Table of Contents

State/Territory Name: OH

State Plan Amendment (SPA) #: 16-013

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) 16-013

Dear Mr. McCarthy:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-013. Effective July 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 rebase NF rates in conjunction with the implementation of the RUG IV system as proposed in OH SPA TN 16-012.

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 16-013 is approved effective July 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,

[redacted]

Kristin Fan
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **16-013**	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 **July 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:	7. FEDERAL BUDGET IMPACT:
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	a. FFY 2016 $21,000 thousands b. FFY 2017 $84,500 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Supplement 1: Section 001.3, page 1 of 1 Section 001.5, page 1 of 2 Section 001.7, page 1 of 1 Section 001.12, page 1 of 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, Supplement 1: Section 001.3, page 1 of 1 (TN 11-022) Section 001.5, page 1 of 2 (TN 13-021) Section 001.7, page 1 of 1 (TN 13-021) Section 001.12, page 1 of 1 (TN 11-022)

10. SUBJECT OF AMENDMENT:
Payment for services: Nursing facility services – Rebasing and Peer Group Changes

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]	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: JUL 01 2016	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMC

23. REMARKS:

FORM CMS-179 (07-92)

Instructions on Back

Base Year
The base year, first used for rates in state fiscal year 2017, is calendar year 2014.

Peer Groups

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

Ancillary and Support and Capital – Establishing Price Components

Six peer groups are used to establish the ancillary and support and capital price 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.

The current price components for Peer Group 3 were calculated using reported costs for facilities with fewer than 100 beds located in Allen, Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Stark, Summit, Trumbull, Union and Wood counties. Peer Group 4 consists of facilities in those counties with 100 or more beds.

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

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) Using calendar year 2014 as the base year, calculate the direct care cost per diem for each provider by dividing the direct care costs the provider reported on the base year Ohio Medicaid 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) Multiply 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 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) Using calendar year 2014 as the base year, calculate the capital cost per diem for each provider by dividing the capital costs the provider reported on the base year Ohio Medicaid 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.