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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 19-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

March 26, 2019

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: State Plan Amendment Transmittal Number 19-004

Dear Ms. Corcoran:

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

Transmittal #19-004
- Payment for Services: Non-Institutional Payment Schedule Updates
- Effective Date: January 1, 2019
- Approval Date: March 26, 2019

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/

Celestine Curry
Acting Deputy Director
Centers for Medicaid & CHIP Services
Regional Operations Group

Enclosure

cc: 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: **19-004**	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 01, 2019**	

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:
Sections 1905(a)(3), (5), (6), (7), (9), (10), (11), (12), (13), (17), (21) and (28) of the Social Security Act; 42 CFR 440.30, 440.50, 440.60, 440.70, 440.90, 440.100, 440.110, 440.120, 440.130, 440.165, and 440.166	a. FFY 2019 $ (751 thousands) b. FFY 2020 $ (1,000 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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:	**Attachment 3.1-A:**
Item 6-d-6, Page 1 of 1	Item 6-d-6, Page 1 of 1 (TN 17-002)
Attachment 4.19-B:	**Attachment 4.19-B:**
Item 3, Page 1 of 1	Item 3, Page 1 of 1 (TN 18-008)
Item 5-a, Page 2	Item 5-a, Page 2 of 3 (TN 17-016)
Item 6-a, Page 1 of 2	Item 6-a, Page 1 of 2 (TN 18-007)
Item 6-a, Page 2 of 2	Item 6-a, Page 2 of 2 (TN 13-036)
Item 6-d-(2), Page 1 of 2	Item 6-d-(2), Page 1 of 2 (TN 17-044)
Item 6-d-(5), Page 1	Item 6-d-(5), Page 1 (TN 17-016)
Item 6-d-(6), Page 2 of 2	Item 6-d-(6), Page 2 of 2 (TN 17-002)
Item 7-c, Page 1 of 2	Item 7-c, Page 1 of 2 (TN 18-017)
Item 9-a, Page 2 of 2	Item 9-a, Page 2 of 2 (TN 18-001)
Item 10, Page 1 of 2	Item 10, Page 1 of 2 (TN 18-012)
Item 11-a, Page 1 of 1	Item 11-a, Page 1 of 1 (TN 18-007)
Item 11-b, Page 1 of 1	Item 11-b, Page 1 of 1 (TN 18-007)
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Item 12-b, Page 1 of 1	Item 12-b, Page 1 of 1 (TN 13-019)
Item 12-c, Page 1 of 1	Item 12-c, Page 1 of 1 (TN 18-017)
Item 13-d-(1), Page 1 of 2	Item 13-d-(1), Page 1 of 2 (TN 17-008)
Item 13-d-(2), Page 2 of 2	Item 13-d-(2), Page 2 of 2 (TN 17-013)
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Item 28, Page 1 of 1	Item 28, Page 1 of 1 (TN 18-007)

10. SUBJECT OF AMENDMENT: Payment for Services: Non-Institutional Payment Schedule Updates

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: **MAUREEN M. CORCORAN**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: February 14, 2019	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
February 14, 2019	March 26, 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
January 1, 2019	/s/
21. TYPED NAME: Celestine Curry	22. TITLE: Acting Deputy Director

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.

d. Other practitioners' services

(6) Licensed advanced practice registered nurses' (APRNs') services provided within their scope of practice under State law.

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 took 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, 2019 and is effective for services provided on or after that date.

The agency's x-ray services rates can be found in the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule, which was set as of January 1, 2019 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).

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 eye care services 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.

The agency's physicians' rates found on the MSRIAP fee schedule were set as of January 1, 2019, 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.

Services Provided in a Community Behavioral Health Agency

Payment rates for evaluation and management services rendered by physicians operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after January 1, 2018, the payment for behavioral health evaluation and management services rendered by physicians operating in a community behavioral health agency will be 117.65% of the 2016 Ohio Medicare Region 00 rates.

Rates for physicians' services are listed on the agency's MSRIAP fee schedule published on the agency's website at http://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

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 for podiatrists' services can be found on the MSRIAP fee schedule 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, 2019, 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.

The following payment scenarios also exist:

The maximum reimbursement for services delivered by a physician assistant employed by or under contract with a physician is the lesser of the provider's billed charge or eighty-five per cent of the Medicaid maximum, except for services delivered by a physician assistant when a physician also provided distinct and identifiable services during the visit or encounter and services that are usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations), which are reimbursed at the lesser of the billed charge or an amount based on the Medicaid maximum for the particular service.

Reimbursement for multiple surgical procedures performed on the same patient by the same provider is the lesser of billed charges or one hundred per cent of the Medicaid maximum allowed for the primary procedure (the primary procedure is the surgical procedure that has the highest Medicaid maximum listed on the fee schedule); fifty per cent of the Medicaid maximum allowed for the secondary procedure; or twenty-five per cent of the Medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Reimbursement for bilateral procedures, when performed bilaterally, on the same patient by the same provider, is the lesser of billed charges or one hundred fifty per cent of the Medicaid maximum allowed for the same procedures performed unilaterally.

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, continued.

d. Other Licensed practitioners' services, continued.

(2) Non-Physician Licensed Behavioral Health Practitioners

Payment for services delivered by Non-Physician Licensed Behavioral Health Practitioners (NP-LBHP), as outlined in Attachment 3.1-A, is the lesser of the billed charge or the Medicaid fee schedule established by the State of Ohio.

The agency's fee schedule rate was set as of January 1, 2019 and is effective for services provided on or after that date. The reimbursement rates for non-physician licensed behavioral health practitioner services rendered in a community behavioral health center certified by ODM or its designee shall be a flat fee for each covered service as specified on the established Medicaid fee schedule.

All rates are published on the Ohio Department of Medicaid (ODM) Fee Schedule and Rates website at: http://medicaid.ohio.gov/providers/FeeScheduleandRates.aspx.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers.

If a Medicare fee exists for a defined covered procedure code, the State will pay the following licensed practitioners at 100% of the Medicaid maximum for the service:

- Psychologists

If a Medicare fee exists for a defined covered procedure code, the State will pay the following independent practitioners at 85% of the Medicaid maximum for the service:

- Board-licensed school psychologists;
- Licensed professional clinical counselors (LPCCs);
- Licensed independent social workers (LISWs);
- Licensed independent marriage and family therapists (LIMFTs); and
- Licensed independent chemical dependency counselors (LICDCs).

If a Medicare fee exists for a defined covered procedure code, the State will pay the following practitioners requiring supervision at 85% of the Medicaid maximum for the service:

- Licensed professional counselors;
- Licensed chemical dependency counselors III;
- Licensed chemical dependency counselors II;
- Licensed social workers;
- Licensed marriage and family therapists;

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. (Continued)

d. Other practitioners' services

(5) Physician assistants' services

Payment for physician assistants' services is the lesser of the billed charge or 85% of the Medicaid maximum for the physicians' service specified in the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule published on the agency's website at http://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx. The MSRIAP fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date.

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 Medicaid maximum payment amount is set at 80% of the Medicare allowed amount.

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

The following payment scenarios apply:

When a physician assistant acts as an assistant-at-surgery for a covered primary surgical procedure, the maximum payment amount for the physician assistant is the lesser of billed charges or 25% of the Medicaid maximum specified for physicians' services in the MSRIAP fee schedule.

Payment rates for evaluation and management services rendered by physician assistants operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after January 1, 2018, the payment for behavioral health evaluation and management services rendered by physician assistants practicing in a community behavioral health agency will be 85% of the rates Ohio pays to physicians practicing in a community behavioral health agency, as described in Item 5-a of this Attachment.

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. Physician assistants are reimbursed the lesser of billed charges or 85% of the established price established through this manual review pricing process.

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.

d. Other practitioners' services.

(6) Licensed advanced practice registered nurses' (APRNs') services, other than described elsewhere in this plan.

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.

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

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

The agency's MSRIAP fee schedule was set as of January 1,2019, 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.

7. Home health services, continued.

c. Medical supplies, equipment, and appliances suitable for use in the home.

Payment for medical supplies, equipment, and appliances is the lesser of the submitted charge or an amount based on the Medicaid maximum for the item or service.

The Medicaid maxima for blood glucose monitors, test strips, lancets, lancing devices, needles including pen needles, calibration solution/chips, and needle-bearing syringes with a capacity up to three milliliters are 107% of the wholesale acquisition cost (WAC); if the WAC cannot be determined, the Medicaid maximum is 85.6% of the average wholesale price (AWP). The State's Diabetic Testing and Injection Supplies payment schedule (part of the Pharmacy payment schedule) was set as of April 1, 2017.

The Medicaid maxima for oxygen are listed on the State's Oxygen payment schedule, which was set as of July 16, 2018.

The Medicaid maxima for wheelchairs, parts, accessories, and related services are listed on the State's Wheelchair payment schedule, which was set as of January 1, 2017.

The Medicaid maxima for enteral nutrition products are listed on the State's main Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule. Where no Medicaid maximum is specified, payment is 77% of the AWP.

The Medicaid maxima for other medical supplies, equipment, and appliances are listed on the State's main DMEPOS payment schedule. Where no Medicaid maximum for a medical supply item is specified, payment is 72% of the list price; if no list price is available, it is 147% of the invoice price.

The State's main DMEPOS payment schedule was set as of January 1, 2019.

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 Medicaid payment schedules and rates are published on the State's website at http://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

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.

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 was set as of January 1, 2019, and is effective for services provided on or after that date.

10. Dental services.

Dental services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.100.

Payment for Dental services is the lesser of the billed charges or an amount based on the Medicaid maximum for the service, except for 'Rural Dental Providers.' The Medicaid maximum is the amount listed on the Department's Dental services fee schedule.

Effective for dates of service on and after January 1, 2016, the maximum reimbursement for dental services rendered by a provider whose office address is in a rural Ohio county is the lesser of the billed charges or 105 percent of the Medicaid maximum for the particular service.

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

The agency's dental services fee schedule was set as of January 1, 2019 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.

Selected dental services are subject to a co-payment as specified in Attachment 4.18-A of the State plan.

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 agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) 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 took effect on January 1, 2014.

All 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 physical therapy fee schedule rate was set as of January 1, 2019 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.

Payment for physical therapy services provided to residents of nursing facilities is included in the nursing facility per diem rate.

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 agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) 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 took effect on January 1, 2014.

All 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 occupational therapy fee schedule rate was set as of January 1, 2019 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.

Payment for occupational therapy services provided to residents of nursing facilities is included in the nursing facility per diem rate.

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 agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) 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 took effect on January 1, 2014.

All 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 speech, hearing, and language disorders services fee schedule rate was set as of January 1, 2019 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.

Payment for SLPA services provided to residents of nursing facilities is included in the nursing facility per diem rate.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, continued.

b. Dentures.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the item. The Medicaid maximum is the amount listed on the Department's fee schedule.

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

The agency's dentures fee schedule was set as of January 1, 2019, 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.

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 submitted charge or an amount based on the Medicaid maximum. The Medicaid maximum for a prosthetic device is listed on the State's main Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule, which was set as of January 1, 2019.

By-report items and services require manual review by appropriate staff members or contractors. Payment for these items and services is determined on a case-by-case basis. The specific method used depends on the item or service (for example, comparison with a similar service that has an established maximum payment rate or application of a percentage of charges). This schema was effective on July 16, 2018.

All Medicaid payment schedules and rates are published on the State's website at http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

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

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

1. Mental Health Rehabilitative services.

Payment for mental health rehabilitative services as described in Attachment 3.1-A, Item 13-d-1 shall be the lesser of the billed charge or an amount based on the Medicaid maximum for the service.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

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

The agency's mental health rehabilitative services fee schedule rates were set as of January 1, 2019 and are effective for services provided on or after that date.

All rates and unit of service definitions are published on the agency's website at http://medicaid.ohio.gov/providers/feescheduleandrates.aspx.

The fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule. No payments for residents of Institutions for Mental Disease will be made under the Rehabilitation section of the State Plan.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

2. Substance use disorder (SUD) services

The fee development methodology is composed of provider cost modeling, although Ohio provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development:

- Staffing assumptions and staff wages;
- Employee-related expenses – benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation);
- Program-related expenses (e.g., supplies);
- Provider overhead expenses; and
- Program billable units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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

The fee schedule rates for substance use disorder services were set as of January 1, 2019 and are effective for services provided on or after that date. All rates and unit-of-service definitions are published on the single state agency's website at http://medicaid.ohio.gov/providers/FeeScheduleandRates.aspx. A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

17. Nurse-midwife services, continued.

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 were set as of January 1, 2019, 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.

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

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 were set as of January 1, 2019 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.

28. Licensed or otherwise state-approved freestanding birth centers (FBC) and licensed or otherwise state-recognized covered professionals providing services in the freestanding birth center.

Payment for FBC facility 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 agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

Payment for FBC services is based on a reimbursement rate for each HCPCS code. Maximum reimbursement for facility services is the lesser of the provider's billed charges or one hundred percent of the rate listed on the fee schedule.

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

The agency's freestanding birth center services rates can be found on the agency's MSRIAP fee schedule which was set as of January 1, 2019, 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.

In addition to reimbursement for facility services, a FBC may also be reimbursed for laboratory procedures, radiological procedures, and diagnostic and therapeutic procedures provided in connection with a covered FBC procedure. To be reimbursed for these procedures, FBC providers must bill using appropriate HCPCS codes. A FBC will not be reimbursed separately for the professional component of such services.