Table of Contents

State/Territory Name: Ohio

State Plan Amendment (SPA) #: 19-0009

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

April 23, 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 19-009

Dear Ms. Corcoran:

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

Transmittal #19-009
- Payment for Services: Programs of All-Inclusive Care for the Elderly (PACE)
- Effective Date: January 1, 2019
- Approval Date: April 22, 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/
Ruth A. Hughes
Deputy Director
Center 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: **19-009**	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 1,2019**	

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: Section 1894(d)(1) of the Social Security Act 42 CFR Part 460	7. FEDERAL BUDGET IMPACT: a. FFY 19 $0.00 b. FFY 20 $0.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 4 to Attachment 3.1-A, pages 5 and 6 Supplement 4 to Attachment 3.1-A, page 6a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 4 to Attachment 3.1-A, pages 5 and 6 (TN 17-019) (new)

10. SUBJECT OF AMENDMENT: Payment for Services: Programs of All-Inclusive Care for the Elderly (PACE)

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: **MAUREEN M. CORCORAN**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: March 27, 2019	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 27, 2019	18. DATE APPROVED: April 22, 2019
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2019	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Deputy Director

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B)._____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)__X__The following formula is used to determine the needs allowance:

Living in the community=65% of 300% of SSI payment standard

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.___ Rates are set at a percent of fee-for-service costs
2.___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.___ Adjusted Community Rate (please describe)
4._X_ Other (please describe): The capitation rates were developed from base fee-for-service (FFS) data, My Care Ohio program data and adjustments underlying the PACE amount that would otherwise have been paid (AWOP). The PACE capitation rate development includes further adjustments to reflect the estimated distribution of nursing facility versus home and community-based service (HCBS) utilization and reduces the non-long-term services and supports component of the rate to reflect the expected impact of care management on services.

The following methodology is intended to meet the requirements specified in 42 CFR 460.182 regarding the prospective monthly capitation payments to a PACE organization for a Medicaid participant enrolled in PACE.

AWOP Methodology

PACE amounts that would otherwise have been paid (AWOP) are developed separately for the Medicaid Only PACE population and the Dual Eligible PACE population. The AWOP methodology differs between the two groups because the Medicaid Only population otherwise eligible for PACE receives services on a fee-for-service (FFS) basis; whereas, the Dual Eligible population otherwise eligible for PACE receives services through the MyCare Ohio managed care program. Consistent with the PACE Medicaid Capitation Rate Setting Guide, an updated calculation of the AWOPs will be prepared on an annual basis and will be calculated for a period no longer than 12 months. While the AWOP must be annually updated and trended to the appropriate 12-month period, a full rebasing of the data underlying the AWOP is only required every three years.

A full rebasing of the Medicaid Only AWOP is developed using updated historical FFS data for non-dual individuals ages 55 and over who reside in Cuyahoga County and meet the nursing facility level of care eligibility (proxy data). Whether or not a full rebasing occurs, the annual Medicaid Only AWOP calculation will reflect claims trend, updated aged-based normalization, and a revised projection of the assumed enrollment distribution between the Nursing Facility (NF) residents and Home and Community-Based Services (HCBS) recipients. The age-based normalization of the proxy data adjusts the experience to match the age distribution (ages 55-64 versus ages 65+) of the PACE population for both NF and HCBS recipients. For a consistent comparison, the AWOP methodology includes addition of projected patient liability amounts because the PACE capitation rates will be filed gross of patient liability (i.e. patient liability will ultimately be determined and administered on an enrollee-specific basis).

The Dual Eligible AWOP is calculated using the MyCare Ohio (MyCare) capitation rates as the base data. The MyCare data is an appropriate proxy because 100% of Dual Eligibles otherwise eligible for PACE are enrolled in the MyCare managed care program and, therefore, the full MyCare Ohio capitation rate would be paid for each recipient not enrolled in PACE. The Dual Eligible AWOP calculation further reflects aged-based normalization and projection of the assumed enrollment distributions between the Nursing Facility (NF) residents and Home and Community-Based Services (HCBS) recipients. The age-based normalization of the proxy data composites the age-banded MyCare Ohio capitation rates to match the age distribution (ages 55-64 versus ages 65+) of the PACE population for both NF and HCBS recipients. For a consistent comparison, the AWOP methodology includes addition of projected patient liability amounts because the PACE capitation rates will be filed gross of patient liability (i.e. patient liability will ultimately be determined and administered on an enrollee-specific basis).

PACE Capitation Rates Methodology

According to the PACE Medicaid Capitation Rate Setting Guide, the corresponding PACE capitation rates may be filed with an effective period of no less than one year, but no more than three years, and must be annually illustrated to be less than the corresponding twelve-month AWOP. To the extent that PACE capitation rates are filed for an effective period of more than one year, the capitation rates need to be filed at amounts lower than the projected AWOPs corresponding to each year of the of the effective period for the capitation. Although the final PACE capitation rates may result from negotiations with the provider and include consideration of actual PACE plan experience, a methodology similar to the AWOP methodology can be used to inform the rate negotiations.

Projected proxy data gross of patient liability should be categorized into two cohorts representing four data groups: (1) HCBS Waiver cohort (Dual Eligible and Medicaid Only enrolled in eligible HCBS); and (2) Nursing Facility population cohort (Dual Eligible and Medicaid Only nursing facility residents.) Because nursing facility utilization is expected to be lower for PACE program enrollees than for the composite PACE-eligible population, the proxy PACE capitation rates are developed assuming a PACE-specific mix of the HCBS Waiver cohort and the Nursing Facility population cohort costs. Additionally, composite utilization of non-long-term services and supports may be reduced to reflect the expected impact of care management on services. The PACE capitation rates are calculated and filed gross of patient liability because liability amounts will be determined and administered on an enrollee-specific basis.