

Methods and Standards for Establishing Payment Rates

**Provider Preventable Conditions (PPCs)**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions (PPCs).

The State identifies the following OPPCs for non-payment in any health care setting where they may occur: Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

TN: 11-014  
Supersedes  
TN: NEW

Approval Date SEP 19 2013  
Effective Date: 7/1/2011

**Methods and Standards for Establishing Payment Rates**

**1. Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management		
<input type="checkbox"/>	HCBS Homemaker		
<input type="checkbox"/>	HCBS Home Health Aide		
<input type="checkbox"/>	HCBS Personal Care		
<input type="checkbox"/>	HCBS Adult Day Health		
<input type="checkbox"/>	HCBS Habilitation		
<input type="checkbox"/>	HCBS Respite Care		
For Individuals with Chronic Mental Illness, the following services:			
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services		
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation		
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)		
<input checked="" type="checkbox"/>	Other Services (specify below)		
	<b><u>Service Name</u></b>	<b><u>HCPCS Code</u></b>	<b><u>Billing Unit</u></b>
	Recovery management (RM)	T1016	15 Minutes
	Peer recovery support (PRS)	H0038	15 Minutes
	Individualized placement and support-supported employment (IPS-SE)	H2023	15 Minutes
		H2025	15 Minutes
<p>A. State Plan Reimbursement Methodology                  Reimbursements for services are based upon a Medicaid fee schedule established by the State of Ohio.                  Payment rates for this 1915(i) program are developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from the other programs that provide similar services, payment rates are determined using modeled rates.</p>			

TN: 15-014

Supersedes:

TN: New

Approved: 7/29/16

Effective: 08/01/2016

The description below is the State Plan FFS reimbursement methodology for the modeled rates. It is a market-based rate-setting approach developing rates on reasonable projected component assumptions that will be necessary to ensure access to care and adequacy of payment related to delivery of the services. Projected component assumptions exclude any non-Medicaid expenses and activities, as well as non-allowable expenses. The State only includes indirect costs for services and overhead that are compliant with 2 CFR Section 225. The rates will be reviewed every three years to ensure that access to care and adequacy of payments are maintained and re-based as appropriate. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payment are maintained. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. The payment for services is as follows: the lesser of the charge or the Medicaid fee schedule (note: there are no similar Medicare rates). The State shall not claim FFP for room and board and for non-Medicaid services. The rates in the department's service fee schedule as authorized by this state plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services.

All rates are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx). The Agency's fee schedule rate was set as of August 1, 2016 and is effective for services provided on or after that date. Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers.

The fee development methodology will primarily be composed of provider component assumption modeling, though 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., FICA, unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- 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.

#### B. Standards for Payment

1. Providers must meet provider participation requirements including certification and licensure of agencies and clinic,
2. All services must be prior authorized and provided in accordance with the approved Person-Centered Plan.
3. Providers must comply with all state and federal regulations regarding subcontracts.

Methods and Standards for Establishing Payment Rates

1. Inpatient Hospital Services

See Attachment 4.19-A

TNS # 90-38  
SUPERSEDES  
TNS # NEW

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

285

## 2. a. Outpatient Hospital Services

Outpatient hospital services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.20.

Outpatient hospital services shall be based upon fee-schedule payments and prospectively determined rates for procedures performed in the outpatient hospital setting. Fee-schedule payments based upon both the Healthcare Common Procedure Coding System (HCPCS) and Physician's Current Procedural Terminology (CPT) codes are established for most outpatient hospital procedures.

Drugs billed with revenue center code (RCC) 025X and/or 0636 with a provider-administered pharmaceuticals HCPCS J-code or Q-code will be reimbursed according to the Department's provider-administered pharmaceuticals fee schedule, at the rate in effect on that date of service. Medical supplies billed with RCC 027X, drugs billed without a HCPCS J-code or Q-code when an applicable J-code or Q-code does not exist for the provider-administered pharmaceutical and drugs listed as "by report" on the provider-administered pharmaceuticals fee schedule will be based upon multiplying the hospital's specific outpatient cost-to-charge ratio from the interim settled Medicaid cost reports during the calendar year preceding the rate year by charges associated with claims processed through the Ohio Medicaid claims system by sixty per cent.

Effective for dates of service on or after January 1, 2016, the temporary rate increase implemented on October 1, 2009 is no longer in effect, with the exception of children's hospitals.

Effective for dates of service on or after January 1, 2016, the initial maximum payment amount for new CPT codes is set at seventy-six per cent of the Medicare allowed amount that is listed on the Medicare outpatient prospective payment system fee schedule effective January 1 of each year but is not to exceed the Medicaid allowed amount of similar procedure codes.

Payment for laboratory services is the lesser of the billed charges or an amount based on the Medicaid maximum for the service. The Medicaid maximum for laboratory services is the amount listed on the Department's Non-Institutional services fee schedule. Payment for all other Outpatient hospital services is the lesser of the billed charges or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's Outpatient hospital services fee schedule.

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

The agency's Outpatient hospital services fee schedule was set as of January 1, 2016, and is effective for services provided on or after that date.

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

TN: 16-007

Supersedes:

TN: 15-008

Approval Date 6/3/16

Effective Date: 01/01/2016

2. a. Outpatient Hospital Services

Outpatient Hospital Services, continued:

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

TN: 13-004  
Supersedes:  
TN: 11-027

Approval Date: 7/11/2014  
Effective Date: 01/01/2013

**2-a. Calculation of Outpatient Hospital Upper Payment Limit Supplemental Payments for Private, Public Non State-Owned and Public State-Owned Hospitals***Supplemental Outpatient Payments for State-owned and Operated Hospitals:*

- A. Ohio hospitals owned and operated by the state as of October 1 of the year preceding payments (state hospitals) shall be paid supplemental amounts for the provision of hospital outpatient services set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services.
- B. Data sources used in calculating supplemental payments to state hospitals include the Medicare Cost Report (CMS 2552-10), the Hospital Cost Report Information System (HCRIS), the Ohio Medicaid Hospital Cost Report (ODM 02930) and Medicaid MMIS outpatient fee-for-service date of service claims data for a state fiscal year not more than two years prior to the current state fiscal year.
- C. The total supplemental payments shall not exceed the amount calculated using the following methodology:
  1. Using the Medicare cost reports as described in paragraph (B), for each state owned or operated hospital, total Medicare outpatient costs from hospital and subprovider worksheet D Part V, columns 5-7, line 202 were divided by the total outpatient Medicare charges from hospital and subprovider worksheet D Part V, columns 2-4, line 202 to establish the hospital specific outpatient Cost to Charge Ratio (CCR).
  2. For each state owned or operated hospital, total Ohio Medicaid outpatient charges are multiplied by the CCR calculated in paragraph (C)(1) to calculate Ohio Medicaid outpatient costs.
  3. The outpatient hospital market basket update value is applied to each state owned or operated Ohio hospital's Medicaid costs from paragraph (C)(2). Ohio Medicaid outpatient costs are additionally multiplied by a factor of 1.01 for the Critical Access Hospitals.
  4. Ohio Medicaid outpatient payments are then subtracted from the result in paragraph (C)(3) to find the outpatient upper payment limit gap. The sum of the differences for these public hospitals represents the total state owned outpatient Upper Payment Limit gap.
- D. From the pool of funds calculated in (C)(4), state owned or operated hospitals shall receive a payment equal to a percentage increase in outpatient hospital Medicaid payments. This percentage increase will be equal to the pool amount divided by total state hospital Medicaid outpatient fee-for-service payments from the state fiscal year ending prior to the month of payments. Supplemental payments shall be paid in four installments within the state fiscal year.

TN: 15-012

Supersedes

TN: 13-017Approval Date: 5/6/16Effective Date: 08/25/2015

- E. Supplemental payments made to cost based providers will be excluded from the cost settlement process.
- F. Hospital payments made under this section, when combined with other payments made under the State plan, shall not exceed the limit specified in 42 CFR 447.321.
- G. The total funds that will be paid to each hospital will be included with all other Medicaid payments in the calculation of disproportionate share limits.

TN: 15-012  
Supersedes  
TN: 13-017

Approval Date: 5/6/16

Effective Date: 08/25/2015

*Supplemental Outpatient Payments for Public Non-state Government-owned and Operated Hospitals:*

- H. Ohio hospitals owned and operated by a government entity other than the state as of October 1 of the year preceding payments (public non-state owned hospitals) shall be paid supplemental amounts for the provision of hospital outpatient services set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services.
  
- I. Data sources used in calculating supplemental payments to public non-state owned hospitals include the Medicare Cost Report (CMS 2552-10), the Hospital Cost Report Information System (HCRIS), the Ohio Medicaid Hospital Cost Report (ODM 02930) and Medicaid MMIS outpatient fee-for-service date of service claims data for a state fiscal year not more than two years prior to the current state fiscal year.
  
- J. The total supplemental payments shall not exceed the amount calculated using the following methodology:
  - 1. Using the Medicare cost report as described in paragraph (I), for each public non-state government owned and operated hospital, total Medicare outpatient costs from hospital and subprovider worksheet D Part V, columns 5-7, line 202 were divided by the total outpatient Medicare charges from hospital and subprovider worksheet D Part V, columns 2-4, line 202 to establish the hospital specific outpatient Cost to Charge Ratio (CCR).
  - 2. For each public non-state government owned and operated hospital, total Ohio Medicaid outpatient charges are multiplied by the CCR calculated in paragraph (J)(1) to calculate Ohio Medicaid outpatient costs.
  - 3. The outpatient hospital market basket update value is applied to Ohio Medicaid outpatient costs from paragraph (J)(2). Ohio Medicaid outpatient costs are additionally multiplied by a factor of 1.01 for the Critical Access Hospitals.
  - 4. Ohio Medicaid outpatient payments are then subtracted from the result in paragraph (C)(3) to find the outpatient upper payment limit gap. The sum of the differences for these public hospitals represents the total non-state government-owned outpatient Upper Payment Limit gap.
  
- K. From a pool of funds calculated in (C)(4), \$3,673,852 in each year shall be paid to all public non-state owned hospitals paid under the outpatient prospective payment system. This payment will be equal to the pool amount multiplied by the hospital specific ratio of hospital's outpatient Medicaid fee-for-service visits to the total Medicaid outpatient fee-for-service visits for all public non-state owned hospitals paid under the outpatient prospective payment system. Supplemental payments under this section shall be paid semiannually.

- L. From the pool of funds calculated in (J)(4) less payments made in (K), public non-state owned hospitals with fewer than 200 hospital beds shall receive a percentage increase applied to outpatient Medicaid fee-for-service payments. This percentage increase will be equal to the pool amount divided by the total small public non-state hospital Medicaid outpatient fee-for-service payments for the state fiscal year ending prior to the month of payments. Supplemental payments under this section shall be paid in four installments within the state fiscal year.
- M. Supplemental payments made to cost-based providers will be excluded from the cost settlement process.
- N. Hospital payments made under this section, when combined with other payments made under the State plan shall not exceed the limit specified in 42 CFR 447.321.
- O. The total funds that will be paid to each hospital will be included with all other Medicaid payments in the calculation of disproportionate share limits.

*Supplemental Outpatient Payments for Private hospitals:*

- P. All privately owned Ohio hospitals as of October 1 of the year preceding payments (private hospitals) shall be paid supplemental amounts for the provision of hospital outpatient services set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services.
- Q. Data sources used in calculating supplemental payments to private hospitals include the Medicare Cost Report (CMS 2552-10), the Hospital Cost Report Information System (HCRIS), the Ohio Medicaid Hospital Cost Report (ODM 02930) and Medicaid MMIS outpatient fee-for-service date of service claims data for a state fiscal year not more than two years prior to the current state fiscal year.
- R. The total supplemental payments shall not exceed the amount calculated using the following methodology:
1. Using the Medicare cost report as described in paragraph (Q), for each private Ohio hospital, total Medicare outpatient costs from hospital and subprovider worksheet D Part V, columns 5-7, line 202 were divided by the total outpatient Medicare charges from hospital and subprovider worksheet D Part V, columns 2-4, line 202 to establish the hospital specific outpatient Cost to Charge Ratio (CCR).
  2. For each private Ohio hospital, total Ohio Medicaid outpatient charges are multiplied by the CCR calculated in paragraph (R)(1) to calculate Ohio Medicaid outpatient costs.
  3. The outpatient hospital market basket update value is applied to Ohio Medicaid outpatient costs from paragraph (R)(2). Ohio Medicaid costs are additionally multiplied by a factor of 1.01 for the Critical Access Hospitals.
  4. Ohio Medicaid outpatient hospital payments are then subtracted to find the outpatient upper payment limit gap. The sum of the differences for these private hospitals represents the total privately-owned outpatient UPL gap.
- S. From a pool of funds calculated in (R)(4), \$11,760,389 in each year shall be paid to all private Ohio hospitals paid under the outpatient prospective payment system, except Children's Hospitals. The payment will be equal to the pool amount multiplied by the ratio of the hospital's outpatient Medicaid fee-for-service visits to the total outpatient Medicaid fee-for-service visits for all Ohio private hospitals paid under the outpatient prospective payment system.
- T. From the pool of funds calculated in paragraph (R)(4), less payments made in paragraph (S), private hospitals will be paid the following supplemental payments for the provision of hospital outpatient services. All private hospitals shall receive a percentage increase applied to total Medicaid outpatient fee-for-service payments. This percentage increase

will be equal to the pool amount divided by total private hospital Medicaid outpatient fee-for-service payments for the state fiscal year ending prior to the month of payments.

- U. Supplemental payments in paragraph (S) shall be paid semiannually and supplemental payments in paragraph (T) shall be paid in four installments within the state fiscal year.
- V. Supplemental payments made to cost-based providers will be excluded from the cost settlement process.
- W. Hospital payments made under this section, when combined with other payments made under the State plan shall not exceed the limit specified in 42 CFR 447.321.
- X. The total funds that will be paid to each hospital will be included with all other Medicaid payments in the calculation of disproportionate share limits.

- 2-b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

Services billed by a rural health clinic (RHC) are reimbursed through an all-inclusive rate, determined by Medicare, cost related reimbursement system. All RHC services are to be billed on the all inclusive rate basis and include laboratory services furnished by the clinic.

For services rendered on or after January 1, 2011, RHCs shall be paid in accordance with the methodology described in Section III of Attachment 4.19-B, Item 2-c.

TN: 11-027

Supersedes:

TN: NEW

Approval Date **DEC 22 2011**

Effective Date: 07/01/2011

**I Federally Qualified Health Center (FQHC) Services**

An eligible provider of FQHC services is an entity that receives a section 330 Public Health Services grant(s) or is an FQHC Look-Alike, as determined by the Centers For Medicare and Medicaid Services (CMS). For the Ohio Department of Job and Family Services (ODJFS) to recognize a facility as an FQHC, the entity must provide the department with documentation that service sites are providing services in accordance with the provisions of section 330 of the Public Health Service Act.

Description of the Ohio FQHC program is accomplished in the State Plan by identifying in rule services that are covered (5101:3-28-02); by specifying limitations and coverage policies that govern FQHC services (5101:3-28-03); and by identifying how FQHC services are billed (5101:3-28-04). Under the prospective payment system (PPS), cost reports are required only for new FQHCs, for FQHCs that add a new category of service, or for FQHCs that request and are approved for a change in scope of service (5101:3-28-09). FQHC PPS cost reports are described (5101:3-28-10) as is billing for FQHC services (5101:3-28-11). Description of the FQHC program also is accomplished by identifying in rule the supplemental payment system (5101:3-28-07) and by describing the PPS (5101:3-28-08).

The plan covers all services listed in Section 1861 (aa) (1) (A), (B) and (C) of the Act, including drugs and biologicals referenced in 1861 (s) (10) (A) and (B) of the Act. The language found in 3-28-02 (A) (02) of the rule allows for services and supplies furnished as "incident to the professional services" to be a covered service. The cost of such services is used to help build the encounter rates.

1. Ohio specifically identifies FQHC covered services in rule. Rule 5101:3-28-02 identifies the core services in (A)(1) to (A)(3) and the noncore covered services are identified in paragraph (B) of the same rule. Noncore covered services are Physical Therapy, Speech Pathology and Audiology, Dental, Podiatry, Optometric/Optician, Chiropractic, Transportation, and Mental Health. EPSDT, laboratory, radiology, other diagnostic services and Pregnancy Related Services (PRS) are a part of Ohio's physician program and are automatically incorporated into the FQHC program by reference to Chapter 5101:3-4 of the Ohio Administrative Code, the chapter of physician rules (see Rules 5101:3-28-03).

Services not routinely covered in Ohio's Medicaid program may be approved by the department if the services are determined to be medically necessary by the department. This coverage, since it affects all Medicaid patients, is broader than what is required by the federal statutory EPSDT provisions of 42 U.S.C 1396d(r).

TNS No. 06-003 Approval Date JUN 30 2006  
Supersedes  
TNS No. 01-006 Effective Date 07/01/2006

The FQHC definition for encounter is a face-to-face contact between a patient and provider of core and non-core services as defined in 5101:3-28-04 (B). Rule 5101:3-28-04 (B)(4) allows for multiple encounters on the same day if the encounters are with different provider types that are distinct centers for direct and indirect cost allocation purposes, each with a separate and distinct PPS rate, as explained as follows:

1. Medical
2. Physical Therapy
3. Speech Pathology and Audiology
4. Dental
5. Podiatry
6. Optometric/Optician
7. Chiropractic
8. Transportation
9. Mental Health

## II Payment for Services Rendered Prior to January 1, 2001

Prior to PPS, Ohio determined each FQHC's rates using allowable and reasonable costs for the provision of covered services divided by the number of billable encounters to determine each FQHC's reimbursement rate(s). A separate rate was developed for each of the nine service types/cost centers previously mentioned. Allowable costs were subject to a 30 percent ceiling for administrative, general and overhead costs, and a \$30,000 exemption to the 30 percent ceiling was allowed for physician recruitment costs. Also, reported costs were subject to efficiency standards for each cost center/type of service, and transportation was limited to \$15.00 per one way trips to a FQHC service. To determine an interim payment rate, allowable and reasonable costs were divided by total encounters. The interim rate was subject to the FQHC cap plus \$1.00 if the FQHC provided Pregnancy Related Services.

FQHCs were interim settled based upon the cost report for the year being settled. New rates, based upon actual costs for the time periods, were determined. These rates were then used to determine urban and rural means for each service; the means were multiplied by regional wage index factors on a site by site basis. The Medicare FQHC cap (plus \$1.00 for Pregnancy Related Services) was compared to the wage index mean. The FQHC was reimbursed either its allowable rates if below the cap, or the cap if the allowable rate exceeded the cap.

TNS No. 06-003 Approval Date JUN 30 2006  
Supersedes  
TNS No. 01-006 Effective Date 07/01/2006

**III FOHC/RHC PPS Payments for Services on or After January 1, 2001**

For services rendered on or after January 1, 2001, FOHCs/RHCs are reimbursed on a PPS basis as required by the provisions of the Benefits Improvement and Protection Act of 2000.

**Base PPS rate for FOHCs**

For each FOHC for the initial year payment, Ohio used the Medicaid FOHC program fiscal year (MPFY) that coincides with the calendar year (CY). Ohio established a PPS rate equal to 100% of the average of the center's costs of furnishing Medicaid covered ambulatory services provided during MPFY 1999 and MPFY 2000, that were related to the costs of furnishing such services and based on tests of reasonableness. These same tests of reasonableness were previously approved by CMS as appropriate measures of reasonable costs and were used to establish each FOHC's reasonable costs in the years prior to PPS. To determine the average, Ohio added together the 1999 rate and the 2000 rate for each service type and divided by two. A separate rate was developed for each of the nine covered service types/cost centers.

**Base PPS rates for Rural Health Clinics (RHCs)**

For each RHC for the initial year payment, Ohio determined a single, all-inclusive rate for fiscal year 1999 and for fiscal year 2000. Computations were based on the clinic's fiscal year. These rates were set based on the payment principles described in Ohio Administrative Code. An average of these rates was calculated by adding together the 1999 Medicare rate and the 2000 Medicare rate and dividing by two. This average was the RHC's rate for January 1, 2001 to September 30, 2001. The PPS system for RHCs was implemented when 1999 and 2000 Medicare cost reports became available. These cost reports were requested and received from each individual Ohio RHC.

When an RHC provided one of the nine service types/cost centers other than medical, the Medicare rate was adjusted to reflect the provision of these services on a per encounter basis and were incorporated into the calculation of the base PPS rate.

**Adjustments for Change in Scope**

The PPS rate for an FOHC/RHC is adjusted, if necessary, to take into account any increase or decrease in the scope of services furnished by a FOHC/RHC during a fiscal year. Any adjustments for increases/decreases in the scope of services address type, duration, intensity and amount of service to the extent that these parameters relate to a change in scope of services. An adjustment for a change in scope of service is always made when there is an addition or deletion of a covered service type/cost center. The service type/cost center is defined as follows: medical, dental, mental health, physical therapy, podiatry, optometry/optician, chiropractic, speech pathology/audiology, and transportation. Adjustments are also made when there is a change in scope for reasons other than the addition or deletion of an entire service type.

TNS No. 06-003 Approval Date JUN 30 2006  
Supersedes  
TNS No. 01-006 Effective Date 07/01/2006

*FQHCs*- For FQHCs, there are two methods for determining if an increase or decrease in scope of services occurred and for determining the appropriate adjustment to the current PPS rate. Method One is used if there is an adjustment due to a change in scope of service because the FQHC added a new or deleted an existing service type. Method Two is used if the FQHC believes that they have changed the scope of the services they provide and the change is not the addition or deletion of a service of a service type.

Under Method One, if there is an adjustment due to a change in scope of service because the FQHC added a new service type, an interim start-up rate for the new service type is assigned and becomes effective on the date the provider added the new service type. The start-up rate is set at the sixtieth percentile of all the values for urban or rural providers offering that service type. The urban and rural sixtieth percentile is calculated on October 1 of each year and is used for rate assignments occurring between October 1<sup>st</sup> and September 30<sup>th</sup>. This rate is in effect until a cost report based rate is established. Upon receipt and review of the provider's pre-and post-change cost report delineating the costs associated with the change in scope of service, Ohio determines and assigns a base PPS rate specific to the FQHC's costs based on reasonable cost parameters and tests of reasonableness described in Administrative Code.

Under Method Two, FQHCs have the option to submit a request for review of documentation to the State claiming that other situations constitute a change in scope of service, e.g., a documented increase in intensity of service. Such requests for review are given individual consideration by Ohio. If there are adjustments necessary due to a change in scope of service due to an increase in intensity, the adjustment takes effect on the first day of the first full month after Ohio reviews the provider's documentation and accompanying cost report and grants the request for a change in scope of service. Upon receipt and review of the provider's pre- and post-change cost report delineating the costs associated with the change in the scope of service, the amount of the adjustment is determined by establishing pre-change and post-change reasonable cost based rates and calculating the difference between the two.

*RHCs* – Since RHCs are paid only under a single all-inclusive payment rate, the method for making adjustments for increases and decreases in scope of services is a hybrid of Method Two described for FQHCs (above), with the basic difference being that only changes in scope due to the addition or deletion of one of the named service types would qualify for an adjustment. For any change in scope of services, the adjustment amount would be determined using the same mechanism described under Method Two.

#### Annual MEI Inflation

On October 1<sup>st</sup> of each fiscal year (since federal fiscal year 2002, beginning October 1, 2001), all PPS rates are adjusted. The adjusted rates are calculated by adjusting the PPS rates in effect on September 30<sup>th</sup> of the previous fiscal year by the percentage increase in the Medicare Economic Index (MEI) for primary care services. The new rates may be adjusted, if necessary, for any increase or decrease in the scope of services furnished during that fiscal year.

TNS No. 06-003 Approval Date JUN 30 2006  
Supersedes  
TNS No. 01-006 Effective Date 07/01/2006

PPS Rates for Newly Qualified FQHCs/RHCs

Newly qualified FQHCs/RHCs have their initial rates set at the level of other FQHC/RHCs in the same or nearest adjacent area that are similar in size, caseload, and scope of services offered. If there is no FQHC/RHC in the nearest adjacent area that is similar, the state-wide rural or state-wide urban sixtieth percentile is used for the start-up rate. After the first year of operation, FQHCs submit a cost report, and that cost report is used to determine the new FQHC's PPS base rate. Rates for newly qualified FQHCs and RHCs are adjusted on October 1 of every year using the MEI method used for established FQHC/RHCs.

IV Supplemental Payments

The Medicaid managed care program in Ohio is not statewide at this time and therefore does not currently affect all FQHCs or RHCs in the state. Ohio makes supplemental payments as necessary to FQHCs or RHCs that provide services to Medicaid managed care enrollees. Ohio's managed care program is limited to the full-risk model and contracts with managed care organizations (MCOs); there is no Primary Care Case Management (PCCM) program. (Please note that in Ohio contracting MCOs are referred to as managed care plans (MCPs).

Since July 1, 2001, in accordance with Ohio's provider agreements with participating managed care plans, MCPs have been required to offer FQHCs/RHCs expedited reimbursement on a service-specific basis in an amount no less than the payment made to other providers for the same or similar services. If the MCP has no comparable service-specific rate structure, the MCP uses the Medicaid fee-for-service payment rates in effect for non FQHC/RHC providers. Ohio's supplemental payment is the difference between the MCP payment and the PPS rate for the service.

The supplemental payment approach differs depending on the date of service delivery. For the period January 1, 2001 to June 30, 2001, Ohio required FQHCs to complete quarterly an FQHC-MCP Medicaid Encounter worksheet, reporting all MCP revenues received for encounters with Medicaid managed care enrollees by type of services.

For services furnished on and after July 1, 2001, the FQHC or RHC bills the MCP for any services provided to an MCP enrollee. Upon receipt of payment by the MCP, the FQHC or RHC submits to the Department a claim reporting the MCP payment as "third party liability (TPL)." The use of the TPL model enables the department to generate the supplemental payment equal to the difference between the MCP reimbursement and the PPS rate(s) for the FQHC or RHC. The Department's supplemental payment obligation is determined using the PPS rate(s) without regard to the effects of any financial performance incentives (positive or negative) received by the FQHC or RHC from the MCP. Claim payments to FQHCs/RHCs using the TPL model are made weekly.

TNS No. 06-003 Approval Date JUN 30 2006

Supersedes

TNS No. 01-006 Effective Date 07/01/2006

Supplemental payments are made at least every four months. Payment is made at a rate equivalent to what the FQHC or RHC would receive under the PPS.

**V. Application of Consumer Co-payments**

For services rendered on or after January 1, 2006, certain consumers have a co-payment for certain services, in accordance with Attachment 3.1 -A, Item 10, page 1 of 1 and Item 6, page 2 of 4 and in accordance with Attachment 4.19-B, Item 10, page 1 of 1 and Item 6, page 1 of 1.

**VI. Alternative Payment Methodology for Governmental-Operated FQHCs**

Effective October 1, 2011, any FQHC operated by a State or local governmental agency may request reimbursement using an alternate payment methodology (APM) administered in accordance with Section 1902(bb)(6) of the Act.

The APM makes interim payments to these FQHCs at the PPS rates and annually reconciles cost to the interim PPS rates. In accordance with Section 1902(bb)(6)(B) of the Act, the FQHCs will be paid APM rates that are at least equal to the amounts paid under PPS. Annually, the State reimburses eligible FQHCs for any reconciled cost that exceed PPS rate payments, regardless of whether the interim payment is made by the State or a managed care organization (MCO).

Under federal requirements in section 1902(bb)(5)(B) of the Act, the State will continue to make managed care wraparound payments at least every four months that equal the difference between PPS and the managed care payment.

At the end of the settlement period, the Department will pay the FQHC for services reimbursed under the APM an additional amount equal to the difference between its actual incurred allowable Medicaid cost and the following sums:

1. Interim PPS-based rates,
2. Payments made by Medicaid managed care plans, and
3. Supplemental payments that must be made by the State to the FQHC at least every four months that equal the difference between the payments made by Medicaid managed care plans and the PPS-based rate

**A. Interim payments**

Interim payment(s) is the PPS rate per visit based on a face-to-face encounter(s)/visits between a patient and FQHC provider of the following Medicaid services:

1. Medical
2. Laboratory
3. Radiology

4. Dental
5. Speech Therapy Services
6. Mental Health Services
7. Transportation
8. Vision Care
9. Podiatry
10. Chiropractic

Rule 5101: 3-28-04 (B)(4) allows for multiple encounters on the same day if the encounters are with different provider types that are distinct centers for direct and indirect cost allocation purposes, for the services listed in Item A. 1-10.

#### B. Cost reports

Cost reports are submitted annually within one hundred twenty (120) days after the close of the FQHC fiscal year. Each service site of a government-operated FQHC uses the cost report CMS approved for TN 10-014 to compile and submit a cost report that identifies the total actual incurred allowable Medicaid costs for the service site during the fiscal year.

#### C. Settlement

The Department reconciles the filed cost report to final payments to the FQHC within one hundred twenty (120) days of receiving a clean cost report.

An average cost per visit for each of the types of visits paid on an interim basis is calculated for each FQHC service, regardless of payer, offered at the site by dividing the total allowable actual incurred cost for the service by the total number of all face-to-face encounters/visits.

For each FQHC service, the total allowable actual incurred Medicaid cost for the fiscal year is the product of the average cost per encounter/visit and the number of face-to-face encounters/visits made by Medicaid-eligible individuals.

If total allowable actual incurred Medicaid reconciled cost for the fiscal year exceeds all interim payments for the fiscal year, then within two years of the end of the fiscal year for which cost was reported, the Department will pay the difference between total allowable actual incurred Medicaid reconciled cost and all interim payments.

If all interim payments for FQHC services for the fiscal year exceed the APM, then the Department recovers the excess payment. Excess payment to an FQHC will be recovered by the Department within sixty (60) days.

TN: 10-014  
Supersedes:  
TN: NEW

Approval Date: NOV 07 2011  
Effective Date: 10/1/2011

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 75%. This payment reduction provision takes effect on July 31, 2014.

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

The agency's laboratory services fee schedule was set as of April 1, 2016 and is effective for services provided on or after that date. The agency's x-ray services fee schedule was set as of January 1, 2016 and is effective for services provided on or after that date.

The following payment scenarios also exist:

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).

TN: 16-019

Supersedes:

TN: 16-016

Approval Date: 9/26/16

Effective Date: 04/01/2016

4a. Skilled Nursing Facility Services for Individuals Under 21 Years of Age or Older

Payment is made according to the provider type rendering service as described elsewhere in this attachment.

4b. Early and Periodic Screening Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Payment is made according to the provider type rendering service as described elsewhere in this attachment.

4c. Family Planning

Payment is made according to the provider type rendering service as described elsewhere in this attachment.

4. d. Tobacco cessation counseling services for pregnant women.

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

The agency's tobacco cessation counseling services fee schedule was set as of January 1, 2012, 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.

Payment for pharmacotherapy for cessation of tobacco use by pregnant women is described in Attachment 4.19-B, Item 12-a of this State plan.

TN: 13-019  
Supersedes  
TN: 11-013

Approval Date 11/25/14  
Effective Date: 09/01/2013

---

5. a. Physicians' services.

Payment for Physicians' 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 Physicians' 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's physicians' services fee schedule rate was set as of January 1, 2016 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.

The following payment scenarios also exist:

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.

Non-covered services are identified on the state developed Medicaid fee schedule [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates) by "NC" as the current price. The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40% of the Medicaid physician visits in the county of location and 10% of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40% of that fee.

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, continued.

- The maximum reimbursement for physician evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum.
- Supplemental Upper Payment Limits for Physicians Employed by The Ohio State University's Academic Medical Centers:

Supplemental payments to employees of The Ohio State University's academic medical centers are made for physician services, as defined in 42 C.F.R. 440.50, in the form of payments up to a defined cap. For dates of service 4/1/2014 to 12/31/2014, primary care services as defined in section 1202 of the Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), 42 USC 1396a, are not eligible for the supplemental payments. The supplemental payments are made only to physicians employed by The Ohio State University's academic medical centers on a quarterly basis. The supplemental payments exclude payments from vaccine administration codes. Anesthesiology codes payments are sometimes split between a physician and a Certified Registered Nurse Anesthesiologist (CRNA), therefore all anesthesiology codes will be combined and payments are estimated by using the reduced rate to be conservative.

The supplemental payments and their payment cap are determined with the following methodology:

1. The supplemental payment cap is the average commercial rate for the top five third-party commercial payers within the accounts receivable system(s) of the Ohio State University's academic medical center. The average commercial rate will be updated on an annual basis;
2. The base fee-for-service rate is compared to the supplemental payment cap;
3. The difference between the base fee-for-service rate and the supplemental payment cap is the available supplemental upper payment limit gap.
4. Supplemental payments are made to physicians up to the payment cap for a given year.

**5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, continued.**

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.

TN: 13-005  
Supersedes:  
TN: 09-035

Approval Date: 08/14/2014

Effective Date: 01/01/2013

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, continued.

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

new patient, problem focused visit	\$49.85
new patient, expanded problem focused visit	\$49.85
established patient, evaluation & management by non-physician	\$19.73
established patient, evaluation & management by physician	\$49.85

TN: 09-035  
Supersedes:  
TN: 97-06

Approval Date: 09/27/12  
Effective Date: 01/01/2010

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, continued.

Psycho-therapy provided by a non-physician employed by or under contract with a physician will be reimbursed as follows:

Services provided by a clinical psychologist will be reimbursed at eighty-five percent of the Medicaid maximum for an examination personally performed by a licensed psychologist.

Individual and group therapy services provided by other non-physicians will be reimbursed at the lesser of the provider's billed charge or fifty percent of the Medicaid maximum for the therapy code.

TN: 09-035  
Supersedes:  
TN: 97-06

Approval Date: 09/27/12  
Effective Date: 01/01/2010

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, continued.

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.

TN: 09-035  
Supersedes:  
TN: 97-06

Approval Date: 09/27/12  
Effective Date: 01/01/2010

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. (Continued)

Optometrists' Services

Payment for Optometrists' 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 Optometrists' 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's physicians' (including optometrists') services fee schedule rate was set as of January 1, 2016 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.

Optometrists' services are subject to a co-payment as referenced in Attachment 4.18-A of the State Plan.

**--FILED AT END--**

**Attachment 4.19-B**

**Items 6, 11, 13, 19, and 24**

**Pages 1, 2, 3, and 4**

**TN 05-020, Approved 08/12/08**

**Cost-Based Reimbursement**

**for IDEA Services Provided**

**in Schools**

**--FILED AT END--**

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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's podiatrists' services fee schedule rate was set as of on January 1, 2016, 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 physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40 percent of the Medicaid physician visits in the county of location and 10 percent of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40 percent of that fee.

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.

TN: 13-036

Supersedes:

TN: 13-019

Approval Date: 2/19/16

Effective Date: 12/31/2013

6. Medical care and any other types of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

- b. Optometrists' Services

Optometrists' services (other than those provided under 42 CFR 435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

TN: 13-019

Supersedes:

TN: 11-009

Approval Date: 11/25/14

Effective Date: 09/01/2013

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.

- c. Chiropractors' services.

Payment 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 fee schedule.

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

The agency's chiropractors' services fee schedule rate was set as of January 1, 2016, 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.

TN: 16-016

Supersedes:

TN: 13-019

Approval Date: 8/18/16

Effective Date: 01/01/2016

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.

(1) Mechanotherapists' services.

Payment 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 fee schedule.

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

The agency's mechanotherapists' services fee schedule was set as of December 31, 2013, 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.

TN: 13-036

Supersedes:

TN: 13-019

Approval Date: 2/19/16

Effective Date: 12/31/2013

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.

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

The agency's fee schedule rate was set as of January 14, 2016 and is effective for services provided on or after that date.

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;
- Doctoral psychology trainees who are under the supervision of a licensed psychologist; and
- Board-registered psychology assistant who are under the supervision of a licensed psychologist.

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 Licensed practitioners' services, continued.

(2) Non-Physician Licensed Behavioral Health Practitioners

- Registered counselor trainees;
- Registered chemical dependency counselor assistants and trainees;
- Registered social work trainees; and
- Registered marriage and family therapist trainees.

The State will pay 100% of the Medicaid maximum fee for psychological testing regardless of the eligible mental health professional providing the service.

Any practitioner other than licensed psychologists, board-licensed school psychologists, LPCCs, LISWs, LIMFTs, and LICDCs providing behavioral health services must operate within a provider agency licensed, certified or designated by ODM or its designee in settings permissible by that designation.

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

(4) Pharmacists' services.

Providers will be reimbursed a fee schedule amount for administering seasonal and pandemic influenza vaccines.

Except as otherwise noted in the state plan, the state developed fee schedule rates for seasonal and pandemic influenza vaccine administration are the same for both governmental and private providers.

All rates are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/ProviderTypes/TheOhioMedicaidDrugProgram.aspx](http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/TheOhioMedicaidDrugProgram.aspx).

The agency's pharmacists' services fee schedule rate was set October 1, 2009, and is effective for services provided on or after that date.

When a provider administers a seasonal or pandemic influenza vaccine in a pharmacy, the administration fee is the lesser of the provider's charge or the Medicaid maximum fee schedule amount of ten dollars. This fee schedule amount is effective for services provided on or after October 1, 2009, and applicable to services rendered by governmental and private providers.

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 an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's Physician assistants' 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's physician assistants' fee schedule was set as of January 1, 2015 and is effective for services provided on or after that date.

The following payment scenarios also exist:

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.

The following payment scenarios applicable to physicians also apply to physician assistants:

The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40% of the Medicaid physician visits in the county of location and 10% of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40% of that fee.

The Department will reimburse for services provided by a physician assistant the lesser of the billed charge or eighty-five per cent of the Medicaid maximum, utilizing a modifier that indicates the provider and services are subject to an adjusted rate, unless the service is the type usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations).

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) Advanced practice nurses.

A. Certified Registered Nurse Anesthetists' (CRNAs') services:

The payment methodology for anesthesia services consists of multiplying the sum of the procedure base units (from the latest Relative Value Guide by the American Society of Anesthesiologists) and the time units (per each 15 minutes) by the conversion factor [ $\$ = (B + T) \times CF$ ].

TN: 13-019  
Supersedes:  
TN: 12-019

Approval Date: 11/25/14

Effective Date: 09/01/2013

B. Clinical Nurse Specialists' (CNS) services:

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

Payment 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 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's clinical nurse specialists' fee schedule rate was set as of January 1, 2016 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.

The following payment scenarios also exist:

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.

The maximum reimbursement for CNSs' services is the lesser of the provider's billed charge or the percentage listed below, whichever is less:

85% of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

100% of the Medicaid maximum when services are provided in any non-hospital place of service.

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

TN: 16-016

Supersedes:

TN: 15-006

Approval Date: 8/18/16

Effective Date: 01/01/2016

new patient, problem focused visit	\$49.85
new patient, expanded problem focused visit	\$49.85
established patient, evaluation & management by non-physician	\$19.73

TN: 13-019  
Supersedes:  
TN: 12-019

Approval Date: 11/25/14  
Effective Date: 09/01/2013

C. Certified Nurse Practitioners' (CNP) services, other than certified pediatric or family nurse practitioners' services

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

Payment 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 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's certified nurse practitioners' fee schedule rate was set as of January 1, 2106 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.

The following payment scenarios also exist:

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.

The maximum reimbursement for CNPs' services is the lesser of the provider's billed charge or the percentage listed below, whichever is less:

85% of the Medicaid maximum when services are provided in the following places:  
an inpatient hospital, outpatient hospital, or hospital emergency department; or

100% of the Medicaid maximum when services are provided in any non-hospital place of service.

TN: 16-016  
Supersedes:  
TN: 15-006

Approval Date: 8/18/16  
Effective Date: 01/01/2016

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

new patient, problem focused visit	\$49.85
new patient, expanded problem focused visit	\$49.85
established patient, evaluation & management by non-physician	\$19.73

TN: 13-019  
Supersedes:  
TN: 12-019

Approval Date: 11/25/14  
Effective Date: 09/01/2013

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 (continued)

(7) Dietitians' services

Payment for dietitians' services is the lesser of the submitted charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is listed on the agency's dietitian fee schedule.

All Medicaid maximum payment amounts are published on the agency's website at [medicaid.ohio.gov/providers/feescheduleandrates.aspx](http://medicaid.ohio.gov/providers/feescheduleandrates.aspx).

The agency's dietitian fee schedule was set as of May 8, 2016, and is effective for services provided on or after that date.

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

7. Home Health Services

- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Payment for an intermittent or part-time nursing visit is the lesser of the billed charge or an amount based on the Medicaid maximum for the service listed on the Department's fee schedule. "Base rate" means the amount reimbursed by Ohio Medicaid for the initial thirty-five to sixty minutes of service delivered. "Unit rate" means the amount paid for each fifteen minute unit of service. Reimbursement for a visit is calculated as follows:

The Medicaid maximum rate for intermittent or part-time nursing services visit not rendered in a group setting is equal to the sum of:

- (1) The base rate; and
- (2) The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate, not to exceed four hours. For an initial visit less than thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

The Medicaid maximum rate for intermittent or part-time nursing services visit rendered in a group setting is equal to seventy-five percent of the sum of:

- (1) The base rate; and
- (2) The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate, not to exceed four hours. For an initial visit less than thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

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

The agency's home health intermittent or part-time nursing services fee schedule was set as of July 1, 2015, 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

b. Home health aide services provided by a home health agency.

Home health aide services provided by a home health agency under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.70.

Payment for a home health aide visit is the lesser of the billed charge or an amount based on the Medicaid maximum for the service listed on the Department's fee schedule. "Base rate" means the amount reimbursed by Ohio Medicaid for the initial thirty-five to sixty minutes of service delivered. "Unit rate" means the amount paid for each fifteen minute unit of service delivered when the initial visit is greater than sixty-minutes in length or less than thirty-five minutes in length. Reimbursement for a visit is calculated as follows:

The Medicaid maximum rate for home health aide services visit not rendered in a group setting is equal to the sum of:

- (1) The base rate; and
- (2) The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate, not to exceed four hours. For an initial visit less than thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the services is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

The Medicaid maximum rate for home health aide services rendered in a group setting is equal to seventy-five percent of the sum of:

- (1) The base rate; and
- (2) The unit rate multiplied by the number of covered units following the first four units included in the base rate.

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

The agency's home health aide services fee schedule was set as of January 1, 2016, 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.

TN: 15-022

Supersedes:

TN: 15-007

Approval Date 12/22/15

Effective Date: 01/01/2016

7. Home health services, continued.

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

Payment for enteral nutrition products is the lesser of the billed charge or an amount based on the Medicaid maximum for the product. The Medicaid maximum is the amount listed on the Department's Durable Medical Equipment fee schedule. Where no Medicaid maximum is specified, payment is the average wholesale price (AWP) minus 23%.

Payment for blood glucose monitors, test strips, lancets, lancing devices, needles including pen needles, calibration solution/chips, and syringes with a needle less than or equal to 1 milliliter will be based on wholesale acquisition cost (WAC) plus seven percent. In the event that WAC cannot be determined, reimbursement will be AWP minus 14.4%. The Medicaid maximum is the amount listed on the Department's Pharmacy fee schedule.

For all other items, payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service or item. The Medicaid maximum is the amount listed on the Department's Durable Medical Equipment fee schedule. Where no Medicaid maximum is specified, payment is 72% of the list price or, if no list price is available, 147% of the invoice price.

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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's Medical supplies, equipment, and appliances fee schedule rate was set as of January 1, 2016 and is effective for services provided on or after that date. The agency's diabetic testing and injection supplies fee schedule rate (under the Pharmacy fee schedule) was set as of July 1, 2013, 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.

- d. Physical therapy, occupational therapy, or speech-language pathology and audiology services provided by a home health agency or rehabilitation facility.

Payment 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 fee schedule.

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

The agency's home health physical therapy, occupational therapy, speech-language pathology, and audiology services fee schedule was set as of January 1, 2010, 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.

TN: 13-019  
Supersedes:  
TN: 11-002

Approval Date 11/25/14  
Effective Date: 09/01/2013

8. Private Duty Nursing Services.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum fee for the service listed on the Department's fee schedule, calculated as follows.

"Base rate" means the amount reimbursed by Ohio Medicaid for the initial thirty-five to sixty minutes of service delivered. "Unit rate" means the amount paid for each fifteen minute unit of service. Reimbursement for a private duty nursing visit is calculated as follows:

The Medicaid maximum rate for a private duty nursing visit not rendered in a group setting is equal to the sum of:

1. The base rate; and
2. The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate up and including no more than sixteen hours per nurse, on the same date or during a twenty-four hour time period. For an initial visit less than thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

The Medicaid maximum rate for a private duty nursing visit rendered in a group setting is equal to seventy-five percent of the sum of:

1. The base rate; and
2. The unit rate multiplied by the number of units over four.

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

The agency's private duty nursing fee schedule was set as of July 1, 2015, 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.

The Department's fee schedule identifies two rates for private duty nursing services, one for agency providers and another for non-agency/independent nurses.

TN: 15-007

Supersedes:

TN: 13-019

Approval Date: 6/22/15

Effective Date: 07/01/2015

9. Clinic services.

a. Free-standing ambulatory health care clinics (AHCCs).

Dialysis

The State uses the Medicare PPS rate as the basis for establishing Medicaid payment to dialysis clinics for dialysis services. The 2003 Medicare PPS rate was used to establish the initial Medicaid rate. The State divides the Medicare monthly PPS rate by 4 to determine the weekly rate and divides the weekly rate by 3 to establish the treatment rate.

Payment for all other AHCCs' 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 AHCCs' 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's Clinic services fee schedule rate was set as January 1, 2016 and is effective for services provided on or after that date.

The following payment scenarios also exist:

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.

9. Clinic services, continued.

b. Outpatient health facilities (OHFs).

OHF services are provided in accordance with 42 CFR 440.90. OHFs are freestanding.

1. Payment for authorized services in an OHF is calculated on a prospective reasonable cost-related basis from cost reports filed by each participating clinic. Rates are calculated on a clinic's cost of allowable items and services, and thus may vary from clinic to clinic, subject to the tests of reasonableness described in paragraphs (4) to (8). While payments under a prospective system are not subject to audit and retroactive settlement or adjustment, the historical costs upon which prospective rates are based are audited. Adjustments to the paid rate will be made if costs are found to be overstated or misrepresented in a manner which resulted in an overstatement of the previously determined prospective rate (see paragraph (11)). Retroactive adjustments may also occur to reconcile payments made to new facilities on the basis of an interim rate as provided in paragraph (3) or in accordance with paragraph (1)(b).

a. Rates will be established for each of the following types of services rendered by a participating OHF:

- (i) medical services
- (ii) laboratory services
- (iii) radiology services
- (iv) dental services
- (v) speech therapy and audiology services
- (vi) mental health services
- (vii) physical therapy services
- (viii) transportation services
- (ix) vision care services

9. Clinic Services (Continued)

(b) Cost of items which were not requirements during the period covered by the base line cost report but which became requirements or were imposed by federal court orders during the prospective rate year are met on a retroactive basis based on cost reports filed at the conclusion of the prospective year. Only those expenses associated with the new requirements, which require the addition of new personnel or equipment, are subject to the one-time retroactive settlement. Thereafter, such costs become recognized according to the methodology described above.

2. For purposes of this paragraph, the "initial program year" is defined as the time period beginning with the effective date and ending December 31, 1983. Rates will be determined based on cost reports submitted for the period beginning January 1, 1982 and ending June 30, 1982, for the initial program year. Rates will be updated by an inflation factor as described in paragraph (9). Rates so established may be used by OHFs in billing for services provided on and after the effective date of the OHF provider agreement.

All OHFs must submit a cost report by October 3, 1983, for the period beginning July 1, 1982 through June 30, 1983. Rates will be established within 45 days of the date upon which a complete cost report is submitted. Rates so established will be used by OHFs in billing for services beginning January 1, 1984. Beginning April 1984 OHFs must adhere to instructions defined in paragraph (10) for cost report filing.

3. Except as noted in paragraph (2), interim rates for new facilities will be computed as follows: interim payments will be granted based on the average rates of all participating OHFs. Ongoing rates will be calculated from a cost report filed after one complete calendar quarter of experience. Ongoing rates will be computed according to the criteria set forth in paragraphs (4) to (8) (with no inflationary allowance) and will be adjusted to compensate for any overpayment/underpayment made during the interim period. For purposes of reimbursement provisions contained in this paragraph, a "new facility" is defined as any of the following:

TNS # 90-38  
SUPERSEDES  
TNS # 84-9

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

9. Clinic Services (Continued)

- a. A facility not participating in the Medicaid program for one year prior to OHF application.
  - b. A facility participating in Medicaid immediately prior to OHF application and expanding or adding services in order to meet the OHF requirements set forth in rule 5101:3-29-01 of the Administrative Code.
  - c. A facility approved as an OHF which undergoes a change of ownership due to purchase or lease (rental) by an unrelated party. Reference paragraph (4)(c) for definition of a related party.
  - d. A facility approved as an OHF which adds a service eligible for payment on a prospective rate basis.
4. "Cost which are reasonable and related to patient care" are those contained in the following reference material in the following priority: "Health Insurance Manual 15 Provider Reimbursement Manual," "Health Insurance Manual 5 Principles of Reimbursement for Provider Costs," and "General Accepted Accounting Principles"; except that:
- a. Costs related to patient care and services that are not covered under the OHF program as described in rule 5101:3-29-01 to 5101:3-29-04 of the Administrative Code are not allowable.
  - b. The straight line method of computing depreciation is required for cost filing purposes, and it must be used for all depreciable assets.
  - c. For purposes of determining allowable and reasonable cost in the purchase of goods and services from a related party, the following definition of related shall be used: "Related" is one who enjoys, or has enjoyed within the previous five years, any degree of another business relationship with the owner or operator of the facility, directly or indirectly, or one who is related by marriage or birth to the owner or operator of the facility.

TNS # 90-38  
SUPERSEDES  
TNS # 84-9

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 5/1/90

9. Clinic Services (Continued)

- d. Tests of reasonableness include those identified in paragraphs (4) to (8).
  - e. The department reserves the right to establish other tests of reasonableness which may be necessary to assure effective and efficient program administration.
5. The ceiling for costs reported on the cost report will be the median plus one standard deviation of the percentage relationship of administrative and general costs to total costs as reported by outpatient hospital departments participating in the Medicaid program in areas of the state where participating OHFs are located.
  6. For each of the services identified in paragraph (1)(a) otherwise allowable costs allocated for items, will be adjusted in instances when hours of operation of the service component are less than 30 per week on an annualized basis. Any adjustment would be computed based on application of the ratio of actual hours of operation of the service component to a base of 30 hours per week on an annualized basis, not to exceed 100 percent.
  7. Costs recognized for rate setting purposes will be adjusted based on minimum required efficiency standards calculated as encounters per hour. Prospective rates established for any of the following service components will not exceed the lower of either the reported allowable cost divided by the product of hours worked by a professional and the encounters per hour as shown below:
    - a. medical services--2.97 encounters per hour
    - b. dental services--1.85 encounters per hour
    - c. mental health services--.8 encounters per hour
    - d. vision care services--2.3 encounters per hour
    - e. speech and hearing services--1.8 encounters per hour
    - f. physical medicine services--2.0 encounters per hour
  8. When the number of participating OHFs is 25 or greater, the test of reasonableness prescribed in this paragraph will replace the tests of reasonableness provided in paragraphs (5) and (6). For each of the services identified in paragraph (1)(a), the median plus one standard deviation weighted by a reasonable utilization factor will be determined from all cost reports filed by participating OHFs. The rate assigned to each OHF for each service component will be the lesser of the OHF's otherwise allowable costs or the weighted median plus one standard deviation for similar services.

TNS # 90-38  
SUPERSEDES  
TNS # 84-9

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

9. Clinic Services (Continued)

9. An OHF's unit rates are calculated from historical cost information as reported in cost reports filed by each participating clinic for a prior cost-reporting period. Allowable and reasonable costs determined will be updated by an inflation factor as described in this paragraph. For allowable costs recognized in the cost report year, an inflationary factor will be added for various categories of cost equal to the total of the actual inflationary factor between the midpoint of the cost report year and the midpoint of the following year as established by the Department of Labor Statistics and an estimated inflationary factor from the midpoint of the preceding year to the midpoint of the year for which the prospective rate is calculated based upon the preceding 12-month average. For each calendar year for each of the following categories of costs, an inflationary factor will be computed from the U.S. Department of Labor's "Monthly Labor Review" (unless otherwise specified):
- a. Personal (e.g., nurses, administration, legal, accounting, management, data services, employee fringe benefits, medical records, operation and maintenance services, housekeeping, and laundry).
  - b. Medical supplies subject to cost-related reimbursement and expenses.
  - c. Nondurable goods (e.g., office supplies and printing).
  - d. Fuel and utilities.
  - e. Transportation services.
  - f. Medical and rehabilitation professional personnel.
  - g. Insurance.
  - h. Real estate taxes.
10. As a condition for participation in the Title XIX program, all OHFs must submit cost reports.
- a. Annual cost reports must be filed, except for the initial program year as provided in paragraph (2), by April 1st of each year for the period beginning January 1st and ending December 31 of the preceding calendar year.

TNS # 90-38  
SUPERSEDES  
TNS # 84-9

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

9. Clinic Services (Continued)

- b. Failure to file an annual cost report by April 1st of each year will result in termination of the OHF's provider agreement, with such termination to be effective within 30 days unless a complete and adequate cost report is submitted by the OHF within that 30-day period.
- c. If an incomplete or inadequate cost report is received prior to April 1st, the department will notify the OHF that information is lacking. A corrected cost report is to be submitted within 45 days of notification of inadequacy. Any resubmission of an inadequate cost report within the 45-day period or any failure to resubmit within 45 days indicates a lack of good-faith effort and will result in immediate termination.
- d. The accrual method of accounting shall be used for all cost reports filed except that government institutions operating on a cash method may file on the cash method of accounting. The "accrual method of accounting" means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. The "cash method" of accounting means that revenues are recognized only when cash is received, and expenditures for expenses and asset items are not recorded until cash is disbursed for them.
- e. OHFs are required to identify all related organizations; i.e., related to the OHF by common ownership or control. The cost claimed on the cost reports for services, facilities, and supplies furnished by the related organization shall not exceed the lower of (a) the cost to the related organization or (b) the price of comparable services, facilities, or supplies generally available.

TNS # 90-38  
SUPERSEDES  
TNS # 84-9

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

9. Clinic Services (Continued)

- 11. The prospective rates for services established for an OHF are not subject to subsequent adjustments except in instances of rate adjustments specified in paragraphs (1) and (3). The difference between the cost reported by a clinic in a cost report used for calculating the various prospective rates and those costs established by a field or on-site audit are subject to recovery in full by means of a retroactive rate adjustment of the prospective rates. Audit exceptions will apply to the various rates established for the prospective year upon which the cost report is based. If the errors in the cost report increase the various unit rates which otherwise would have been paid. All overpayments found in on-site audits not repaid within 30 days after the audit is finalized shall be certified to the state auditor and/or attorney general for collection in accordance with the provisions of state law.

Audits will be conducted by ODPW for services rendered by OHFs participating in Title XIX (Medicaid). These audits are made pursuant to federal regulatory law and are empowered to ODPW through section 5101.37 of the Revised Code. The examination of OHF costs will be made in accordance with generally accepted auditing standards necessary to fulfill the scope of the audit. To facilitate this examination, providers are required to make available all records necessary to fully disclose the extent of services provided to program recipients. The principal objective of the audit is to enable ODPW or its designee to determine that payments which have been made, or will be made, are in accordance with federal, state, and agency requirements. Based on the audit, adjustments will be made as required. Records necessary to fully disclose the extent services provided and costs associated with those services must be maintained for a period of three years (or until the audit is completed and every exception is resolved). These records must be made available, upon request, to ODPW and the U.S. Department of Health and Human Services for audit purposes. No payment for outstanding unit rates can be made if a request for audit is refused.

TNS # 90-38  
SUPERSEDES  
TNS # 84-9

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

9. Clinic Services (Continued)

There are basically two types of audits.

- a. The first is a desk audit of cost reports filed each year and subsequent calendar quarterly reports to ensure that no mathematical error occurs, that the cost calculations are consistent with the rate-setting formula as established by the department, and to identify categories of reported costs which, because of their exceptional nature, bear further contact with the OHF for clarification/amplification.
- b. The second is a field audit. These are performed on-site or where the necessary disclosure information is maintained to assure the OHF has complied with both cost principles and program regulations.

Cost reports shall be retained for at least three years. Summary reports for all on-site audits shall be maintained for public review in the Ohio Department of Public Welfare for a period of one year. The depth of each on-site audit may vary depending upon the findings of computerized risk analysis profiles developed by the department taking into consideration such factors as cost category screens (cost categories above median), location, level of services provided Medicaid recipients, occasions or frequency of services, and multi-shared costs. The depth of each on-site audit shall be at least sufficiently comprehensive in scope to ascertain, in all material respects, whether the costs as reported and submitted by the OHF are true, correct, and representative to the best of the facility's ability. Failure to retain or provide the required financial and statistical records renders the OHF liable for monetary damages equal to the difference between:

- (i) established categorical unit rates paid to the provider for the prospective year in question and;
- (ii) the lowest categorical unit rates for like services paid in the state of Ohio to an OHF similar in structure.

YES - 90-38  
SUPERVISOR  
INS# 84-9

ISSUE DATE 10/12/90  
EFFECTIVE DATE 7/1/90

**Outpatient health facilities (OHFs).**

12. Based on the filing of calendar quarterly utilization evaluation reports, adjustments will be made in the rates. Quarterly reports for utilization evaluation must be filed within 30 days of calendar quarter end. This filing will result in a utilization adjustment of rates, if variances in utilization would result in a five percent or greater increase or decrease in the prospective rate, with 60 days of due date. The approved rates will be adjusted to reflect the four most current calendar quarters of reported utilization. During the initial four quarters of participation of an OHF, the utilization factors will be adjusted by substituting the reporting quarterly utilization for the average quarterly utilization factors report. Failure to file the quarterly utilization evaluation report (see paragraph (6)) will result in suspension of payment for eligible services rendered until such time as the quarterly report is received, evaluated, and adjusted by the Division of Fiscal Affairs. The OHF will then be notified of any adjustment and any new rates applicable. If the quarterly utilization evaluation report is not received within 60 days after suspension, termination will be recommended.

TN: 13-005  
Supersedes:  
TN: 09-035

Approval Date: 08/14/2014

Effective Date: 01/01/2012

9. Clinic services, continued.

c. Ambulatory surgery centers (ASCs).

Payment for ASCs' 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 ASCs' services fee schedule.

Covered ASC surgical services are listed under the column headings "Current ASC Group" and "Previous ASC Group" on the agency's fee schedule, identified by number one, two, three, four, five, six, seven, eight, or nine.

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

The agency's ASC services fee schedule was set as of September 1, 2013 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.

TN: 13-019  
Supersedes:  
TN: 13-005

Approval Date: 11/25/14

Effective Date: 09/01/2013

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](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's dental services fee schedule was set as of January 1, 2016 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.

**--FILED AT END--**

**Attachment 4.19-B**

**Items 6, 11, 13, 19, and 24**

**Pages 1, 2, 3, and 4**

**TN 05-020, Approved 08/12/08**

**Cost-Based Reimbursement**

**for IDEA Services Provided**

**in Schools**

**--FILED AT END--**

## 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 Department's 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 takes effect on January 1, 2014.

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

The agency's physical therapy fee schedule rate was set as of December 31, 2014 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.

For residents of nursing facilities (NFs), physical therapy services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for physical therapy services provided to residents of NFs is included in the facility per diem.

TN: 14-024

Supersedes:

TN: 14-018Approval Date: 5/11/16Effective Date: 12/31/2014

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 Department's 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 takes effect on January 1, 2014.

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

The agency's occupational therapy fee schedule rate was set as of January 1, 2014 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.

For residents of nursing facilities (NFs), occupational therapy services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for occupational therapy services provided to residents of NFs is included in the facility per diem.

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 Department's 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 takes effect on January 1, 2014.

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

The agency's speech, hearing, and language disorders services fee schedule rate was set as of January 1, 2014 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.

For residents of nursing facilities (NFs), SLPA services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for SLPA services provided to residents of NFs is included in the facility per diem.

TN: 14-018

Supersedes:

TN: 14-005

Approval Date: 4/11/16

Effective Date: 07/31/2014

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

- a. Prescribed drugs

Payment for prescribed drugs meets all reporting requirements and provisions of section 1927 of the Social Security Act.

Payment for prescribed drugs will be made based on the various categories as specified below.

Payment for selected over-the-counter drugs provided by nursing facilities (NFs) for their recipient-residents is included in the nursing facility services. Nursing facilities receive a per diem amount that includes payment for selected over-the-counter drugs and are responsible for ensuring that their recipient-residents obtain those drugs. Payment for selected over-the-counter drugs provided to residents of NFs is included in the facility per diem and is not eligible for reimbursement on a fee-for-service basis. Reimbursement methodology for nursing facilities is described in Attachment 4.19-D.

TN: 13-019  
Supersedes:  
TN: 09-018

Approval Date: 11/25/14

Effective Date: 09/01/2013

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

**Determination of allowable pharmaceutical product cost: Drugs dispensed for take-home use (“pharmacy benefit”).**

No supplemental allowance will be authorized for broken-lot charges, prescription delivery charges or state and local sales tax.

Billings must be submitted on the basis of the pharmacy's reasonable and customary charge, that is, a charge which does not exceed the average prescription price paid by the general public for similar services, including billing charges, family prescription profiles, delivery charges, and other pharmaceutical services.

Payment for covered drugs is the lesser of the submitted charge or the calculated allowable minus any applicable co-payment. The calculated allowable consists of product cost and a dispensing fee.

(1) Maximum Allowable Cost (MAC) pharmaceuticals

- (A) Maximum allowable costs have been determined by the federal Department of Health and Human Services for selected drugs. The Department shall not make reimbursement for these products, in the aggregate, at a rate higher than the federal upper limit (FUL) prices.
- (B) The Department may establish a MAC for additional selected drugs where either bio-equivalency of the drugs has been established or bio-inequivalency of the drugs has not been established. Reimbursement for state MAC drugs shall be based on the sixty-fifth percentile of the estimated acquisition cost of all readily available generically equivalent drugs.

(2) Estimated Acquisition Cost (EAC) pharmaceuticals

- (A) All products, other than those designated as MAC drugs, will be considered EAC drugs. Reimbursement will be based on the estimate of wholesale acquisition cost (WAC) determined by periodic review of pricing information from Ohio drug wholesalers, pharmaceutical manufacturers and a pharmacy pricing update service. The maximum reimbursement for these drugs will be WAC plus seven per cent.
- (B) In the event that WAC cannot be determined, the Department will define “EAC” as average wholesale price (AWP) minus 14.4 per cent.

TN: 13-019  
Supersedes:  
TN: 09-018

Approval Date: 11/25/14

Effective Date: 09/01/2013

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

a. Prescribed drugs (continued)

(3) Dispensing fee

The dispensing fee for non compounded drugs shall be one dollar and eighty cents.

The State has a separate dispensing fee for compounded prescriptions. Claims submitted for infusion compounds will receive a dispensing fee of ten dollars per day, with a maximum dispensing fee of seventy dollars per claim. Total parenteral nutrition claims will receive a dispensing fee of fifteen dollars per day, with a maximum dispensing fee of one hundred fifty dollars per claim. Compounded drugs that are not infusion compounds or total parenteral nutrition claims will receive a single six dollar dispensing fee per prescription.

TN: 13-019  
Supersedes:  
TN: 09-018

Approval Date: 11/25/14

Effective Date: 09/01/2013

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

**Determination of allowable pharmaceutical product cost: Drugs administered in the professional provider setting.**

All maximum payment amounts are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx). The agency's vaccines, toxoids, and other provider-administered pharmaceuticals fee schedule was set as of November 1, 2015, 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.

The payment amount for a covered non-VFC vaccine, toxoid, or other provider-administered pharmaceutical is the lesser of the submitted charge or the Medicaid maximum, which is the first applicable item from the following ordered list:

- (a) An amount specified in or determined in accordance with the Ohio Administrative Code;
- (b) The state's maximum allowable cost (MAC), which is defined on page 2 of this item;
- (c) The payment limit shown in the current Medicare part B drug pricing file;
- (d) One hundred seven per cent of the wholesale acquisition cost (WAC); or
- (e) Eighty-five and six-tenths per cent of the average wholesale price (AWP).

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](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's dentures fee schedule was set as of January 1, 2010, 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.

TN: 13-019  
Supersedes:  
TN: 09-035

Approval Date: 11/25/14  
Effective Date: 09/01/2013

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 billed charge or an amount based on the Medicaid maximum for the service or item. The Medicaid maximum is the amount listed on the Department's fee schedule. Where no Medicaid maximum is specified, the provider must submit either the list price or the invoice price. The Medicaid agency will pay 72 per cent of the list price or 147 per cent of the invoice price.

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

The agency's prosthetic devices fee schedule rate was set as of January 1, 2016, 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.

TN: 16-016

Supersedes:

TN: 13-019

Approval Date: 8/18/16

Effective Date: 01/01/2016

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

d. Eyeglasses.

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](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's eyeglasses fee schedule was set as of January 1, 2010, 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.

TN: 13-019  
Supersedes:  
TN: 09-035

Approval Date: 11/25/14  
Effective Date: 09/01/2013

**--FILED AT END--**

**Attachment 4.19-B**

**Items 6, 11, 13, 19, and 24**

**Pages 1, 2, 3, and 4**

**TN 05-020, Approved 08/12/08**

**Cost-Based Reimbursement**

**for IDEA Services Provided**

**in Schools**

**--FILED AT END--**

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

**One-time lead investigations to determine the source of lead poisoning:**

A public health lead investigation consists of one or more of the following components, depending on the specific circumstances relevant to each child:

- Completion of a comprehensive on-site questionnaire;
- Interview of the parent, guardian or other appropriate adult;
- Gathering of information about habits of the child; and
- Identifying potential lead sources in the child's home or primary residence.

**Rate(s):**

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

Medicaid reimbursement includes payment for collection of specimens, assessment of the home or primary residence of a child identified as having an elevated blood lead level, and on-site testing. The State will only pay for those components of the one-time lead investigation that are performed. The State will not pay for external laboratory testing.

**Payment for one-time lead investigations to determine the source of lead poisoning:**

The State reimburses the Ohio Department of Health (ODH) for the cost of conducting a one-time lead investigation to determine the source of lead poisoning, utilizing a cost settlement and reconciliation payment methodology, in accordance with 2 CFR 200 Subpart E - Cost Principles. The State will reimburse ODH for the lead investigation at a unit rate of \$1,289.00 per investigation, and will settle to actual cost. The unit rate was derived by using actual provider cost data related to salary, travel and equipment for state fiscal year 2014. The analysis showed that the proposed rate was within a reasonable range when compared to both the average and median unit cost, with some falling below and some falling above. The State will continue to reimburse ODH based on established statewide rates, and ODH will complete a cost report at the conclusion of each quarter.

TN: 15-017

Supersedes:

TN: 09-011

Approval Date: 10/19/16

Effective Date: 12/01/2015

The reimbursement methodology is as follows:

**Claims Payment Process:**

The Ohio Department of Health submits claims to the single state agency listed in section 1.1(a) of the state plan. The single state agency processes the claims and reimburses the Ohio Department of Health at 100%.

**Direct Medical Services Payment Methodology:**

The cost settlement methodology will consist of a CMS-approved cost report and reconciliation to actual allowable cost, entitled “Ohio Department of Medicaid Lead Investigations Cost Report”.

The following will be required to determine the Medicaid-allowable direct and indirect costs of providing direct medical services to individuals who are Medicaid eligible and receive Lead Investigation services:

Direct costs for medical service include payroll costs and other costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services of personnel providing direct medical services.

Other direct costs include non-personnel costs directly related to the delivery of medical services, such as purchased services, capital outlay, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs.

Total direct costs for direct medical services are reduced on the cost report by any restricted public health service grant payments as defined in 2 CFR 200 Subpart E resulting in adjusted direct costs for direct medical services.

Indirect costs are calculated using the actual direct payroll cost of individuals who perform direct medical services times the federally approved indirect cost rate. The federally approved indirect cost rate does not include any costs otherwise included in the cost report.

Total indirect costs do not include any restricted public health service grant payments as defined in 2 CFR 200 Subpart E resulting in adjusted indirect costs.

An actual time report is used to determine the percentage of time spent by medical service personnel on Medicaid covered services, administrative duties, and non-reimbursable activities in compliance with applicable rules and regulations.

The total service rate is calculated by dividing the total allowable cost by the total number of services performed during the cost report period. The total service rate is compared to the interim rate for cost reconciliation purposed.

TN: 15-017

Supersedes:

TN: 09-011

Approval Date: 10/19/16

Effective Date: 12/01/2015

**Certification of Expenditures:**

On an annual basis, the Ohio Department of Health (ODH) will certify through its cost report its total actual, incurred Medicaid allowable costs.

**Annual Cost Report Process:**

For Medicaid covered services, ODH shall file an annual cost report as directed by the Ohio Department of Medicaid (ODM) in accordance with 42 CFR 413 Subpart B and 42 CFR 447.202.

The primary purposes of the governmental cost report are to document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid covered services using a CMS-approved cost allocation methodology and cost report, and to reconcile annual interim payments to total CMS-approved, Medicaid allowable costs using a CMS-approved cost allocation methodology and cost report.

**The Cost Reconciliation Process:**

The cost reconciliation process must be completed within twelve months of the receipt of the cost report. The total Medicaid-allowable costs are determined based in accordance with 42 CFR 413 Subpart B and the CMS Provider Reimbursement Manual methodology and are compared to the ODH Medicaid interim payments delivered during the reporting period as documented in the Medicaid Information Technology System (MITS), resulting in a cost reconciliation.

**The Cost Settlement Process:**

If a provider's interim payments exceed the provider's certified cost for Medicaid services furnished by ODH to Medicaid recipients, the provider will remit the excess federal share of the overpayment at the time the cost report is submitted. The federal share will be returned via the CMS-64 Report.

If the certified cost of ODH's provider exceeds the interim payments, ODM will pay the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

TN: 15-017

Supersedes:

TN: NewApproval Date: 10/19/16Effective Date: 12/01/2015

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

c. Preventive services.

Payment for preventive 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 Preventive 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 are published on the agency's website at [medicaid.ohio.gov/OHP/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/OHP/PROVIDERS/FeeScheduleandRates.aspx).

The agency's fee schedule was set as of January 1, 2015, 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.

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

d. Rehabilitative services

1. Rehabilitative services provided by community mental health facilities.

Each community mental health agency shall maintain a schedule of usual and customary charges for all community mental health services it provides. The agency shall use its usual and customary charge schedule when billing Medicaid for rendered services. Reimbursement for community mental health services shall be the lesser of the charged amount or the Medicaid maximum amount.

Calculation of the Medicaid maximum amount for community mental health services:

- A. For all community mental health services except community psychiatric supportive treatment (CPST), the Medicaid maximum amount is equal to the unit rate for the service according to the department's service fee schedule multiplied by the number of units rendered.
- B. For CPST services not rendered in a group setting, the Medicaid maximum amount is calculated as follows:
1. If the total number of service units rendered by a provider per date of service is less than or equal to six, the Medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.
  2. If the total number of services units rendered by a provider per date of service is greater than six, the Medicaid maximum amount is equal to the sum of:
    - a. The unit rate according to the department's service fee schedule multiplied by six; and
    - b. Fifty percent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.
- C. For CPST services rendered in a group setting, the Medicaid maximum amount is calculated as follows:
1. If the total number of service units rendered by a provider per date of service is less than or equal to six, the Medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.
  2. If the total number of services units rendered by a provider per date of service is greater than six, the Medicaid maximum amount is equal to the sum of:
    - a. The unit rate according to the department's service fee schedule multiplied by six; and

TN: 13-019  
Supersedes  
TN: 11-010

Approval Date: 11/25/14

Effective Date: 09/01/2013

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

d. Rehabilitative services

1. Rehabilitative services provided by community mental health facilities, continued

a. Fifty percent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

As a condition of participation, all Medicaid providers of community mental health services must have a current "Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations". Providers agree to comply with state statutes, Ohio Administrative Code rules, and Federal statutes and rules.

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 fee schedule rates are effective for services provided on or after October 4, 2010.

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

The State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR 441 Subparts C and D.

The State shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or State definition of a qualified Medicaid provider.

With respect to individuals who are receiving rehabilitation services as residents of facilities the State shall not claim FFP for room and board and for non Medicaid services as a component of the rate for services authorized by this section of the state plan (Attachment 4.19-B, Item 13-d-1 page 2 of 2.) The rates in the department's service fee schedule as authorized by this plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services such as costs associated with the cafeteria. Only those facility (direct or indirect) costs that can be identified as directly supporting the provision of the non-institutional services will be included in the rates.

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

2. Rehabilitative services provided by alcohol and other drug treatment programs

Each community alcohol and other drug treatment program shall maintain a schedule of usual and customary charges for all community alcohol and other drug treatment services it provides. The program shall use its usual and customary charge schedule when billing community Medicaid for rendered services. Payments for covered services will be based on the lesser of the charged amount or the Medicaid maximum amount for the rendered service according to the department's service fee schedule.

As a condition of participation, all Medicaid providers of alcohol and other drug treatment services must have a current "Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations". Providers agree to comply with state statutes, Ohio Administrative Code rules, and Federal statutes and rules.

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 fee schedule rates are effective for services provided on or after October 4, 2010.

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

The State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR 441 Subparts C and D.

TN: 14-010  
Supersedes:  
TN: 13-019

Approval Date: 8/17/2015  
Effective Date: 06/19/2014

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

2. Rehabilitative services provided by alcohol and other drug treatment programs, continued

The State shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or State definition of a qualified Medicaid provider.

With respect to individuals who are receiving rehabilitation services as residents of facilities, the State shall not claim FFP for room and board and for non-Medicaid services as a component of the rate for services authorized by this section of the plan (Attachment 4.19-B, Item 13-d-2, page 2 of 2). The rates in the department's service fee schedule as authorized by this plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services such as costs associated with the cafeteria. Only those facility (direct or indirect) costs that can be identified as directly supporting the provision of the non-institutional services will be included in the rates.

TN: 13-019  
Supersedes:  
TN: 12-007

Approval Date: 11/25/14

Effective Date: 09/01/2013

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

**d. Rehabilitative services (Continued)**

**3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

**Effective Date:** Reimbursement methodology for January 1, 2004—April 4, 2004

~~ODJFS will establish the fee schedule for Habilitation Center Services, also known as Community Alternative Funding System (CAFS).~~

**1). Methodology:**

~~The CAFS reimbursement to a habilitation center service provider will be based on a tiered fee schedule. The tiered fee schedule is developed according to the following process:~~

~~a.—Data~~

~~Desk reviewed costs and actual total reported units from the provider FY 2000 cost reports (received at ODJFS by 4/30/03), which include all costs for the habilitation center service provider to operate, were identified for each provider. From the cost reports, the rate for each habilitation center service<sup>1</sup> is identified for each provider. Providers with outlier rates, rates that fall outside the range of rates that the middle fifty percent of providers fall within, are identified and removed. The weighted average rate for a county is identified after the outlier rates are eliminated by dividing the cost reported funds for the remaining providers in a county by the total number of units collectively provided by those providers.~~

~~b.—Creating tier ranges and calculating rates for each tier~~

- ~~1. For each habilitation center service, the weighted average cost rate for each county is ordered lowest to highest.~~
- ~~2. The maximum rate of the lowest tier of all habilitation center services is derived by multiplying the lowest non-outlier county weighted average rate by 1.15 (a 15% increase).~~

<sup>1</sup> Refer to Table 1 for a description of each habilitation center service.

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

**d. Rehabilitative services (Continued)**

**3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

- ~~3. The tier rate assigned to the lowest tier is the sum of the lowest non-outlier county weighted average rate and  $\frac{2}{3}$ <sup>rd</sup> of the difference between the lowest non-outlier county weighted average rate and the maximum rate for the lowest tier range.~~
- ~~4. The minimum rate of the next tier is \$.01 more than the maximum rate of the previous tier.~~
- ~~5. Using the minimum rate established in step 3, increase this rate by 15%. This is the maximum rate for the tier range.~~
- ~~6. Steps 3 and 4 are repeated until a tier range is established that encompasses the highest non-outlier county weighted average rate.~~
- ~~7. The tier rate for tier ranges other than the lowest tier range is the sum of the minimum rate of that tier and  $\frac{2}{3}$ <sup>rd</sup> of the difference between the minimum and the maximum rate of that tier.~~

~~e. Inflation of the tiered fee schedule~~

- ~~1. The monthly "Consumer Price Index" (CPI) developed by the U.S. Department of Labor, Bureau of Labor Statistics shall be used to inflate the rates. Specifically, the monthly CPI for services by other medical professionals (excluding physician, dental, and optometry) and for intra-city transportation for all urban consumers shall be identified.~~
- ~~2. The beginning period used to establish the inflation rate shall be June 2000.~~
- ~~3. Using regression analysis, a forecast for the CPI shall be made to August 2004.~~
- ~~4. The rate of change in the CPI for other medical professional services and for transportation from June 2000 August 2004 shall be identified.~~
- ~~5. The tiered rates for each habilitation center service, with the exception of transportation, shall be increased by the rate of change for other medical professional services.~~
- ~~6. The tiered rates for transportation shall be increased by the rate of change for transportation.~~

TN NO. 05-008 APPROVAL DATE: ALSO 2-1-2005  
SUPERCEDES  
TN NO. 03-024 EFFECTIVE DATE: 7/1/05

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

d. Rehabilitative services (Continued)

3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS

d. Assigning rates

The rate ascribed to a county for each unit of habilitation center service provided to an eligible individual will be the adjusted rate for the tier in which the county's weighted average rate for that service is indicated. There are eighty-eight (88) counties in Ohio. There are separate rates for adults and children. Therefore, there are two (2) rates per service per county. Rates for aggregated services are daily rates. When the services are billed as an aggregated rate the methodology is the same as that described for the above referenced time period.

If there is no rate information available for a county for a service, the county will be ascribed the adjusted rate of the middle tier for that service. If a service has an even number of tiers for that service, the adjusted rate of the highest tier of the two middle tiers will be ascribed to the county.

If the county's weighted average rate for a service is beyond the range of the tiered fee schedule, the county will be ascribed the adjusted rate of the middle tier for that service. If there is an even number of tiers for that service, the adjusted rate of the highest tier of the two middle tiers will be ascribed to the county.

For public providers, revenue cannot exceed expenditures and any overpayment shall be recovered.

2) Reimbursement:

When Habilitation Centers provide habilitation center services they shall receive rates as described above. ODJFS will no longer reimburse for physician services through the Habilitation Center program effective with this SPA.

3) Non-federal share:

The non-federal match required to claim Federal financial participation (FFP) is met through the use of public funds appropriated directly from the legislature, along with certified public expenditures (CPEs) or local public monies from county boards of MRDD and participating local public school districts. Public providers are required to expend public funds for the cost of habilitation center services prior to making a claim for the eligible federal share of reimbursement. The protocol for 2004 cost reconciliation includes verification of the eligibility for match of any certified public expenditure.

TN NO. 05-008  
SUPERCEDES  
TN NO. 03-024

APPROVAL DATE: AUG 2 5 2005  
EFFECTIVE DATE: 7/1/05

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

**d. Rehabilitative services (Continued)**

**3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

**Effective Date:** Reimbursement methodology for April 5, 2004 July 1, 2004

**1). Methodology:**

The methodology uses individual provider rates established by desk reviewed data from 1999 cost reports received by ODJFS for each of the services contained in Table 1<sup>2</sup>. The rates established are the rates that were in place on December 31, 2003 as part of the approved state plan amendment with the following exceptions:

1. The provider specific rates have been reduced by 1.79% to address potential unallowable costs associated with operational fees that may have been included in some cost reports.
2. New providers and providers who had not yet been assigned rates based on cost reported data are now assigned rates equal to 100% of the statewide average of all provider specific rates for a particular service.

Rates for aggregated services are daily rates. When the services are billed as an aggregated rate the methodology is the same as that described for the above referenced time period.

For public providers, revenue cannot exceed expenditures and any overpayment shall be recovered.

**2). Reimbursement:**

When Habilitation Centers provide habilitation center services they shall receive rates as described above. ODJFS will no longer reimburse for physician services through the Habilitation Center program with this SPA.

**3). Non-federal share:**

The non-federal match required to claim Federal financial participation (FFP) is met through the use of public funds appropriated directly from the legislature, along with certified public expenditures (CPEs) or local public monies from county boards of MRDD and participating local public school districts. Public providers are required to expend public funds for the cost of habilitation center services prior to making a claim for the eligible federal share of reimbursement. The protocol for 2004 cost reconciliation includes verification of the eligibility for match of any certified public expenditure.

TN NO. <u>05-008</u>	APPROVAL DATE: <u>AUG 27 2005</u>
SUPERCEDES	
TN NO. <u>03-024</u>	EFFECTIVE DATE: <u>7/1/05</u>

<sup>2</sup> Refer to Table 1 for a description of each habilitation center service.

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

**d. Rehabilitative services (Continued)**

**3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

**Effective Date:** Reimbursement methodology for July 2, 2004 through September 30, 2004.

**1). Methodology:**

Refer to the methodology contained in the January 1, 2004 through April 4, 2004 methodology narrative for transportation.

Rates for school-based providers use the same methodology as described for the April 5, 2004 to July 1, 2004 period.

Rates for all other providers are based on rates paid in other Medicaid programs for occupational therapy, physical therapy, speech language pathology and audiology, nursing, psychology, and social work and counseling services. Rates for aggregated services are daily rates. When the services are billed as an aggregated rate the methodology is the same as in the January 1, 2004 to April 4, 2004 time period.

A cost of doing business (CODB) factor is added to the rates based on the location at which the service is provided. The CODB groupings were derived from Title 33 CODB factors.

For all providers, revenue cannot exceed expenditures and any overpayment shall be recovered.

**2). Reimbursement:**

When Habilitation Centers provide habilitation center services they shall receive rates as described above. ODJFS will no longer reimburse for physician services through the Habilitation Center program with this SPA. ODJFS will no longer reimburse for nutrition services through the Habilitation Center program effective with this SPA.

**3). Non federal share:**

The non federal match required to claim Federal financial participation (FFP) is met through the use of public funds appropriated directly from the legislature, along with certified public expenditures (CPEs) or local public monies from county boards of MRDD and participating local public school districts. Public providers are required to expend public funds for the cost of habilitation center services prior to making a claim for the eligible federal share of reimbursement. The protocol for 2004 cost reconciliation includes verification of the eligibility for match of any certified public expenditure.

TN NO. 05-008  
SUPERCEDES  
TN NO. 03-024

APPROVAL DATE: AUG 2 3 2005  
EFFECTIVE DATE: 7/1/05

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

**d. Rehabilitative services (Continued)**

**3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

**Effective Date:** Reimbursement methodology for ~~October 1, 2004~~ June 30, 2005

**1). Methodology:**

Refer to the methodology contained in the January 1, 2004 through April 4, 2004 methodology narrative for transportation.

Rates for school based providers use the same methodology as described for the April 5, 2004 to July 1, 2004 period.

Rates for all other providers were based on rates paid in other Medicaid programs for occupational therapy, physical therapy, speech language pathology and audiology, nursing, psychology, and social work and counseling services. Rates for aggregated services are daily rates. When the services are billed as an aggregated rate the methodology is the same as in the January 1, 2004 to April 4, 2004 time period.

~~The (CODB) factor was removed from the rates.~~

For all providers, revenue cannot exceed expenditures and any overpayment shall be recovered.

**2). Reimbursement:**

When Habilitation Centers provide habilitation center services they shall receive rates as described above. ODJFS will no longer reimburse for physician services and nutrition services through the Habilitation Center program.

**3). Non-federal share:**

The non-federal match required to claim Federal financial participation (FFP) is met through the use of public funds appropriated directly from the legislature, along with certified public expenditures (CPEs) or local public monies from county boards of MRDD and participating local public school districts. Public providers are required to expend public funds for the cost of habilitation center services prior to making a claim for the eligible federal share of reimbursement. The protocol for 2004 and 2005 cost reconciliation includes verification of the eligibility for match of any certified public expenditure.

TN NO. 05-008 APPROVAL DATE: AUG 25 2005  
SUPERCEDES  
TN NO. 04-015 EFFECTIVE DATE: 7/1/05

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

**d. Rehabilitative services (Continued)**

**3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

<b>Table 1</b>			
<b>Service</b>	<b>Activities</b>	<b>Unit</b>	<b>Providers</b>
<p><b><u>Counseling and social work:</u></b>                      The application of clinical counseling principles, methods or procedures or specialized knowledge of human development and behavior and social, economic, and cultural systems in directly assisting individuals to improve or restore their capacity for social functioning, the use of psychological interventions and social psychotherapy.</p>	<ol style="list-style-type: none"> <li>1. Assessment, evaluations and screenings</li> <li>2. Diagnostic services</li> <li>3. Treatment and therapy</li> <li>4. Crisis intervention</li> <li>5. Consultation</li> </ol>	*15-minute	Certified Habilitation Centers
<p><b><u>Nursing services:</u></b>                      The application of nursing care requiring knowledge, judgment and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences.</p>	<ol style="list-style-type: none"> <li>1. Nursing diagnosis, evaluations and assessments</li> <li>2. Treatment and therapy</li> <li>3. Consultation services</li> <li>4. Crisis intervention</li> </ol>	*15-minute	Certified Habilitation Centers
<p><b><u>Occupational therapy:</u></b>                      The evaluation of learning and performance skills and the analysis, selection, and adaptation of activities for an individual whose abilities to cope with daily living, perform tasks normally performed at the individual's stage of development, and perform vocational tasks are threatened or impaired by developmental deficiencies, the aging process, environmental deprivation, or physical, psychological, or social injury or illness</p>	<ol style="list-style-type: none"> <li>1. Diagnosis</li> <li>2. Assessment</li> <li>3. Treatment</li> <li>4. Therapy</li> <li>5. Consultation</li> </ol>	*15-minute	Certified Habilitation Centers

TN NO. 05-008 APPROVAL DATE: AUG 25 2005  
 SUPERCEDES  
 TN NO. 03-024 EFFECTIVE DATE: 7/1/05

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

d. Rehabilitative services (Continued)

3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS

<b>Table 1 (continued)</b>			
<b>Service</b>	<b>Activities</b>	<b>Unit</b>	<b>Providers</b>
<p><b><u>Physical therapy:</u></b>                      The evaluation and treatment of a person by physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating any disability.</p>	<p>1. <del>Diagnosis/Assessment</del>                      2. <del>Technique/Therapy</del>                      3. <del>Consultation</del>                      4. <del>Design, fabrication, revision, education, and instruction in the use of various assistive devices</del></p>	<p>*15-minute</p>	<p>Certified Habilitation Centers</p>
<p><b><u>Psychology services:</u></b>                      Rendering or offering to render any service involving the application of psychological procedures for the assessment, diagnosis, prevention, treatment or amelioration of psychological problems or emotional or mental disorders; or for the assessment or improvement of psychological adjustment or functioning of individuals or groups, whether or not there is a diagnosable pre-existing psychological condition.</p>	<p>1. <del>Diagnosis/Assessment</del>                      2. <del>Treatment/Therapy</del>                      3. <del>Consultation</del></p>	<p>*15-minute</p>	<p>Certified Habilitation Centers</p>
<p><b><u>Speech language pathology and audiology services:</u></b>                      The application of principles, methods, or procedures related to the development and disorders of human communication, including auditory comprehension and processing; oral, pharyngeal or laryngeal sensorimotor competencies; auditory or visual processing; auditory or visual memory and cognition; communication; and assisted augmentative communication treatment and services.</p>	<p>1. <del>Diagnosis/Assessment</del>                      2. <del>Treatment/Therapy</del>                      3. <del>Consultation</del></p>	<p>*15-minute</p>	<p>Certified Habilitation Centers</p>

TN NO. 05-008 APPROVAL DATE: AUG 24, 2005  
 SUPERCEDES  
 TN NO. 03-024 EFFECTIVE DATE: 7/1/05

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

**d. Rehabilitative services (Continued)**

**3. REHABILITATIVE SERVICES PROVIDED BY HABILITATION CENTERS**

<b>Table 1 (continued)</b>			
<b>Service</b>	<b>Activities</b>	<b>Unit</b>	<b>Providers</b>
<b><u>Transportation services:</u></b> The conveyance of an eligible individual in a vehicle for the purpose of receiving habilitation center services in compliance with federal requirements.	Trip to and/or from the community alternative funding system (CAFS) provider service delivery site	One-way trip	Certified Habilitation Centers
<b><u>Nutrition services:**</u></b> Means either a nutritional assessment to develop an individualized nutritional care component of a plan or nutrition counseling provided by a dietician.	1. Assessment 2. Counseling 3. Initial evaluations & assessments 4. Consultation	*15-minute	Certified Habilitation Centers
<b><u>Aggregated habilitation center services:</u></b> When aggregated services are billed using the daily rate, they cannot be billed as discrete services.	All habilitation center services excluding transportation.	Daily rate	Certified Habilitation Centers

\* A 15 minute unit may be claimed for service duration from eight (8) to twenty-two (22) minutes.  
 \*\* ODJFS no longer reimburses for nutrition services through the Habilitation Center program effective July 2004.  
 \*\*\* The reimbursement methodologies listed in this SPA also apply to Targeted Case Management and Service Coordination.

Rehabilitation services provided by Habilitation Centers will no longer be covered or reimbursable under the state plan for dates of service after June 30, 2005.

TN NO. 05-008 APPROVAL DATE: AUG 2 2005  
 SUPERCEDES  
 TN NO. 03-024 EFFECTIVE DATE: 7/1/05

14. Services For Individuals Age 65 or Older In Institutions For Mental Diseases

b. Skilled nursing facility services

None designated to date.

c. Intermediate care facility services

None designated to date.

TNS # 90-38  
SUPERSEDES  
TNS # 89-27

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

336

15. Intermediate Care Facility Services.

See Attachment 4.19-C, Supplement 2; Attachment 4.19-D, Supplement 2; and Attachment 4.19-D.

TN: 13-007  
Supersedes:  
TN: 93-39

Approval Date: APR 02 2014

Effective Date: 01/10/2013

17. Nurse-midwife services.

Payment for Nurse-midwife 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 Nurse-midwife 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's nurse-midwife services fee schedule rate was set as of January 1, 2016 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.

The following payment scenarios also exist:

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.

The maximum reimbursement for certified nurse-midwife services is the lesser of the provider's billed charge or the percentage listed below, whichever is less:

eighty-five per cent of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the Medicaid maximum when services are provided in any non-hospital place of service.

The maximum reimbursement for nurse-midwife evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum.

TN: 12-005  
Supersedes:  
TN: 09-035

Approval Date: 11/25/14

Effective Date: 01/01/2012

17. Nurse-midwife services, continued.

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

new patient, problem focused visit	\$49.85
new patient, expanded problem focused visit	\$49.85
established patient, evaluation & management by non-physician	\$19.73
established patient, evaluation & management by physician	\$49.85

TN: 09-035  
Supersedes:  
TN: 90-38

Approval Date: 09/27/12

Effective Date: 01/01/2010

## 18. Hospice Care.

Reimbursement for Hospice care will be made at predetermined rates for each day in which a beneficiary is under the care of the Hospice. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day. With the exception of payment for physician services, the following categories or levels of care into which Medicaid hospice is classified are:

- Routine home care, (RHC). (Providers are paid one of two levels of RHC on or after January 1, 2016; see below)
- Continuous home care
- Inpatient respite care
- General inpatient care
- Service Intensity Add-On

The State pays the Medicaid Hospice rates published annually by CMS. Medicaid Hospice rates are based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using the indices published in the Federal Register and the daily Medicaid hospice payment rates announced through the Centers for Medicare and Medicaid's memorandum titled "Annual Change in Medicaid Hospice Payment Rates—ACTION" issued by the Deputy Director of the Center for Medicaid, CHIP Services Financial Management Group (FMG).

The State posts on the agency's website two separate rate tables for Medicaid hospice providers to use. The first table reflects full payment for providers that comply with quality data reporting requirements, while the second table reflects a two-percentage-point payment reduction specific for any Medicaid hospice provider that failed to comply with Section 3004 of the Affordable Care Act [Section 1814(i)(5)(A)(i)] and the Hospice Quality Reporting Program (HQRP).

Upon notice from CMS that a provider has failed to comply with HQRP the previous fiscal year, the State directs the provider to submit all hospice claims to the Ohio Department of Medicaid for the ensuing federal fiscal year using rates posted online at <http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/SchedulesandRates> for "Providers that Failed to Comply with Quality Reporting Requirements". The two-percentage-point payment reduction is reflected in categories of hospice care, including routine home care, continuous home care, inpatient respite, and general inpatient care.

Effective January 1, 2016, rates for routine home care are to be paid at a two-tiered per diem, as set by CMS based on a beneficiary's length of stay—with a higher rate for the first 60 days of hospice care and a lower rate starting on day 61. The two-tier rates are applicable irrespective of:

- the beneficiary's level of hospice care;
- whether hospice was elected prior to January 1, 2016;
- whether a beneficiary revokes, transfers, or is discharged from hospice care; and/or
- whether a lapse or break in hospice service occurs after January 1, 2016. A minimum of 60 days' gap in Hospice services is required to reset the counter which determines which payment category a participant is qualified for.

In addition, a service intensity add-on (SIA) payment is payable for services provided by a registered nurse (RN) or social worker in the last seven days of a hospice beneficiary's life. The SIA is available on and after January 1, 2016, under the following conditions:

- The day of care is a routine home care day;
- The day occurs during the last seven days of life;
- The patient's discharge is due to death;
- The direct care provided by an RN or social worker occurred during an in-person visit;
- The total hours paid for the SIA does not exceed four hours in a day for the RN and social worker combined;
- The SIA payment equals the hourly rate for continuous home care, multiplied by the number of hours of RN and social worker direct patient care visit time;
- The SIA payment is paid retrospectively by CMS claims, in addition to the routine home care rate paid by Medicaid; and
- Visits for the pronouncement of death are not be counted for the SIA payment.

Hospices will also be reimbursed a per diem amount to cover room and board services provided by the nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID) to the Medicaid beneficiary who has elected Hospice care and resides in the NF or ICF-IID. This reimbursement rate is equal to 95 percent of the base rate paid to that particular facility of residence.

Physicians who provide direct patient care are reimbursed according to Medicaid's fee-for-service system. This reimbursement is in addition to the daily rate paid to the Hospice. If the physician is a Hospice employee, the Hospice will bill for services on behalf of the physician. If the physician is the beneficiary's attending physician and is not a Hospice employee, the physician will bill the department directly.

A Hospice's annual Medicaid reimbursement cannot exceed its annual Medicaid caseload multiplied by the statutory cap amount. Total Medicaid payments made to the Hospice for services provided by physicians who are Hospice employees, along with total payments made at the various Hospice daily rates, will be counted in determining whether the cap amount has been exceeded. Payments made for the services of physicians who are not Hospice employees and for payments made for room and board will not be included in the cap calculation. A hospice will not be reimbursed for inpatient days (general and respite) beyond 20 percent of the total days of care it provides to Medicaid beneficiaries during the "cap year."

TN: 16-011

Supersedes

TN: NewApproval Date: 6/9/16Effective Date: 01/01/2016

**--FILED AT END--**

**Attachment 4.19-B**

**Items 6, 11, 13, 19, and 24**

**Pages 1, 2, 3, and 4**

**TN 05-020, Approved 08/12/08**

**Cost-Based Reimbursement**

**for IDEA Services Provided**

**in Schools**

**--FILED AT END--**

19. Case management services and tuberculosis related services.
- a. Methods and standards for payment/reimbursement of case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A Target Group C: DD (in accordance with Section 1905(a) (19) of Section 1915(g) of the Act).

**Rates:**

Qualified Targeted Case Management (TCM) providers, which are limited to County Boards of Developmental Disabilities (CBDDs), are reimbursed for the actual incurred costs of providing TCM to eligible Medicaid beneficiaries. The CMS-approved Department of Developmental Disabilities, County Boards Income and Expense Report is submitted by the CBDDs at the end of May for the previous calendar year. Reconciliation is completed after all county board cost reports have been audited for the reporting period. CBDDs are paid an interim rate of \$19.50 per fifteen minute unit for providing TCM services. Once all CBDD cost reports have been audited, a final settlement will be processed. The payments will be paid to each provider in an amount based on the provider's reconciled costs for providing TCM services to Medicaid recipients, less amounts already paid to the provider for TCM services under the state plan. Reconciled costs will be calculated using CMS-approved cost reporting methods. Government providers are required to comply with cost allocation principles found in 2 CFR 200. For purposes of the TCM payments, effective for services provided on or after November 1, 2016, costs shall be calculated as described in paragraphs A through E.

A. Direct Services Payment Methodology

The annual cost settlement methodology will consist of audited CMS-approved cost reports and cost reconciliation. If Medicaid payments exceed Medicaid-allowable costs, the excess will be recouped and returned to the federal government.

The Medicaid-allowable direct and indirect costs of providing direct services to Medicaid recipients receiving Targeted Case Management services are determined as follows:

- (1) Direct costs are those that can be identified directly to a particular program/cost objective. These costs are primarily made up of payroll and other expenses related to the compensation of employees, but also include costs not related to compensation, such as cost of materials, equipment, travel, and similar items that can be directly assigned to the benefitting program/cost objective as described in 2 CFR 200.
- (2) Indirect costs are those that are general in nature and not directly assignable to a particular program/cost objective. These indirect costs are allocated through the approved cost report to ensure that all revenue and non-revenue producing programs/cost objectives receive the appropriate share of these costs.
- (3) Determine the amount of each provider's Medicaid reimbursement for claims incurred during the provider's fiscal year and adjudicated to a paid status through the Medicaid Information Technology System (MITS).

TN: 16-028  
Supersedes:  
TN: 15-005

Approval Date: 10/13/16  
Effective Date: 11/01/2016

- (4) Determine the amount of each provider's reconciled costs for the provider's fiscal year for providing TCM services for Medicaid-eligible persons.
- (5) Determine the cost settlement ceiling which will be the lesser of the CBDD's actual cost per unit or 112% times a weighted statewide average cost per unit. The 112% weighted statewide average rate will be calculated by removing outliers and weighting the average using the total number of units. Outliers are defined as any rate exceeding three standard deviations from the mean rate; these outliers will be removed prior to calculation of the average. Costs will be settled at the lower of the CBDD's audited rate or the cost settlement ceiling. Reimbursement will not exceed the cost of providing service to Medicaid-eligible persons.
- (6) If the amount calculated in item (5) is greater than zero, the provider will receive a payment equal to the amount calculated in item (5) multiplied by the Federal Medical Assistance Percentage (FMAP) rate in effect at the time of the payment. If the amount calculated in item (5) is less than zero, the Medicaid reimbursement exceeds the cost calculated in item (4). The federal portion of the overpayment would be collected and returned to the federal government.

All expenditures reported and allocation methodologies used must be in compliance with 2 CFR 200 and all reports are audited. Audits are currently performed by the office of the Ohio auditor of State.

#### B. Certification of Expenditures

Qualified targeted case management (TCM) providers, which are limited to CBDDs, certify actual incurred costs of providing TCM to eligible Medicaid beneficiaries. Each provider must certify its expenditures as eligible for federal financial participation in order to settle to actual incurred costs for Medicaid TCM services.

#### C. Annual Cost Report Process

CBDDs are required to file a cost report for the preceding calendar year not later than the last date of May unless a later date is established.

Cost reports are filed and audited. The audit is certified as complete and a copy of the certified audit is filed in the office of the clerk of the governing body, executive officer of the governing body, and chief fiscal officer of the audited CBDD.

#### D. The Cost Reconciliation Process

CBDDs are paid an interim rate per fifteen minute TCM unit. Once all CBDD cost reports have been audited, a cost settlement will be processed. The payments will be paid to

each provider in an amount based on the provider's reconciled costs for providing TCM services to Medicaid recipients, less amounts already paid to the provider for TCM services under the state plan. Reconciled costs will be calculated using CMS-approved cost reporting methods. CBDDs are required to comply with cost allocation principles found in 2 CFR 200.

#### E. The Cost Settlement Process

For purposes of these payments, for costs calculated in item A of this document for payments exceeding the Medicaid allowable costs, the provider will remit the federal share of the overpayment. Reconciliation is completed after the Ohio Auditor of State has audited all county board cost reports for the reporting period.

#### **Unit Definition:**

A unit of service is equivalent to fifteen (15) minutes. Minutes of service provided to a specific individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific individual divided by fifteen plus one additional unit if the remaining number of minutes is eight or greater minutes.

#### **Claims Payment Process:**

Providers will submit claims to the Ohio Department of Developmental Disabilities (DODD). For all providers of TCM, DODD will have a voluntary reassignment of claims payment form on file.

DODD will receive the claims through their system, conduct up-front edits and forward the claims to the Ohio Department of Medicaid for adjudication.

DODD will post claims adjudication status as well as remittance advice information to their secure website for providers to access and download.

19. Case management services and Tuberculosis related services.
- a. Methods and standards for payment/reimbursement of case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A Target Group E: HMG-HV Help Me Grow Home Visiting Program (in accordance with Section 1905(a)(19) of Section 1915(g) of the Act).

**Rate(s):**

The rates of \$11.50 and \$13.50 per quarter hour were derived by using data collected for a salary survey referenced in the Ohio Department of Health, Help Me Grow, Cost Survey, June 2010. The reported survey costs for the early childhood educator/specialist and service coordinator were averaged to determine the \$11.50 rate, and the reported survey costs for the licensed nurse and licensed social worker were averaged to determine the \$13.50 rate. The rates were adjusted for fringe benefits, productivity assumptions, an administrative percentage and travel costs to determine a base rate which was then inflated for year 2011.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Targeted Case Management services provided to Medicaid-eligible expectant first time parents, first time parents, infants, and toddlers under the age of three years who are enrolled and participating in Ohio's Help Me Grow Home Visiting Program. The proposed effective date for the fee schedule reimbursement rates is 7/1/2012 and would be effective for services provided on or after that date.

The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific individual divided by fifteen plus one additional unit if the remaining number of minutes is at least eight minutes.

**Unit Definition:**

A unit of service is equivalent to a quarter hour (fifteen minutes). Up to 232 units of this service may be provided to an individual over one year.

A fifteen minute unit may be billed if the individual receives more than 8 minutes of service.

19. Case management services and Tuberculosis related services.

- a. Methods and standards for payment/reimbursement of case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A Target Group F: ODADAS (in accordance with Section 1905(a)(19) of Section 1915(g) of the Act).

**Rate(s):**

The unit rate of \$ 78.17 per hour was derived by using provider cost data for state fiscal year 2006. The analysis showed that the proposed rate was within a reasonable range when compared to both the average and median unit cost, with some falling below and some falling above. The reimbursement methodology is as follows:

- 1) If the total number of service units rendered and billed by a provider per date of service to a unique client is less than or equal to 1.5, the Medicaid payment amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units billed or the provider billed amount based upon their established usual and customary charge, whichever is less.
- 2) If the total number of service units rendered and billed by a provider per date of service to a unique client is greater than 1.5, the Medicaid payment amount is equal to the sum of:
  - The unit rate according to the department's service fee schedule multiplied by 1.5; and
  - Fifty percent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units billed minus 1.5.

The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day from a specific provider for a specific individual divided by sixty plus one additional tenth of a unit if the remaining number of minutes is at least four (4) minutes.

**Unit Definition:**

A unit of service is equivalent to one hour and may be billed in tenth of an hour (six minute) increments.

A tenth of a unit may be billed if the individual receives more than four (4) minutes of service.

**Claims Payment Process:**

Providers will submit claims to the Ohio Department of Job and Family Services (ODJFS). The ODJFS will process the claims and reimburse the providers at 100%.

TN: 12-007

Supersedes:

TN: NEW

Approval Date: JUN 27 2012

Effective Date: 07/01/2012

20. Extended services to pregnant women.

Reimbursement for extended services to pregnant women is made to the service provider in accordance with the reimbursement descriptions found in corresponding medical service items in 4.19.

TNS # 90-38  
SUPERSEDES  
TNS # NEW

APPROVAL DATE 10/12/90  
EFFECTIVE DATE 7/1/90

23. Certified pediatric and family nurse practitioners' services.

Payment for certified pediatric and family nurse practitioners' 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 certified pediatric and family nurse practitioners' 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 are published on the agency's website at [medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's certified pediatric and family nurse practitioners' services fee schedule was rate was set as of January 1, 2016 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.

The following payment scenarios also exist:

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.

The maximum reimbursement for certified pediatric and family nurse practitioners' services is the lesser of the provider's billed charge or the percentage listed below, whichever is less:

eighty-five per cent of the Medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the Medicaid maximum when services are provided in any non-hospital place of service.

The maximum reimbursement for certified pediatric and family nurse practitioners' evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum.

TN: 12-005  
Supersedes:  
TN: 09-035

Approval Date: 11/25/14

Effective Date: 01/01/2012

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

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

new patient, problem focused visit	\$49.85
new patient, expanded problem focused visit	\$49.85
established patient, evaluation & management by non-physician	\$19.73
established patient, evaluation & management by physician	\$49.85

TN: 09-035  
Supersedes:  
TN: NEW

Approval Date: 09/27/12

Effective Date: 01/01/2010

**--FILED AT END--**

**Attachment 4.19-B**

**Items 6, 11, 13, 19, and 24**

**Pages 1, 2, 3, and 4**

**TN 05-020, Approved 08/12/08**

**Cost-Based Reimbursement**

**for IDEA Services Provided**

**in Schools**

**--FILED AT END--**

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-a. Transportation.

Payment is the lesser of the billed charge or the Medicaid maximum for the service. 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](http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

The agency's transportation fee schedule was set as of January 1, 2010, 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.

Transportation provided by nursing facilities for their recipient-residents is included as a part of nursing facility services. Nursing facilities receive a per diem amount that includes payment for all transportation services and are responsible for ensuring that their recipient-residents obtain those transportation services. Such services are paid for by the nursing facilities and are not eligible for reimbursement on a fee-for-service basis. For dates of service beginning 08/18/2009 and ending 09/30/2009, however, transportation providers may submit claims directly on a fee-for-service basis for providing transportation services to nursing facility residents.

TN: 13-019  
Supersedes:  
TN: 09-035

Approval Date: 11/25/14  
Effective Date: 09/01/2013

State of Ohio

Attachment 4.19-B

Item 24-b

Page 1 of 1

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-b. Services Furnished in a Religious Nonmedical Health Care Institution

Payment is the same as it is for any nursing facility (NF) or intermediate care facility (ICF).

---

Transmittal Number 09-010

Supersedes

Transmittal Number 90-45

Approval Date: **SEP 23 2011**

Effective Date: 8/1/09

State of Ohio

Attachment 4.19-B

Item 24-c

Page 1 of 1

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-c. Affiliations

This item is not applicable.

---

Transmittal Number 09-010

Supersedes

Transmittal Number 90-45

Approval Date:

**SEP 23 2011**

Effective Date: 8/1/09

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-d. Skilled Nursing Facility Services for Individuals Under Age 21

Payment is the same for services provided to individuals younger than 21 as it is for services provided to individuals 21 years of age or older.

State of Ohio

Attachment 4.19-B

Item 24-e

Page 1 of 1

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-e. Emergency Hospital Services

Payment is made on the same basis as for out-of-state hospital services.  
(See Attachment 4.19-A.)

---

Transmittal Number 09-010

Supersedes

Transmittal Number 90-45

Approval Date:

**SEP 23 2011**

Effective Date: 8/1/09

State of Ohio

Attachment 4.19-B

Item 24-f

Page 1 of 1

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-f. Personal Care Services

This item is not applicable.

---

Transmittal Number 09-010

Supersedes

Transmittal Number 90-45

Approval Date:

**SEP 23 2011**

Effective Date: 8/1/09

State of Ohio

Attachment 4.19-B

Item 24-g

Page 1 of 1

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-g. Critical Access Hospital (CAH) Services

This item is not applicable.

---

Transmittal Number 09-010

Supersedes

Transmittal Number 90-45

Approval Date:

**SEP 23 2011**

Effective Date: 8/1/09

## 26. Telemedicine

**Payment Methodology:**

The payment amount for a health care service delivered through the use of telemedicine, a telemedicine originating fee, or an evaluation and management service is the lesser of the submitted charge or the maximum amount shown in the professional fee schedule for the date of service.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of telemedicine. The agency's fee schedule rate was set as of 12/31/2014 and is effective for services provided after that date. All rates are published at <http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

**Payment Limitations:**

When the originating site is located within a five mile radius from the distant site, providers at the distant or originating site are not eligible for payments related to telemedicine.

The distant site provider may submit a professional claim for the health care service delivered through the use of telemedicine. No institutional (facility) claim may be submitted by the distant site provider for the health care service delivered through the use of telemedicine. All appropriate codes and modifiers must be reported.

An originating site provider that is neither an inpatient hospital nor a nursing facility may submit a claim for a telemedicine originating fee. If such an originating site provider renders a separately identifiable evaluation and management service to the patient on the same date as the health care service delivered through the use of telemedicine, the provider may submit either a claim for the evaluation and management service or the telemedicine originating fee with the appropriate modifier. No originating site provider may receive both a telemedicine originating fee and payment for an evaluation and management service provided to a patient on the same day.

The rendering practitioner at the distant site must be a medical doctor, doctor of osteopathic medicine or licensed psychologist or a federally qualified health center. When the rendering provider is a federally qualified health center the rendering practitioner must be a medical doctor, doctor of osteopathic medicine or licensed psychologist.

A provider will not be eligible for payment as both the originating and distant site for the same patient, same date of service.

TN: 14-022  
Supersedes  
TN: NEW

Approval Date 6/11/15

Effective Date 01/01/2015

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 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](http://medicaid.ohio.gov/PROVIDERS/FeeSchedulesandRates.aspx).

The agency's fee schedule was set as of January 1, 2012, 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.

TN: 13-019  
Supersedes:  
TN: 12-004

Approval Date: 11/25/14  
Effective Date: 09/01/2013

---

**--FILED AT END--**

**Attachment 4.19-B**

**Items 6, 11, 13, 19, and 24**

**Pages 1, 2, 3, and 4**

**TN 05-020, Approved 08/12/08**

**Cost-Based Reimbursement**

**for IDEA Services Provided**

**in Schools**

**--FILED AT END--**

## Cost-Based Reimbursement for IDEA Services Provided in Schools

1. The reimbursement for providers, other than Medicaid school program providers, is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.
2. Effective for dates of service on and after (date approved by CMS), reimbursement for direct medical services (salaries, benefits, and contract compensation) provided by a school approved as a Medicaid school program provider of services will be at an interim rate which will be the lesser of the billed charge or the Medicaid maximum for the particular service according to the department's procedure code reference file. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of a cost reconciliation and a cost settlement for that period. Services delivered through a Medicaid school program provider that are allowable for Medicaid reimbursement are:
  - a. Audiology (reference pre-print page 4, item 11)
  - b. Counseling (reference pre-print pages 5 and 6, item 13)
  - c. Nursing (reference pre-print pages 2 and 3, item 6)
  - d. Occupational Therapy (reference pre-print page 4, item 11)
  - e. Physical Therapy (reference pre-print page 4, item 11)
  - f. Psychology (reference pre-print pages 5 and 6, item 13)
  - g. Social Work (reference pre-print pages 5 and 6, item 13)
  - h. Speech Language Pathology (reference pre-print page 4, item 11)
  - i. Targeted Case Management (reference pre-print page 8, item 19)
  - j. Transportation - Reimbursed per unit of service. The unit of service is based on a one-way trip. (reference pre-print page 9, item 24)
3. Certification of public expenditures: The non-federal share of the cost of the services will be paid by the Medicaid school program provider. The Medicaid school program provider shall certify, via attestation at the time of claiming, the availability of appropriate and sufficient non-federal share of the costs for which claim for reimbursement is made. The single state Medicaid agency (ODJFS) will reimburse the Medicaid school program provider at the interim rate the federal financial participation (FFP) portion of the claim only.
4. Reimbursement for other direct medical services (ex. Travel, materials and supplies), indirect costs, and equipment will be made through the cost report reconciliation process.
5. To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients, the following steps are performed:

TN No. 05-020 APPROVAL DATE: AUG 12 2008  
SUPERSEDES  
TN No. new EFFECTIVE DATE: 7/1/05

Cost-Based Reimbursement for IDEA Services Provided in Schools

- a. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by schools, excluding transportation personnel.
- b. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, capital outlay, travel, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs.
- c. Total direct costs for direct medical services are reduced by any federal payments for those costs, resulting in adjusted direct costs for direct medical services.
- d. Adjusted direct costs are then allocated to direct medical services regardless of payer source by applying the direct medical services percentage from the CMS-approved time study, resulting in net direct costs.
- e. A CMS-approved time study methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, including targeted case management, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. This time study methodology will utilize three mutually exclusive cost pools representing individuals performing administrative activities and direct services. A sufficient number of medical services personnel will be sampled to ensure time study results that will have a confidence level of at least 98 percent within a precision of plus or minus two percent overall. The same single direct medical services time study percentage is applied against costs for all medical disciplines.
- f. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs as approved by ODE under the authority of USDE, which is the cognizant agency for school districts.
- g. Net direct costs and indirect costs are combined, and the results are multiplied by the ratio of the total number of students with Individualized Education Programs (IEPs) receiving medical services and eligible for Medicaid to the total number of students with IEPs receiving medical services.
- h. To determine the direct and indirect costs of specialized transportation services to Medicaid-eligible students, the following steps are performed:

TN No. 05-020 APPROVAL DATE: AUG 12 2008  
SUPERSEDES  
TN No. new EFFECTIVE DATE: 7/1/05

Cost-Based Reimbursement for IDEA Services Provided in Schools

- i. Identification of direct costs for covered specialized transportation services includes: direct payroll costs (salaries and benefits and contract compensation) of bus drivers and mechanics, gasoline and other fuels, other maintenance and repair costs, vehicle insurance, rentals, and vehicle depreciation. Depreciation must be documented by completing the depreciation schedule in the cost report. These direct costs are accumulated on the annual cost report, resulting in total direct transportation costs.
  - ii. Total direct transportation costs are reduced by any federal payments for those costs, resulting in adjusted direct transportation costs.
  - iii. Adjusted direct transportation costs are then allocated to Medicaid by applying the ratio of one-way trips provided pursuant to an IEP to Medicaid beneficiaries over total one-way specialized trips resulting in *net direct transportation costs*. Trip logs will be maintained daily to record one-way specialized transportation trips.
  - iv. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its *net direct transportation costs* as approved by ODE under the authority of USDE, which is the cognizant agency for school districts.
  - v. Net direct costs and indirect costs are combined.
6. Annual Cost Report Process: Each Medicaid school program provider will complete an annual cost report for all services delivered during the previous state fiscal year covering July 1 through June 30. The primary purposes of the cost report are to:
- a. Document the provider's total CMS-approved, Medicaid-allowable scope of costs for delivering Medicaid school services, including direct costs and indirect costs, based on a CMS-approved cost allocation methodology and procedures, and
  - b. Reconcile its interim payments to its total CMS-approved Medicaid-allowable scope of costs based on CMS-approved cost allocation procedures.
7. The Cost Reconciliation Process: The cost reconciliation process will be completed within twelve (12) months of the State fiscal year. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

Cost-Based Reimbursement for IDEA Services Provided in Schools

For the purposes of cost reconciliation, Ohio will not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or the CMS-approved time study for cost-reporting purposes referenced in this state plan amendment except by CMS approval prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

For claims submitted after the effective date of SPA 05-007 and SPA 05-020; that is July 1, 2005, and prior to the implementation of the CMS-approved time study only, cost reconciliation will be performed in accordance with a methodology developed by the Department and approved by CMS that utilizes the quarterly results of the prospectively approved time study and applies them to prior period claims.

8. Cost Settlement for a Medicaid school program provider: The actual Medicaid share of each Medicaid school programs provider's costs for the year will be compared to the total Medicaid reimbursements to the Medicaid school program provider for that year. Any overpayment determined as a result of the annual reconciliation of cost will be paid and/or collected and reimbursed in accordance with State and federal Medicaid rules. Any underpayment determined as a result of the annual reconciliation of cost will be paid in accordance with State and federal Medicaid rules.

TN No. 05-020 APPROVAL DATE: AUG 12 2008  
SUPERSEDES  
TN No. new EFFECTIVE DATE: 7/1/05