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State/Territory Name: OH

State Plan Amendment (SPA) #: 18-027

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

January 10, 2019

James Tassie, Acting Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: Ohio State Plan Amendment (SPA) 18-027

Dear Mr. Tassie:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-027. Effective November 1, 2018, this State Plan Amendment removes the Nursing Facility cost report and chart of accounts from the State Plan.

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 18-027 is approved effective November 1, 2018. We are enclosing the HCFA-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,

Kristin Fan,
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **18-027**

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 **November 1, 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
Section 1902(a)(30)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 $0 thousands
b. FFY 2020 $0 thousands

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Supplement 1
Section 001.17, Pages 1-2 of 2
Section 001.27, page 1 of 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, Supplement 1
Section 001.17, Pages 1-2 of 2 (TN 18-020)
Section 001.27, page 1 of 2 (TN 17-003)
Section 001.27 Appendix A, Pages 1-61 of 61 (TN 18-003) Delete
Section 001.28, page 1 of 1 (TN 17-003) Delete
Section 001.28 Appendix A, Pages 1-51 of 51 (TN 18-003) Delete

10. SUBJECT OF AMENDMENT: Payment for Services: Nursing Facility Services – Removal of Cost Report and Chart of Accounts

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]

13. TYPED NAME: **BARBARA R. SEARS**

14. TITLE: **STATE MEDICAID DIRECTOR**

15. DATE SUBMITTED: November 7, 2018

16. RETURN TO:

Carolyn Humphrey
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN 10 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/01/18 NOV 01 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)

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 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 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 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 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.

Cost Reports

Cost Report Filing
Nursing facilities shall file annual Medicaid cost reports not later than 90 days after the end of the calendar year using software that is available on the Department of Medicaid's website at https://medicaid.ohio.gov/Provider/ProviderTypes/LongTermCareFacilities/AutomatedCostReporting at least 60 days before the due date of the cost report for each cost reporting period via the Medicaid information technology system (MITS) web portal or other electronic means designated by the Department.

The cost reports shall cover a calendar year or portion of a calendar year during which the nursing facility participated in the Medicaid program.

1) In the case of a nursing facility that has a change of operator during a calendar year, the cost report by the new provider shall cover the portion of the calendar year following the change of operator encompassed by the first day of participation up to and including December 31st.
2) In the case of a new nursing facility with an initial provider agreement that goes into effect after October 1st, the provider shall file the first cost report for the immediately following calendar year.
3) In the case of a nursing facility that begins participation after January 1st and ceases participation before December 31st of the same calendar year, the reporting period shall be the first day of participation to the last day of participation.
4) In the case of a state-operated nursing facility, the annual cost report shall cover the 12-month period ending June 30th of the preceding year, or portion thereof, if Medicaid participation was less than 12 months.

The minimum level of detail to be included in the Medicaid nursing facility cost report shall be established using a chart of accounts. A chart of accounts is a numbered list of accounts that categorizes each class of nursing facility costs for which money is spent. The accounts include the four main cost centers: ancillary costs, capital costs, direct care costs and tax costs.

Filing Extensions
A nursing facility may submit a cost report within 14 days after the original due date if the facility receives written approval from the Department prior to the original due date of the cost report. Extension requests must be in writing and explain the need for an extension. If a nursing facility does not submit the cost report within fourteen days after the original due date or by an approved extension due date, or if the nursing facility submits an incomplete or inadequate cost report, the Department shall provide immediate written notice to the facility that its provider agreement will be terminated in 30 days unless the facility submits a complete and adequate cost report within 30 days of receiving the notice.

Late File Penalty
If a cost report is not received by the original due date or by an approved extension due date, the Department may assess a late file penalty of $2.00 for each day a complete and adequate cost report is not received beginning on the day after the original due date or the day after the extension due date, whichever is applicable, and shall continue until the complete and adequate cost report is received or the nursing facility is terminated from the Medicaid program. The late file penalty shall