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State/Territory Name: OH

State Plan Amendment (SPA) #: 16-0016

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



August 18, 2016

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

RE: TN 16-016

Dear Mr. McCarthy:

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

Transmittal #16-016 - Payment for Services: Non-institutional fee schedule updates
 - Effective Date: January 1, 2016

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.

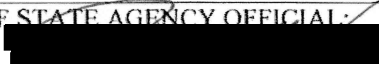
Sincerely,

/s/

Alan Freund
Acting 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		1. TRANSMITTAL NUMBER: 16-016	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 January 1, 2016	
5. TYPE OF PLAN MATERIAL (Check One):			
<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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Subpart F 447.300		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2016 \$19,490 thousands	
		b. FFY 2017 \$25,867 thousands	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	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 Attachment 4.19-B item 5a page 1 of 7 Attachment 4.19-B item 5a page 7 of 7 Attachment 4.19-B item 6a page 1 of 2 Attachment 4.19-B item 6c page 1 of 1 Attachment 4.19-B item 6d 6 page 2 of 5 Attachment 4.19-B item 6d 6 page 4 of 5 Attachment 4.19-B item 7c page 1 of 1 Attachment 4.19-B item 9a page 1 of 1 Attachment 4.19-B item 12c page 1 of 1 Attachment 4.19-B item 17 page 1 of 3 Attachment 4.19-B item 23 page 1 of 3		Attachment 4.19-B item 3 page 1 of 1 (TN 15-006) Attachment 4.19-B item 5a page 1 of 7 (TN 15-006) ^{eD} Attachment 4.19-B item 5a page 7 of 7 (TN 13-036 - 15-006) Attachment 4.19-B item 6a page 1 of 2 (TN 15-006) Attachment 4.19-B item 6c page 1 of 1 (TN 13-019) Attachment 4.19-B item 6d 6 page 2 of 5 (TN 15-006) Attachment 4.19-B item 6d 6 page 4 of 5 (TN 15-006) Attachment 4.19-B item 7c page 1 of 1 (TN 15-006) Attachment 4.19-B item 9a page 1 of 1 (TN 15-006) Attachment 4.19-B item 12c page 1 of 1 (TN 13-019) Attachment 4.19-B item 17 page 1 of 3 (TN 15-006) Attachment 4.19-B item 23 page 1 of 3 (TN 15-006)	
10. SUBJECT OF AMENDMENT: Payment for Services: Non-Institutional Payment Schedule Updates			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED:	
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		The State Medicaid Director is the Governor's designee	
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
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: March 31, 2016		18. DATE APPROVED: August 18, 2016	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2016		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Alan Freund		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 rate was set as of January 1, 2016 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).

TN: 16-016

Supersedes:

TN: 15-006

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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 rate was set as of January 1, 2016 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.

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 rate was set as of January 1, 2016 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 rate was set as of on January 1, 2016, 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.

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.

- c. Chiropractors' services.

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 Department's fee schedule.

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

The agency's chiropractors' services fee schedule rate was set as of January 1, 2016, 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.

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Supersedes:

TN: 13-019

Approval Date: 8/18/16

Effective Date: 01/01/2016

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 rate was set as of January 1, 2016 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.

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:

TN: 16-016

Supersedes:

TN: 15-006

Approval Date: 8/18/16

Effective Date: 01/01/2016

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 rate was set as of January 1, 2106 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.

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.

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Effective Date: 01/01/2016

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 rate was set as of January 1, 2016 and is effective for services provided on or after that date. The agency's diabetic testing and injection supplies fee schedule rate (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.

TN: 16-016

Supersedes:

TN: 15-006

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Effective Date: 01/01/2016

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 rate was set as January 1, 2016 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.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, continued.

c. Prosthetic devices.

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 fee schedule. Where no Medicaid maximum is specified, the provider must submit either the list price or the invoice price. The Medicaid agency will pay 72 per cent of the list price or 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 prosthetic devices fee schedule rate was set as of January 1, 2016, 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.

TN: 16-016

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Effective Date: 01/01/2016

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 rate was set as of January 1, 2016 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 rate was set as of January 1, 2016 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 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.