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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 17-005

This file contains the following documents in the order listed:

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

June 7, 2017

Barbara R. Sears, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: State Plan Amendment Transmittal Number 17-005

Dear Ms. Sears:

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

Transmittal #17-005
- Coverage & Limitations and Payment for Services: Physicians' Services
- Effective Date: January 1, 2017
- Approval Date: June 7, 2017

If you have any questions regarding this State Plan Amendment, 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: **17-005 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 **January 1, 2017**	

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:
42 CFR 440.50	a. FFY 2017 $ 1,630 thousands b. FFY 2018 $ 2,173 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, page 2 Attachment 3.1-A, Item 5-a, p 1 of 1	Attachment 3.1-A, page 2 (TN 11-013) Attachment 3.1-A, Item 5-a pp 1 and 2 of 3 (TN 12-005) Attachment 3.1-A, Item 5-a p 3 of 3 (TN 11-009)
Attachment 4.19-B, Item 5-a, pp 1 through 3 of 3	Attachment 4.19-B, Item 5-a, pp 1 and 7 of 7 (TN 16-016) Attachment 4.19-B, Item 5-a, p 2 of 7 (TN 14-008) Attachment 4.19-B, Item 5-a, p 3 of 7 (TN 13-005) Attachment 4.19-B, Item 5-a, pp 4,5,6 of 7 (TN 09-035)

10. SUBJECT OF AMENDMENT: Coverage and Limitations and Payment for Services: Physicians' Services: HCPCS update, OTP code adjustment, multiple birth

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: **BARBARA R. SEARS**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: March 9, 2017	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 9, 2017	18. DATE APPROVED: June 7, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Alan Freund	22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

State/Territory: Ohio

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ☐ No limitations ☑ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. (i) Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Attachment 2.2-A, B, if this eligibility option is elected by the State.

Provided: ☐ No limitations ☑ With limitations*

(ii) Family planning-related services provided under the above State Eligibility Option.

d. Tobacco cessation counseling services for pregnant women (as defined in 1905(bb) of the Social Security Act)

Provided: ☑ No limitations ☐ With limitations*

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

Provided: ☑ No limitations ☐ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a)(5)(B) of the Act).

Provided: ☐ No limitations ☑ With limitations*

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.

☑ Provided: ☐ No limitations ☑ With limitations*

☐ Not provided.

*Description provided on attachment.

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

Physicians' services are covered by Ohio Medicaid in accordance with 42 CFR 440.50.

Services determined by the agency not to be medically necessary will not be covered.

In certain circumstances, the State might use prior authorization to determine medical necessity.

Services furnished by an optometrist within an optometrist's scope of practice are considered to be physicians' services under this plan.

Optometrists' services furnished to a resident of a long-term care facility must be requested in writing by the resident or the resident's authorized representative.

Recipients younger than age twenty-one can access physicians' services without limitation when such services are medically necessary.

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

Unless otherwise specified, the maximum payment amount for a physicians' service is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

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 listed on the agency's MSRIAP fee schedule is set at 80% of the Medicare allowed amount.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

For dates of service on or after January 1, 2017, payment for anesthesia services furnished by an anesthesiologist is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by the following formula:

Maximum payment amount =
(Base unit value + Time unit value) x Conversion factor x Multiplier

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. Effective for dates of service on or after January 1, 2017, the conversion factor and multiplier are listed on the agency's Anesthesia fee schedule at http://medicaid.ohio.gov/ProvidersFee ScheduleandRates.aspx.

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

Optometrists' services

Optometrists' services are subject to a co-payment, explained in Attachment 4.18-A of the plan.

The agency's rates for dispensing of ophthalmic materials such as contact lenses, low vision aids, etc. are on the vision care fee schedule published on the agency's website at http://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx. These rates were set as of May 1, 2016, and are effective for services provided on or after that date.

Specific physician groups

The maximum payment amount for a service is the lesser of the submitted charge or 140% of the Medicaid maximum listed on the agency's MSRIAP fee schedule if the provider is a physician group that (1) contracts with a hospital to provide physician hospital clinic services in the physician group practice setting and (2) provides 40% of the Medicaid physician visits in the county of location and 10% of the visits in contiguous counties.

The agency's physicians' rates found on the MSRIAP fee schedule were set as of January 1, 2017, and are 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.

The agency's MSRIAP fee schedule is published on the agency's website at http://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

Supplemental Upper Payment Limits for Physicians Employed by The Ohio State University's Academic Medical Centers

Supplemental payments to employees of The Ohio State University's academic medical centers are made for physician services, as defined in 42 C.F.R. 440.50, in the form of payments up to a defined cap. For dates of service 4/1/2014 to 12/31/2014, primary care services as defined in section 1202 of the Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), 42 USC 1396a, are not eligible for the supplemental payments. The supplemental payments are made only to physicians employed by The Ohio State University's academic medical centers. These payments will be made no earlier than the end of the quarter following the quarter of service. Payments may be adjusted up to 12 months after the end of the quarter of service in order to account for claims submission lag. The supplemental payments exclude payments from vaccine administration codes. Anesthesiology codes payments are sometimes split between a physician and a Certified Registered Nurse Anesthesiologist (CRNA), therefore all anesthesiology codes will be combined and payments are estimated by using the reduced rate to be conservative.

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

The supplemental payments and their payment cap are determined with the following methodology:

1. The supplemental payment cap is the average commercial rate for the top five third-party commercial payers within the accounts receivable system(s) of the Ohio State University's academic medical center. The average commercial rate will be updated on an annual basis;

2. The base fee-for-service rate is compared to the supplemental payment cap;

3. The difference between the base fee-for-service rate and the supplemental payment cap is the available supplemental upper payment limit gap.

4. Supplemental payments are made to physicians up to the payment cap for a given year.