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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 17-010

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 15, 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 17-010

Dear Ms. Sears:

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

Transmittal #17-010
- Coverage & Limitations and Payment for Services: Non-Institutional Fee Schedule Updates; Advanced Imaging Multiple Procedure Reduction; Removal of Scope of Practice Limitations
- Effective Date: January 1, 2017
- Approval Date: June 15, 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 FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **17-010**	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 **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 Part 447	a. FFY 2017 $31.25 thousands b. FFY 2018 $41.7 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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 7	Attachment 3.1-A, page 7 (TN 95-16)
Attachment 3.1-A, page 8a	Attachment 3.1-A, page 8a (TN 12-003)
	Attachment 3.1-A, Item 17 pages 1 and 2 of 2 (TN 12-019)
	Attachment 3.1-A, Item 23 pages 1 and 2 of 2 (TN 12-019)
Attachment 4.19-B, Item 3 page 1 of 1	Attachment 4.19-B, Item 3 page 1 of 1 (TN 16-019)
Attachment 4.19-B, Item 6-a page 1 of 2	Attachment 4.19-B, Item 6-a page 1 of 2 (TN 16-016)
Attachment 4.19-B, Item 9-a page 1 of 1	Attachment 4.19-B, Item 9-a page 1 of 1 (TN 16-016)
Attachment 4.19-B, Item 11-a page 1 of 1	Attachment 4.19-B, Item 11-a page 1 of 1 (TN 14-024)
Attachment 4.19-B, Item 11-b page 1 of 1	Attachment 4.19-B, Item 11-b page 1 of 1 (TN 14-018)
Attachment 4.19-B, Item 11-c page 1 of 1	Attachment 4.19-B, Item 11-c page 1 of 1 (TN 14-018)
Attachment 4.19-B, Item 12-c page 1 of 1	Attachment 4.19-B, Item 12-c page 1 of 1 (TN 16-016)
Attachment 4.19-B, Item 17 pages 1 and 2 of 2	Attachment 4.19-B, Item 17 page 1 of 3 (TN 16-016)
	Attachment 4.19-B, Item 17 pages 2 of 3 (TN 12-005)
	Attachment 4.19-B, Item 17 pages 3 of 3 (TN 09-035)
Attachment 4.19-B, Item 23 pages 1 and 2 of 2	Attachment 4.19-B, Item 23 page 1 of 3 (TN 16-016)
	Attachment 4.19-B, Item 23 pages 2 of 3 (TN 12-005)
	Attachment 4.19-B, Item 23 pages 3 of 3 (TN 09-035)

10. SUBJECT OF AMENDMENT: Coverage and Limitations and Payment for Services: Non-Institutional Payment Schedule Updates, Advanced Imaging Multiple Procedure Payment Reduction Change, Removal of Scope-of-Practice Limitations

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 21, 2017	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 21, 2017	18. DATE APPROVED: June 15, 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)

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

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided

*Description provided on attachment.

State/Territory: Ohio

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

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided

23. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided

*Description provided on attachment.

3. Other laboratory and x-ray services.

Other laboratory and x-ray services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.30.

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, **that is not to exceed the Medicare rate on a per-test basis**. The Medicaid maximum for other laboratory services is the amount listed on the Department's laboratory services fee schedule. The Medicaid maximum for x-ray services is the amount listed on the Department's 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 95%. This payment provision takes effect on January 1, 2017.

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

The agency's laboratory services fee schedule was set as of January 1, 2017 and is effective for services provided on or after that date. The agency's x-ray services fee schedule was set as of January 1, 2017 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 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).

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, 2017, 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.

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, 2017 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 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.

11. Physical therapy and related services.

a. Physical therapy.

Physical therapy services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for physical therapy services provided by outpatient hospitals, physicians, limited practitioners, and clinics 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.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision takes effect on January 1, 2014.

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

The agency's physical therapy fee schedule rate was set as of January 1, 2017 and is effective for services provided on or after that date.

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

Payment for physical therapy services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG-exempt.

Payment for physical therapy services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

For residents of nursing facilities (NFs), physical therapy services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for physical therapy services provided to residents of NFs is included in the facility per diem.

11. Physical therapy and related services, continued.

b. Occupational therapy.

Occupational therapy services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for occupational therapy services provided by outpatient hospitals, physicians, limited practitioners, and clinics 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.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision takes effect on January 1, 2014.

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

The agency's occupational therapy fee schedule rate was set as of January 1, 2017 and is effective for services provided on or after that date.

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

Payment for occupational therapy services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for occupational therapy services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

For residents of nursing facilities (NFs), occupational therapy services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for occupational therapy services provided to residents of NFs is included in the facility per diem.

11. Physical therapy and related services, continued.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Speech-language pathology and audiology (SLPA) services are covered as hospital, home health agency, physician, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (7), and (9) for reimbursement provisions.

Payment for speech-language pathology and audiology (SLPA) services provided by outpatient hospitals, physicians, limited practitioners, and clinics 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.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision takes effect on January 1, 2014.

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

The agency's speech, hearing, and language disorders services fee schedule rate was set as of January 1, 2017 and is effective for services provided on or after that date.

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

Payment for SLPA services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for SLPA services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

For residents of nursing facilities (NFs), SLPA services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for SLPA services provided to residents of NFs is included in the facility per diem.

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, 2017, 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.

17. Nurse-midwife services.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse-midwife (CNM) in a non-hospital setting 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; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNM will be made to the hospital.

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.

17. Nurse-midwife services, continued.

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 nurse-midwife services rates can be found on the MSRIAP fee schedule published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's nurse-midwife services rates found on the MSRIAP fee schedule was set as of January 1, 2017, 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.

23. Certified pediatric and family nurse practitioners' services.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse practitioner (CNP) in a non-hospital setting 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; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNP will be made to the hospital.

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.

23. Certified pediatric and family nurse practitioners' services, continued.

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 certified pediatric and family nurse practitioners' services rates can be found on the MSRIAP fee schedule published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's certified pediatric and family nurse practitioners' services rates found on the MSRIAP fee schedule was set as of January 1, 2017 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.