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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 17-032

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

December 14, 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 17-032

Dear Ms. Sears:

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

Transmittal #17-032
- Payment for Services: Outpatient Hospital
- Effective Date: August 1, 2017
- Approval Date: December 14, 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/

Ruth A. Hughes
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 – 032 Revised**	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 **August 01, 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: 42 CFR Part 447, Subpart F	7. FEDERAL BUDGET IMPACT: a. FFY 2017 $ 5,200 thousands b. FFY 2018 $ 31,200 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 2-a, Page 1 of 1 Attachment 4.19-B, Item 2-a, Pages 1-1 to 1-7	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, Item 2-a, Page 1 of 1 (TN 15-004) Attachment 4.19-B, Item 2-a, Page 1 of 8 (TN 17-009) Attachment 4.19-B, Item 2-a, Page 2 of 8 (TN 13-004)

10. SUBJECT OF AMENDMENT: Outpatient Hospital Services Reimbursement Methodology

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: September 27, 2017	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 27, 2017	18. DATE APPROVED: December 14, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Associate Regional Administrator

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

2. a. Outpatient hospital services.

Outpatient services are provided pursuant to 42 CFR 440.20 and those professional services provided to a patient at a hospital facility which meets Medicare conditions of participation. Outpatient services include services provided to a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission. Services included under this benefit also include urgent care and behavioral health services provided in outpatient provider-based settings.

Medicaid does not cover, as an outpatient service, those physicians' services furnished to individual patients. In determining whether services are covered as a physician service or a hospital service, Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

Items and services that are not medically necessary or are provided in a medically unnecessary place of service are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; services of an experimental nature; and dental procedures which can be performed in the dentist's office or other non-hospital setting.

A limited number of services are covered under the Ohio Medicaid program upon the provider obtaining prior authorization from the Ohio Medicaid agency or its designee. Limits on number or duration of services are not placed on beneficiaries aged 21 and younger when medically necessary.

2. a. Outpatient Hospital Services

Outpatient hospital services are covered by Ohio Medicaid in accordance with 42 CFR 440.20. Except as noted below, all hospital services provided by Medicaid providers of outpatient hospital services are reimbursed under an Enhanced Ambulatory Patient Grouping (EAPG) system based prospective payment system (PPS).

I. Outpatient Hospital Services

(A) Eligible Provider

All hospitals described in Attachment 4.19-A, section I(A) are eligible to provide outpatient hospital services.

(B) Classification of Hospitals

Hospital peer groups are for the purposes of setting rates and making payments under EAPG or PPS. The classification of hospitals and peer groups established in Attachment 4.19-A, section I(B) shall also apply for the provision of outpatient hospital services.

(C) Hospital Services Subject to Non-EAPG Prospective Payment

Effective for dates of service on or after August 1, 2017, hospital services subject to non-EAPG prospective payment, providers are paid by applying a percentage of the hospital's ratio of cost to allowed charges. Cost-to-charge ratio is derived from the Medicaid outpatient costs as reported on ODM 02930, schedule H, section II divided by Medicaid outpatient charges as reported on ODM 02930, schedule H, section II. The cost report used to complete these calculations is the interim settled cost report ending in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January first of the calendar year to which the new ratio shall apply.

Billing must reflect the hospital's customary charge for the service rendered. Payment is made for those items and services recognized as reasonable and allowable under Title XVIII standards and principles. Hospital services subject to non-EAPG prospective payment include:

(1) Freestanding rehabilitation hospitals and long-term acute care hospitals as described in Attachment 4.19-A, section I(B), shall be reimbursed at 90% of the cost-to-charge ratio described in this paragraph .

(2) Hospitals that are excluded from Medicare's PPS as described in Attachment 4.19-A, section I(B), shall be reimbursed at 90% of the cost-to-charge ratio described in this paragraph.

(3)Hospitals recognized by Medicare as cancer hospitals as described in Attachment 4.19- A, section I(B), shall be reimbursed at 91.7% of the cost-to-charge ratio described in this paragraph.

(D) Outpatient Hospital Services Subject to EAPG Prospective Payment

Effective for dates of service on or after August 1, 2017, payment for outpatient hospital services provided in hospitals other than those described in subsection (C) of this section will be subject to a prospective payment methodology utilizing the EAPG system developed and maintained by 3M Health Information Systems.

The EAPG system groups and reimburses outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of International Classification of Diseases diagnosis codes, current procedural terminology (CPT) code set and healthcare common procedure coding system (HCPCS) procedure codes.

The facility payment for all hospital level outpatient services will be determined using EAPG. This includes but is not limited to surgery, radiology, laboratory, occupational therapy, physical therapy, speech, audiology and language services. Select services such as pharmacy, dental, durable medical equipment and observation may be grouped under EAPG but paid from a fee schedule or a flat rate as described in subsection (I) of this section.

(E) EAPG Payment Formula

The EAPG system may apply the following discounting factors for multiple significant procedures and/or repeated ancillary services. Ancillary services are diagnostic or therapeutic services provided as prescribed by a healthcare professional.

(1) Full payment of the EAPG payment with no applicable discounting factor.

(2) Consolidation factor of 0% applicable for services designated with a same procedure consolidation flag or clinical procedure consolidation flag by the EAPG grouper under default EAPG settings.

(3) Packaging factor of 0% applicable for services designated with a packaging flag by the EAPG grouper under default EAPG settings.

(4) Discounting factor of 50% or 100% applicable for multiple significant procedures and/or repeated ancillary services designated by default EAPG settings. For bilateral surgeries, the discounting factor is 150%. The appropriate percentage will be applied to the highest weighted of the multiple procedures or ancillary payment group.

The EAPG payment calculation is the hospital specific base rate adjusted for risk corridor, multiplied by the EAPG relative weight for which the service was assigned by the EAPG grouper, round the product to the nearest whole cent, multiplied by any applicable discounting factor (full payment, consolidation, or packaging), rounded to the nearest whole cent.

Laboratory services billed with valid CPT/HCPCS code(s) shall be reimbursed the lesser of charges or the assigned EAPG payment. Payment for all laboratory services will be no more than the Medicare fee schedule amount.

Radiology services billed with valid CPT/HCPCS code(s) shall be reimbursed the lesser of charges or the assigned EAPG payment.

(F) Sources for Inputs in the Payment Formula

The dataset used as inputs in the payment formula and determination of relative weights established for dates of service on or after August 1, 2017 consists of:

(1) All outpatient hospital claims with dates of service from January 1, 2012 through December 31, 2014;

(2) Cost reports submitted by Ohio hospitals to the State on its Medicaid cost report for the hospital years that end in state fiscal years 2012, 2013, 2014 and 2015.

(3) Inflation factors are computed for Ohio by Global Insight, which computes similar factors for the Medicare program. The inflation factors were used to inflate the total cost computed for each case inflating it to June 30, 2017.

(G) Computation of Case Mix Adjust Average Cost Per Case (Base Rate)

(1) For each Ohio peer group, sum the total inflated cost for all cases; divided by

(2) The number of cases assigned to each peer group; and multiply the result by a budget neutrality factor of 71.9%.

(3) For each Ohio peer group, sum the relative weight values for all cases assigned to the peer group; divided by

(4) The number of cases in the peer group.

(5) Multiply the amount in subsection (G)(2) by the quotient of subsection (G)(3) and subsection (G)(4) of this section.

(6) For non-Ohio peer groups, the peer group base rate is 70% of the statewide average.

(7) Peer group risk corridors.

Effective for dates of service on or after August 1, 2017, the following will apply to Ohio hospital peer groups:

(a) The peer group base rate calculated in subsection (F) of this section if the peer group base rate does not result in more than a 0% reduction or 5% gain in payments compared to the prospective payment system in effect prior to August 1, 2017; or

(b) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a 0% reduction or 5% gain in payments compared to the prior prospective payment system.

(H) Computation of Relative Weights

The relative weight is equal to:

(1) The average inflated cost per case within each EAPG; divided by

(2) The average inflated cost per case across all EAPGs.

(I) Items which may be paid outside of EAPG

(1) Select items may follow the payment methodology listed in subsection (I)(1) of this section.

(a) Pharmaceuticals.

(i) For services rendered on or after August 1, 2017, reimbursement for outpatient hospital pharmaceuticals shall be the lesser of charges or the payment amounts in the provider-administered pharmaceutical fee schedule as published on the department's website, http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

(ii) Additional payments for pharmaceuticals will be made in accordance with the discounting factors as determined by the EAPG grouper.

(iii) Pharmaceutical line items without a National Drug Code will be denied payment by the State.

(b) Durable medical equipment (DME).

(i) Payments for DME may be made for all line items grouping to DME EAPG codes.

(ii) For services rendered on or after August 1, 2017, reimbursement for outpatient hospital DME shall be the lesser of charges or the payment amounts in the Medicaid durable medical equipment fee schedule as published on the department's website, http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

(iii) Payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.

(c) Independently billed services for drugs or medical supplies and devices.

(i) To request independently billed payment under EAPG, hospitals must report all services provided on the date of service; and

(ii) Report modifier UB with the primary procedure performed. Claims submitted with modifier UB are subject to the following payment methodology:

(1) Charges listed in line items that carry revenue center codes 025X and/or 0636 with a provider administered HCPCS J-code or Q-code will pay in accordance to the provider-administered pharmaceutical fee schedule.

(2) Charges listed in line items that carry revenue center code 025X without a provider-administered pharmaceutical CPT/HCPCS code or revenue center code 027X with or without a DME HCPCS code will be multiplied by 60% of the hospital specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(3) Charges listed in line items that carry revenue center code 025X and/or 0636 with a provider-administered pharmaceutical HCPCS J-code, except J-code J0714, that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will be multiplied by 60% of the hospital's specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(iii) Charges listed in line items that carry revenue center code 025X and/or 0636 with a non-pharmaceutical HCPCS Q-code not listed on the provider-administered pharmaceutical fee schedule will be denied payment by the State.

(iv) All other detail lines on the same date of service will be paid $0.

(d) Dental services.

For dates of service during the interim period, reimbursement for claims assigned to dental service EAPG will be paid as follows:

(i) Children's hospitals, as defined in subsection (B) of this section, will be paid $1,062.

(ii) All other hospitals will be paid $1,192.

(iii) Payments shall be multiplied by any applicable discounting factor.

(e) Vaccines for children (VFC).

(i) The administration of immunizations covered under the VFC program may be reimbursed for recipients 18 years or younger.

(ii) Reimbursement for the administration of immunizations covered under the VFC program will be ten dollars for individuals eighteen years of age or younger, contingent

upon the EAPG grouper. However, no payment will be made for vaccines that can be obtained at no cost through the federal VFC program.

(iii) Additional payments for designated free vaccines will be made in accordance with the discounting factors as determined by the EAPG grouper.

(f) Observation services.

(i) For dates of service during the interim period: payment for observation HCPCS code G0378 will be made using an average rate.

(ii) Payments for observation services grouped to observation EAPG code, will be limited to one unit per day, and a maximum of two consecutive days, except as provided in subsection (I)(1)(f)(iii) of this section.

(iii) Payments for observation services reported with HCPCS code G0378 will be made for up to 24 units per day or 48 consecutive units (which could extend over a three-day period).

(iv) Additional payment for observation services will be made in accordance with the discounting factors as determined by the EAPG grouper.

(g) Outpatient Hospital Services

Outpatient Hospital Services are subject to a co-payment as referenced in Attachment 4.18-A of the State plan.

(2) Additional items paid outside of EAPG.

Behavioral health (BH) services.

(a) All hospitals that meet the Medicare conditions of participation, have accreditation by national accrediting body and have accreditation for the BH services they provide, may provide outpatient BH services.

(b) Each hospital claim for BH services must contain the following:

(i) HE modifier at the detail level for each BH CPT/HCPCS code;

(ii) Revenue center code 0671, 0900, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919 or 1002 for each BH detail line; and

(iii) A BH diagnosis code,

(c) For services rendered on or after August 1, 2017, payments for BH services will be paid in accordance with the outpatient hospital behavioral health fee schedule as published on the department's website, http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.