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State/Territory Name: OH

State Plan Amendment (SPA) #: 18-020

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

December 11, 2018

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

RE: Ohio State Plan Amendment (SPA) 18-0020

Dear Ms. Sears:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-0020. Effective September 22, 2018, this State Plan Amendment updates Nursing Facility Services.

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 18-020 is approved effective September 22, 2018. We are enclosing the CMS-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

3TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **18-020 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 **September 22, 2018**	

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: Section 1905(a)(4)(A) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2018 $ 0 thousands b. FFY 2019 $ 0 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMEN **Attachment 4.19-D Supplement 1:** Section 001.5, Pages 1-2 of 2 Section 001.17, Pages 1-2 of 2 Section 001.18, Pages 1-2 of 2 Section 001.20.1, Page 1 of 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D Supplement 1:** Section 001.5, Page 1 of 2 (TN 16-013) Section 001.5, Page 2 of 2 (TN 13-021) Section 001.17, Pages 1-2 of 2 (TN 16-021) Section 001.18, Pages 1-2 of 2 (TN 16-021) Section 001.20.1, Page 1 of 1 (TN 17-004)

10. SUBJECT OF AMENDMENT: Payment for Services: Nursing Facility Services – Peer Groups, Quality, New Facility

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: **Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **BARBARA R. SEARS**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: September 25, 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: DEC 11 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP 22 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

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 with fewer than 100 beds 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.

Ancillary and Support and Capital – Calculating Rates

Six peer groups are used to assign price components for ancillary and support and capital when calculating 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.

Peer Group 3 consists of facilities with fewer than 100 beds located in 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, Union and Wood counties. Peer Group 4 consists of facilities in those counties with 100 or more beds.

Peer Group 5 consists of facilities with fewer than 100 beds located in Adams, Allen, 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, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties. Peer Group 6 consists of facilities in those counties with 100 or more beds.

Quality Indicators and Quality Payment Rate

Quality Indicators

Department of Medicaid determines the per Medicaid day quality payment rate for nursing facilities based on the number of quality points nursing facilities earn for meeting various quality indicators.

The Department of Medicaid will use data from the following measurement periods to determine quality points:

1) For state fiscal year 2017, the period beginning July 1, 2015 and ending December 31, 2015.
2) For each subsequent state fiscal year, the calendar year immediately preceding the calendar year in which the state fiscal year begins.

A nursing facility may earn a maximum of one point for each of the following quality indicators during the measurement period. For the pressure ulcer quality indicator and the antipsychotic medication quality indicator, nursing facilities may earn a maximum of one point each for rates for short-stay residents and a maximum of one point each for rates for long-stay residents. Based on the number of quality indicator points earned, the Department of Medicaid will calculate a per Medicaid day quality payment rate for each nursing facility. To earn a point for each of the quality indicators, the nursing facility shall meet the following criteria.

1) Pressure Injuries

Score no more than the 40th percentile for pressure injury rates. The Department of Medicaid obtains pressure injury rates from the Centers for Medicare and Medicaid Services (CMS) website using the CMS quality measure for short-stay residents who have a new or worsened pressure ulcer, and the CMS quality measure for long-stay residents with pressure ulcers. If a nursing facility has insufficient data to calculate a pressure injury rate, the facility shall not receive a quality point for this indicator.

2) Antipsychotic Medications

Score no more than the 40th percentile, as established by ODM, for antipsychotic medication use rates. If a nursing facility has insufficient data to calculate an antipsychotic medication use rate, the facility shall not receive a quality point for this indicator. The antipsychotic medication use rates shall not include short-stay nursing facility residents who newly received an antipsychotic medication in conjunction with hospice care, or long-stay nursing facility residents who received an antipsychotic medication in conjunction with hospice care.

3) Unplanned Weight Loss

Score no more than the 40th percentile of the long-stay nursing facility residents' unplanned weight loss rate. The Department of Medicaid obtains the unplanned weight loss rate from the CMS website using the CMS quality measure for long-stay residents who lose too much weight.

4) Employee Retention

Attain an employee retention target rate of at least the 75th percentile. The Department of Medicaid calculates the percentile using the employee retention rates from section eight of all Medicaid nursing facility annual cost reports. If a nursing facility enters a NO"

response or does not provide a response in the employee retention portion of section eight of the Medicaid nursing facility annual cost report, the facility shall not receive a quality point for this indicator.

5) *Preferences for Everyday Living Inventory (PELI)*
Utilize the nursing home version of the PELI for all of its residents, and indicate in section eight of the nursing facility's annual cost report that it was used. If a nursing facility enters a "NO" response or does not provide a response in the PELI portion of section eight of the Medicaid nursing facility annual cost report, the facility shall not receive a quality point for this indicator.

Religious nonmedical health care institutions (RNHCIs) shall receive one point each for the pressure injury, antipsychotic medication, and unplanned weight loss quality indicators.

Calculation of the Quality Payment Rate

For state fiscal year 2017 and each fiscal year thereafter, the Ohio Department of Medicaid shall calculate the per Medicaid day quality payment rate for each nursing facility as follows:

1) Determine the number of inpatient Medicaid days reported by each nursing facility on the Medicaid nursing facility annual cost report for the calendar year preceding the fiscal year in which the quality payment will be paid.
2) Determine the total number of inpatient Medicaid days reported by all nursing facilities on the Medicaid nursing facility annual cost report for the calendar year preceding the fiscal year in which the quality payment will be paid.
3) Determine the number of quality points earned by each nursing facility during the applicable measurement period as specified in section 001.17 of Attachment 4.19-D, Supplement 1.
4) For each nursing facility, multiply the number of inpatient Medicaid days as determined in paragraph 1) above for the nursing facility by the number of quality points earned by the nursing facility as determined in paragraph 3) above. This product is the point days earned by each nursing facility.
5) Determine the total number of point days for all nursing facilities.
6) Multiply $1.79 by the total number of Medicaid days delivered by all nursing facilities as determined in paragraph 2) above. This product is the total amount of quality funds to be paid to nursing facilities by the Ohio Department of Medicaid in the applicable fiscal year.
7) Divide the total amount of quality funds to be paid as calculated in paragraph 6) above by the total number of point days for all nursing facilities as determined in paragraph 5) above.
8) Multiply the amount calculated in accordance with paragraph 7) above by the quality points earned by each nursing facility as determined in paragraph 3) above. This product is the per Medicaid day quality payment for each nursing facility.

The largest per Medicaid day quality payment for a fiscal year shall be paid to nursing facilities that meet all of the quality indicators for the measurement period.

If a nursing facility undergoes a change of operator during a state fiscal year, the per Medicaid day quality payment rate to be paid to the entering operator for nursing facility services that the nursing facility provides during the period beginning on the effective date of the change of operator and ending on the last day of the state fiscal year shall be the same amount as the per Medicaid day quality payment rate that was in effect on the day immediately preceding the effective date of the change of operator and paid to the nursing facility's exiting operator. For the immediately following state fiscal year, the per Medicaid day quality payment rate shall be as follows:

1) If the effective date of the change of operator is on or before the first day of October of the calendar year immediately preceding the state fiscal year, the amount determined for the nursing facility in accordance with section 001.18 of Attachment 4.19-D, Supplement 1 for the state fiscal year.

2) If the effective date of the change of operator is after the first day of October of the calendar year immediately preceding the state fiscal year, the mean per Medicaid day quality payment rate for all nursing facilities for the state fiscal year.

Nursing facility providers may request a rate reconsideration on the basis of a possible error in the calculation of the per Medicaid day quality payment rate.

New Facility

The initial rate for a facility with a first date of licensure or Medicaid certification on or after July 1, 2006, including a facility that replaces one or more existing facilities shall be calculated as follows:

1) The direct care rate component equals the product of the direct care price determined for the facility's peer group and the facility's case mix score.
   a) If the nursing facility replaces an existing facility that participated in the Medicaid program immediately prior to the first day the new facility begins to participate in the Medicaid program, the case mix score is the semiannual case mix score most recently determined for the facility being replaced, adjusted for any difference in the number of beds between the new facility and the facility being replaced.
   b) For all other new facilities, the case mix score shall be the median annual average case-mix score for the facility's peer group.
2) The ancillary and support rate component equals the ancillary and support price determined for the facility's peer group.
3) The capital cost rate component equals the capital price determined for the facility's peer group.
4) The tax rate component equals the amount determined by dividing a facility's projected tax costs by the number of inpatient days the facility would have for the calendar year in which it obtains an initial provider agreement if its occupancy rate were 100%. If a new facility does not submit the documentation required to support its projected tax costs, or if the Department of Medicaid determines the documentation to be unsatisfactory, the tax rate component equals the median tax rate component for the facility's ancillary and support peer group.
5) The quality incentive payment equals the mean quality incentive payment made to nursing facilities.