0667
62	PC1	1.8889
63	PB2	1.5556
64	PB1	1.4444
65	PA2	1.1111
66	PA1	1.0000

Calculation of Nursing Facility Case Mix Scores

After processing MDS 3.0 resident assessment data and classifying residents using the RUG classification system, the Department of Medicaid calculates quarterly, semiannual, and annual nursing facility case mix scores. Two quarterly facility average case mix scores are calculated each quarter. The first is the quarterly facility average total case mix score. The second is the quarterly facility average Medicaid case mix score. For each nursing facility that submits timely, accurate, and sufficient resident assessment data, the quarterly facility average total case mix score is calculated as follows:

1) Add together all resident case mix scores for the quarter, including resident case mix scores in the RUG default group. The lowest weight for the RUG groups (1.0000) is used as the weight for the default group.

2) Divide the sum of the resident case mix scores by the total number of residents.

For each nursing facility that submits timely, accurate, and sufficient resident assessment data, the quarterly facility average Medicaid case mix score is calculated as follows:

1) Add together all Medicaid resident case mix scores for the quarter, including Medicaid resident case mix scores in the RUG default group. The lowest weight for the RUG groups (1.0000) is used as the weight for the default group.

2) Divide the sum of the Medicaid resident case mix scores by the total number of Medicaid residents.

Data is considered timely when the nursing facility submits the resident assessment data by the filing date, and the data includes assessments for all residents in Medicaid certified beds as of the reporting period end date. Data is considered accurate and sufficient when data that is submitted timely provides sufficient information for accurately classifying at least 90% of all residents in Medicaid certified beds into RUG non-default groups. Additionally, data is considered accurate and sufficient when data that is submitted timely and corrected timely provides sufficient information for accurately classifying at least 90% of all residents in Medicaid certified beds into RUG non-default groups. For each nursing facility that does not submit timely, accurate, or sufficient resident assessment data, the department shall assign a penalty score that is 5% less than that facility's quarterly facility average case mix score for the preceding calendar quarter.

The semiannual facility average Medicaid case mix score is determined as follows:

1) The semiannual facility average Medicaid case mix score for the payment period beginning the first day of July for a given fiscal year shall be the average of the quarterly facility average Medicaid case mix score from the preceding December and March reporting quarters. If a facility does not have a quarterly facility average Medicaid case mix score for both the December and March reporting quarters, the median annual facility average case mix score for the nursing facility's peer group shall be assigned as the semiannual facility average Medicaid case mix score.

2) The semiannual facility average Medicaid case mix score for the payment period beginning the first day of January for a given fiscal year shall be the average of the quarterly facility average Medicaid case mix score from the preceding June and

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Supersedes
TN <u>NEW</u>   Effective Date <u>03/01/2016</u>

September reporting quarters. If a facility does not have a quarterly facility average Medicaid case mix score for both the June and September reporting quarters, the median annual facility average case mix score for the nursing facility's peer group shall be assigned as the semiannual facility average Medicaid case mix score.

The annual facility average case mix score is calculated as follows:

1) Add all qualifying case mix scores.
2) Divide the sum of the qualifying case mix scores by the total number of quarters of qualifying scores.

Qualifying case mix scores are scores for facilities that have at least two quarterly facility average total case mix scores, and that also submitted resident assessment data timely, accurately, and sufficiently. If the department assigned a nursing facility a quarterly facility average total case mix score but the facility did not submit resident assessment data timely, accurately, or sufficiently, the assigned score is not used to calculate the facility's annual average case mix score.
In addition, for any score that was adjusted, the adjusted score is substituted according to the following hierarchy:

1) Adjusted quarterly facility average total case mix scores established by a rate reconsideration decision resulting from an exception review of resident assessment information conducted according to Section 001.8.4 of Attachment 4.19-D, Supplement 1 before the effective date of the rate.
2) Adjusted quarterly facility average total case mix scores as a result of exception review findings from an exception review conducted according to Section 001.8.4 of Attachment 4.19-D, Supplement 1.

Exception Reviews

An exception review is a review of minimum data set (MDS) resident assessment data. Exception reviews are conducted at selected nursing facilities by registered nurses or other appropriate licensed or certified health professionals as determined by the Department of Medicaid who are employed by or under contract with the department to identify any patterns or trends related to resident assessments that could result in inaccurate case mix scores. Facilities may be selected for an exception review based on the findings of a Medicaid certification survey conducted by the Department of Health, a risk analysis, or prior performance of the nursing facility.

If an exception review is conducted before the effective date of a nursing facility's rate for direct care costs, and the exception review results in findings that exceed tolerance levels specified by the department and indicate the facility received a higher rate than it was entitled to receive, the department will use the exception review findings to calculate or recalculate individual resident case mix scores, and to calculate or recalculate the nursing facility's quarterly facility average total case mix scores, quarterly and semiannual facility average Medicaid case mix scores, and annual facility average case mix scores. The department will use the nursing facility's quarterly facility average total case mix scores, quarterly and semiannual facility average Medicaid case mix scores, and annual facility average case mix scores based on exception review findings to calculate or recalculate the facility's rate for direct care costs for the appropriate six month period.

APPENDIX A

EXCEPTION REVIEW
RESIDENT INITIAL SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
1–4	All
5–10	5
11–20	8
21–40	10
41–44	11
45–48	12
49–52	13
53–56	14
57–75	15
76–80	16
81–85	17
85–90	18
91–95	19
96–100	20
101–105	21
106–110	22
111–115	23
116–160	24
161–166	25
167–173	26
174–180	27

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APPENDIX A

EXCEPTION REVIEW
RESIDENT INITIAL SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
181–186	28
187–193	29
194–300	30
301–310	31
311–320	32
321–330	33
331–340	34
341–350	35
351–360	36
361–370	37
371–380	38
381–400	39
401–410	40
411–420	41
421–430	42
431–440	43
441–450	44
451–460	45
461–470	46
471–480	47
481–490	48
491–500	49
501 or greater	50

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APPENDIX B

EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10–11	10
12	11
13	12
14–15	13
16	14
17	15
18–19	16
20	17
21–22	18
23	19
24–25	20
26	21
27–28	22

APPENDIX B

EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
29–30	23
31	24
32–33	25
34–35	26
36–37	27
38–39	28
40–41	29
42–43	30
44–45	31
46–47	32
48–50	33
51–52	34
53–55	35
56–57	36
58–60	37
61–62	38
63–65	39
66–68	40
69–71	41
72–74	42
75–77	43
78–81	44

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APPENDIX B

EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
82–84	45
85–88	46
89–92	47
93–95	48
96–100	49
101–104	50
105–108	51
109–113	52
114–118	53
119–123	54
124–128	55
129–134	56
135–140	57
141–146	58
147–152	59
153–159	60
160–167	61
168–174	62
175–183	63
184–191	64
192–201	65
202–211	66

APPENDIX B

EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
212–221	67
222–232	68
233–245	69
246–258	70
259–272	71
273–287	72
288–304	73
305–322	74
323–342	75
343–364	76
365 or greater	77