

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)		
	<u>Service Name</u>	<u>HCPCS Code</u>	<u>Billing Unit</u>
	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. 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 2/1/90

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2. a. Outpatient Hospital Services

Outpatient hospital services are covered by Ohio Medicaid in accordance with 42 CFR 440.20. Except as noted below, all hospital services provided by Medicaid providers of outpatient hospital services are reimbursed under an Enhanced Ambulatory Patient Grouping (EAPG) system based prospective payment system (PPS).

I. Outpatient Hospital Services

(A) Eligible Provider

All hospitals described in Attachment 4.19-A, section I(A) are eligible to provide outpatient hospital services.

(B) Classification of Hospitals

Hospital peer groups are for the purposes of setting rates and making payments under EAPG or PPS. The classification of hospitals and peer groups established in Attachment 4.19-A, section I(B) shall also apply for the provision of outpatient hospital services.

(C) Hospital Services Subject to Non-EAPG Prospective Payment

Effective for dates of service on or after August 1, 2017, hospital services subject to non-EAPG prospective payment, providers are paid by applying a percentage of the hospital's ratio of cost to allowed charges. Cost-to-charge ratio is derived from the Medicaid outpatient costs as reported on ODM 02930, schedule H, section II divided by Medicaid outpatient charges as reported on ODM 02930, schedule H, section II. The cost report used to complete these calculations is the interim settled cost report ending in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January first of the calendar year to which the new ratio shall apply.

Billing must reflect the hospital's customary charge for the service rendered. Payment is made for those items and services recognized as reasonable and allowable under Title XVIII standards and principles. Hospital services subject to non-EAPG prospective payment include:

- (1) Freestanding rehabilitation hospitals and long-term acute care hospitals as described in Attachment 4.19-A, section I(B), shall be reimbursed at 90% of the cost-to-charge ratio described in this paragraph .
- (2) Hospitals that are excluded from Medicare's PPS as described in Attachment 4.19-A, section I(B), shall be reimbursed at 90% of the cost-to-charge ratio described in this paragraph.
- (3) Hospitals recognized by Medicare as cancer hospitals as described in Attachment 4.19- A, section I(B), shall be reimbursed at 91.7% of the cost-to-charge ratio described in this paragraph.

TN: 17-032

Supersedes:

TNs: 17-009, 13-004

Approval Date: 12/14/17

Effective Date: 08/01/2017

(D) Outpatient Hospital Services Subject to EAPG Prospective Payment

Effective for dates of service on or after August 1, 2017, payment for outpatient hospital services provided in hospitals other than those described in subsection (C) of this section will be subject to a prospective payment methodology utilizing the EAPG system developed and maintained by 3M Health Information Systems.

The EAPG system groups and reimburses outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of International Classification of Diseases diagnosis codes, current procedural terminology (CPT) code set and healthcare common procedure coding system (HCPCS) procedure codes.

The facility payment for all hospital level outpatient services will be determined using EAPG. This includes but is not limited to surgery, radiology, laboratory, occupational therapy, physical therapy, speech, audiology and language services. Select services such as pharmacy, dental, durable medical equipment and observation may be grouped under EAPG but paid from a fee schedule or a flat rate as described in subsection (I) of this section.

(E) EAPG Payment Formula

The EAPG system may apply the following discounting factors for multiple significant procedures and/or repeated ancillary services. Ancillary services are diagnostic or therapeutic services provided as prescribed by a healthcare professional.

- (1) Full payment of the EAPG payment with no applicable discounting factor.
- (2) Consolidation factor of 0% applicable for services designated with a same procedure consolidation flag or clinical procedure consolidation flag by the EAPG grouper under default EAPG settings.
- (3) Packaging factor of 0% applicable for services designated with a packaging flag by the EAPG grouper under default EAPG settings.
- (4) Discounting factor of 50% or 100% applicable for multiple significant procedures or repeated ancillary services designated by default EAPG settings or both. For bilateral surgeries, the discounting factor is 150%. The appropriate percentage will be applied to the highest weighted of the multiple procedures or ancillary payment group.

The EAPG payment calculation is the hospital specific base rate adjusted for risk corridor, multiplied by the EAPG relative weight for which the service was assigned by the EAPG grouper, round the product to the nearest whole cent, multiplied by any applicable discounting factor (full payment, consolidation, or packaging), rounded to the nearest whole cent.

Laboratory services billed with valid CPT/HCPCS code(s) shall be reimbursed the lesser of charges or the assigned EAPG payment. Payment for all laboratory services will be no more than the Medicare fee schedule amount.

TN: 18-023

Supersedes:

TN: 17-032Approval Date: 11/7/18Effective Date: 09/01/2018

Radiology services billed with valid CPT/HCPCS code(s) shall be reimbursed the lesser of charges or the assigned EAPG payment.

(F) Sources for Inputs in the Payment Formula

The dataset used as inputs in the payment formula and determination of relative weights established for dates of service on or after January 2, 2020 consists of:

- (1) All outpatient hospital claims with dates of service from October 1, 2015 through September 30, 2018;
- (2) Cost reports submitted by Ohio hospitals to the State on its Medicaid cost report for the hospital years that end in state fiscal years 2016 (ODM 02930 rev. 4/2016) and 2017 (ODM 02930 rev. 4/2017); and
- (3) Inflation factors are computed for Ohio by Global Insight, which computes similar factors for the Medicare program. The inflation factors were used to inflate the total cost computed for each case inflating it to June 30, 2020.

(G) Computation of Case Mix Adjust Average Cost Per Case (Base Rate)

- (1) For each Ohio peer group, sum the total inflated cost for all cases; divided by
- (2) The number of cases assigned to each peer group; and multiply the result by a factor of 71.9%.
- (3) For each Ohio peer group, sum the relative weight values for all cases assigned to the peer group; divided by
- (4) The number of cases in the peer group.
- (5) Multiply the amount in subsection (G)(2) by the quotient of subsection (G)(3) and subsection (G)(4) of this section.
- (6) For non-Ohio peer groups, the peer group base rate is 70% of the statewide average.

(H) Risk corridors.

Effective for dates of service on or after August 1, 2017, the following will apply to Ohio hospital peer groups:

- (1) The peer group base rate calculated in subsection (G) of this section if the peer group base rate does not result in more than a 0% reduction or 5% gain in payments compared to the prospective payment system in effect prior to August 1, 2017; or

- (2) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a 0% reduction or 5% gain in payments compared to the prior prospective payment system.

(I) Computation of Relative Weights

The relative weight is equal to:

- (1) The average inflated cost per case within each EAPG; divided by
- (2) The average inflated cost per case across all EAPGs.
- (3) A budget neutrality factor is applied to all EAPGs in each EAPG type:
 - (a) significant procedures are increased by 1.517;
 - (b) physical therapy and rehabilitation procedures are increased by 1.221;
 - (c) mental health and counseling procedures are increased by 1.138;
 - (d) radiologic procedures are increased by 0.886;
 - (e) diagnostic significant procedures are increased by 1.092;
 - (f) medical visits are increased by 1.187;
 - (g) ancillary services are increased by 1.532; and
 - (h) dental procedures, incidental services, drugs, durable medical equipment (DME), and unassigned services are increased by 1.254.

(J) Items conditionally payable outside of EAPG

(1) Pharmaceuticals.

- (a) For services rendered on or after August 1, 2017, reimbursement for outpatient hospital pharmaceuticals HCPCS J-code or Q-code billed with revenue center code 25X or 636 shall be the lesser of charges or the payment amounts in the provider-administered pharmaceutical fee schedule as published on the department's website, <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.
- (b) Additional payments for pharmaceuticals will be made in accordance with the discounting factors as determined by the EAPG grouper.
- (c) Pharmaceutical line items without a National Drug Code will be denied payment by the State.
- (d) Charges listed in line items that carry revenue center code 025X or 636 with a provider-administered pharmaceutical HCPCS J-code or Q-code that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will be multiplied by 60% of the hospital's specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(2) Durable medical equipment (DME).

- (a) Payments for DME may be made for all line items grouping to DME EAPG codes.
- (b) For services rendered on or after August 1, 2017, reimbursement for outpatient hospital DME shall be the lesser of charges or the payment amounts in the Medicaid durable medical equipment fee schedule as published on the department's website, <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

(c) Payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.

(3) Independently billed services for drugs or medical supplies and devices.

(a) To request independently billed payment under EAPG, hospitals must report all services provided on the date of service; and

(b) Report modifier UB with the primary procedure performed. Claims submitted with modifier UB are subject to the following payment methodology:

(i) Charges listed in line items that carry revenue center codes 025X or 0636 with a provider administered HCPCS J-code or Q-code will pay in accordance to the provider-administered pharmaceutical fee schedule.

(ii) Charges listed in line items that carry revenue center code 025X without a provider-administered pharmaceutical CPT/HCPCS code or revenue center code 027X with or without a DME HCPCS code will be multiplied by 60% of the hospital specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(iii) Charges listed in line items that carry revenue center code 025X or 0636 with a provider-administered pharmaceutical HCPCS J-code or Q-code that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will be multiplied by 60% of the hospital's specific Medicaid outpatient cost-to-charge ratio as described in subsection (C) of this section.

(iv) All other detail lines on the same date of service will be paid \$0.

(4) Dental services.

For dates of service during the interim period, reimbursement for claims assigned to dental service EAPG will be paid as follows:

(a) Children's hospitals, as defined in subsection (B) of this section, will be paid \$1,062.

(b) All other hospitals will be paid \$1,192.

(c) Payments shall be multiplied by any applicable discounting factor.

(5) Vaccines for children (VFC).

(a) The administration of immunizations covered under the VFC program may be reimbursed for recipients 18 years or younger.

(b) Reimbursement for the administration of immunizations covered under the VFC program will be ten dollars for individuals eighteen years of age or younger, contingent upon the EAPG grouper.

TN: 20-009

Supersedes:

TN: 18-023

Approval Date: 05/08/20

Effective Date: 01/02/2020

However, no payment will be made for vaccines that can be obtained at no cost through the federal VFC program.

(c) Additional payments for designated free vaccines will be made in accordance with the discounting factors as determined by the EAPG grouper.

(6) Observation services.

(a) For dates of service during the interim period: payment for observation HCPCS code G0378 will be made using an average rate.

(b) Payments for observation services grouped to observation EAPG code, will be limited to a maximum of two consecutive days, except as provided in subsection (I)(6)(c) of this section.

(c) Payments for observation services reported with HCPCS code G0378 will be made for up to 24 units per day or 48 consecutive units (which could extend over a three-day period).

(7) Outpatient Hospital Services

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

(K) Additional items paid outside of EAPG.

Behavioral health (BH) services.

(1) All hospitals that meet the Medicare conditions of participation, have accreditation by national accrediting body and have accreditation for the BH services they provide, may provide outpatient BH services.

(2) Each hospital claim for BH services must contain the following:

(a) HE modifier at the detail level for each BH CPT/HCPCS code;

(b) Revenue center code 0671, 0900, 0901, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919 or 1002 for each BH detail line; and

(c) A BH diagnosis code.

(L) Payment neutrality.

(1) Outpatient hospital services provided between October 1, 2017 and September 30, 2018 were priced using the hospital-specific base rates as described in subsection (G) of this section to determine total hospital payments under EAPG version 3.9.

(2) To determine total hospital payments for outpatient hospital services under EAPG version 3.14 after the effective date of this SPA, the hospital-specific base rates will be adjusted to achieve payment neutrality for each hospital.

(3) No adjustment will be made for non-Ohio peer groups.

TN: 20-009

Supersedes:

TN: 18-023

Approval Date: 05/08/20

Effective Date: 01/02/2020

(c) For services rendered on or after August 1, 2017, payments for BH services will be paid in accordance with the outpatient hospital behavioral health fee schedule as published on the department's website, <http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

TN: 17-032

Supersedes:

TNs: 17-009, 13-004

Approval Date: 12/14/17

Effective Date: 08/01/2017

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TN: 19-029
Supersedes:
TN: NEW

Approval Date: 01/27/2020

Effective Date: 01/02/2020

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TN: 19-029
Supersedes:
TN: NEW

Approval Date: 01/27/2020

Effective Date: 01/02/2020

III. Outpatient Hospital Cost Coverage Add-On

This section applies to all Ohio hospitals reimbursed under the outpatient prospective payment system as described in Attachment 4.19-B, Section I, subsection (D) or reimbursed under non-DRG prospective payment as described in Attachment 4.19-B, Section I, subsection (C). This section does not apply to the coordination of benefits calculation pertaining to beneficiaries eligible for both Medicare and Medicaid.

(A) Source Data for Calculations

The calculations used in determining the cost coverage add-on will be based on data provided by annual cost reports submitted to the department. The cost reports used will be the hospital's cost reporting year ending in the state fiscal year prior to the state fiscal year that ends immediately preceding the state fiscal year to which the cost coverage add-on applies.

(B) Outpatient Cost Coverage Add-on Policy Pools

Appropriations authorized by the Ohio General Assembly each state fiscal year will be divided into the following policy pools:

- (1) The outpatient cost coverage standard pool, which is the lesser of \$168,054,601.29 or 23.59 percent of the appropriated funds.
- (2) The outpatient cost coverage sustainability pool which is ninety percent of the amount allocated under Attachment 4.19-B, Section VI, subsection (B)(2) less the amount allocated under Attachment 4.19-A, Section VI, subsection (B)(3).
- (3) Hospitals that have a dedicated Psychiatric Emergency Department (PED) established prior to October 1, 2019 and do not receive payments as described in Attachment 4.19-B, Item 5-a will receive \$4,750,000.00.

(C) Outpatient Cost Coverage

(1) Cost Coverage Standard Pool

- (a) Each hospital will be allocated from subsection (B)(1) of this section an amount equal to the outpatient non-claims specific lump sum payments not resulting from payments described in Supplement 2 to Attachment 4.19-B and Attachment 4.19-A, subsection (D).

(b) Any amounts in subsection (C)(1)(a) of this section allocated to a closed hospital are reallocated to the remaining hospitals based on the ratio of each hospital's allocation in subsection (C)(1)(a) of this section to the sum of the allocation for all remaining hospitals.

(c) For each hospital, sum the amount allocated in subsection (C)(1)(a) of this section and the amount calculated in subsection (C)(1)(b) of this section.

(2) Divide the amount in subsection (B)(2) of this section by the total Medicaid visits for all hospitals, then multiply the results by the number of total Medicaid visits for each hospital.

(3) For all hospitals with a PED, divide the amount in subsection (B)(3) of this section by the total Medicaid visits for all hospitals with a PED, then multiply the results by the number of Medicaid visits for each hospital with a PED.

(D) Outpatient Cost Coverage Add-On Amount Per Detail for Hospitals Subject to the Payment Methodology Under Attachment 4.19-B, Item 2-a, section I, subsection (D)

(1) For each hospital, divide the sum of subsections (C)(1) to (C)(3) of this section by the total Enhanced Ambulatory Patient Groups (EAPG) detail lines used in the outpatient case-mix calculation.

(2) For each hospital, divide the results in subsection (D)(1) of this section by the outpatient case-mix.

(3) The cost coverage add-on per detail amount is equal to the amount calculated in subsection (D)(2) of this section, rounded to two decimal places.

(4) The amount calculated in subsection (D)(3) of this section will be added to the hospital's outpatient base rate.

(E) Outpatient Cost Coverage Add-On for Hospitals Subject to the Payment Methodology Under Attachment 4.19-B, Item 2-a, section I, subsection (C)

(1) For each hospital, calculate total outpatient payments by multiplying total Medicaid outpatient charges by the outpatient cost-to-charge ratio described under Attachment 4.19-B, Section I, subsection (C) calculated from the source data described in subsection (A) of this section..

- (2) For each hospital, divide the amount in subsections (E)(1) of this section by the total Medicaid outpatient costs.
- (3) For each hospital, sum the total outpatient program payments calculated in subsection (E)(1) of this section.
- (4) For each hospital, divide the results in subsection (E)(3) of this section by the total Medicaid outpatient cost
- (5) For each hospital, calculate the outpatient cost coverage increase by subtracting the result in subsection (E)(2) of this section from the result in subsection (E)(4) of this section and dividing the result by subsection (E)(2) of this section, round to four decimal places.
- (6) For each hospital, multiply the result in subsection (E)(5) of this section by the outpatient cost-to-charge ratio calculated in subsection (E)(1) of this section.
- (7) Apply the amount calculated in subsection (I)(6) of this section as an increase to the hospital's outpatient cost-to-charge ratio.

2. a. Outpatient Hospital Services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

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

A. RHC Prospective Payment System (PPS)

In the RHC PPS, a separate all-inclusive per-visit payment amount (PVPA) (encounter) is established for RHC services (see Attachment 3.1-A, Item 2-b, Page 1 of 1) provided at an RHC service site (one PVPA for all services). A PVPA is specific to an RHC service site. The state-calculated RHC rates comply with the statutory requirements for the payment of RHC services for Medicaid in Section 1902(bb) of the Social Security Act (the Act).

For every RHC service site already enrolled as a Medicaid provider, the State establishes a new PVPA equal to the current PVPA adjusted by the percentage of the latest available Medicare Economic Index (MEI). For an existing RHC that requests an adjustment based on a change in scope, the State may establish a new PVPA based on a cost report that reflects the incremental change in rate due to the change in scope of service.

For an RHC that is enrolling as a new Medicaid provider, the State establishes an initial PVPA by setting it equal to the PVPAs of other RHCs in the immediate area that are similar in size, caseload, and scope of services. If no such RHC exists, then the initial PVPA is set equal to the current PVPA at the statewide sixtieth percentile for RHCs. This initial PVPA remains in effect until a new PVPA is established. After the initial PVPA is set, the RHC submits a cost report. A new PVPA is established on the basis of the cost report and is adjusted by any changes in the MEI that have occurred since the cost report was submitted.

The cost report used by the State for RHCs is the CMS-222-92, "Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report". When required, the State reconciles the annual cost report to final payments to the RHC within 120 days of receiving a clean cost report.

Co-payments may apply to services rendered by an RHC.

B. Supplemental Payments and Medicaid Managed Care Plans (MCPs)

An RHC receiving payment from an MCP for an RHC service is eligible to receive a supplemental (wraparound) payment from the State if the amount the RHC was paid by the MCP is less than the amount the RHC would have received under the PPS.

"Supplemental payment" or "wraparound payment" is an amount, equal to the MCP payment gap (any positive difference obtained when the MCP payment is subtracted from the amount that would have been paid to the cost-based clinic under PPS) that is paid by the department to augment the MCP payment. The wraparound payment amount equals the difference between the MCP payment and the payment that the RHC would have received under PPS.

The State pays valid claims for supplemental (wraparound) payments on a claim-by-claim basis as they are submitted. The supplemental payment is therefore made no less than every four months.

TN: 16-033

Supersedes:

TN: 11-027

Approval Date 03/17/2017

Effective Date: 10/01/2016

2-c. Federally Qualified Health Center (FQHC) Services

A. FQHC Prospective Payment System (PPS)

In the FQHC PPS, a separate all-inclusive per-visit payment amount (PVPA) (encounter) is established for each FQHC service (see Attachment 3.1-A, Item 2-c, page 1 of 1) provided at an FQHC service site (multiple PVPAs for services). A PVPA is specific to an FQHC service site. The state-calculated FQHC rates comply with the statutory requirements for the payment of FQHC services for Medicaid in Section 1902(bb) of the Social Security Act (the Act).

For every FQHC service site that is already enrolled as a Medicaid provider, the State establishes new PVPAs equal to the current PVPAs adjusted by the percentage of the latest available Medicare Economic Index (MEI). For an existing FQHC that requests an adjustment based on a change in scope, the State may establish a new PVPA based on a cost report that reflects the incremental change in rate due to the change in scope of service.

For an FQHC that is enrolling as a new Medicaid provider or is adding new FQHC services, the State establishes initial PVPAs by setting them equal to the PVPAs of other FQHCs in the immediate area that are similar in size, caseload, and scope of services. If no such FQHC exists, then the initial PVPA for each service provided is set equal to the current PVPA at the applicable statewide sixtieth percentile for either urban or rural FQHCs. If no current PVPA at the applicable statewide sixtieth percentile is available, then the initial PVPA for the service is developed. These initial PVPAs remain in effect until new PVPAs are established. After the initial PVPAs are set, the FQHC submits a cost report. New PVPAs are established on the basis of the cost report and are adjusted by any changes in the MEI that have occurred since the cost report was submitted.

If no current PVPA at the applicable statewide sixtieth percentile is available, then the initial PVPA for a service, P , is obtained by the formula $P = M \times (S / E)$, rounded up to the next whole dollar. M is the greater of two figures: (i) The current PVPA for medical services at the applicable statewide sixtieth percentile for urban FQHCs; or (ii) The current PVPA for medical services at the particular FQHC. S is the Medicaid maximum payment amount (or the unweighted average of the Medicaid maximum payment amounts) for a procedure (or a group of procedures) typical of the service for which a PVPA is being established. E is the Medicaid maximum non-facility payment amount for a mid-level evaluation and management service (office visit) for an established patient.

A ceiling is established for each FQHC service. The current sixtieth percentile PVPAs for the FQHC service are determined for all rural FQHCs and urban FQHCs respectively. An urban wage adjustment factor is calculated as the quotient of two figures published in the Federal Register for the relevant year: the overall wage index for Ohio divided by the rural wage index for Ohio. For each FQHC service provided at a rural FQHC service site, the ceiling is the statewide rural sixtieth percentile PVPA. For each FQHC service provided at an urban FQHC service site, the ceiling is the product of the statewide urban sixtieth

TN: 16-033

Supersedes:

TN: 06-003Approval Date: 03/17/2017Effective Date: 10/01/2016

percentile PVPA and the UWAF for the relevant year. The final PVPA for an FQHC service is the least of the allowed cost, the limit, or the ceiling.

The cost report used by the State for FQHCs is ODM Form 03421, “Federally Qualified Health Center / Outpatient Health Facility Cost Report.” When required, the State reconciles the annual cost report to final payments to the FQHC within one-hundred twenty days of receiving a clean cost report.

Co-payments may apply to services rendered by an FQHC.

B. Supplemental Payments and Medicaid Managed Care Plans (MCPs)

An FQHC receiving payment from an MCP for FQHC services is eligible to receive a supplemental (wraparound) payment from the State if the amount the FQHC was paid by the MCP is less than the amount the FQHC would have received under the PPS.

“Supplemental payment” or “wraparound payment” is an amount, equal to the MCP payment gap (any positive difference obtained when the MCP payment is subtracted from the amount that would have been paid to the cost-based clinic under PPS) that is paid by the department to augment the MCP payment. The supplemental (wraparound) payment amount equals the difference between the MCP payment and the payment that the FQHC would have received under PPS.

The State pays valid claims for supplemental (wraparound) payments on a claim-by-claim basis as they are submitted. The supplemental payment is therefore made no less than every four months.

C. Alternative Payment Method (APM) for Determining FQHC Payment

An FQHC operated by a State or local governmental agency may request payment using an alternate payment methodology (APM) administered in accordance with Section 1902(bb)(6) of the Act. Under the APM, a government-operated FQHC receives payment in addition to amounts established under the FQHC PPS.

The APM makes interim payments to 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 Medicaid managed care plan.

Under federal requirements in section 1902(bb)(5)(B) of the Act, the State will continue to make managed care supplemental (wraparound) payments that equal the difference between PPS and the managed care payment. The State pays valid claims for supplemental

(wraparound) payments on a claim-by-claim basis as they are submitted. The supplemental payment is therefore made no less than every four months.

At the end of the settlement period, the State will pay the FQHC for services paid 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 (wraparound) payments that must be made by the State to the FQHC 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 encounters/visits between a patient and FQHC provider of the following Medicaid services:

1. Medical services
2. Dental services
3. Physical therapy services and occupational therapy services
4. Mental health services
5. Speech pathology and audiology services
6. Podiatry services
7. Vision services
8. Chiropractic services

Multiple visits on the same day are allowable if the visits are with different provider types that are distinct centers for direct and indirect cost allocation purposes, for the services listed in Item A. 1-8. The visits must involve different cost-based clinic services; or the services rendered must be for different purposes, illnesses, injuries, conditions, or complaints or for additional diagnosis and treatment.

B. Cost reports

Cost reports are submitted annually within one hundred twenty (120) days after the close of the FQHC's fiscal year. Each service site of a government-operated FQHC uses the State's FQHC cost report (ODM Form 03421, "Federally Qualified Health Center / Outpatient Health Facility Cost Report") to compile and submit a cost report that identifies the total actual incurred allowable Medicaid costs for the service site during FQHC's fiscal year.

C. Settlement

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

TN: 16-033

Supersedes:

TN: 06-003

Approval Date: 03/17/2017

Effective Date: 10/01/2016

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 State 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 State recovers the excess payment. Excess payment to an FQHC will be recovered by the State within sixty (60) days.

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 Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one advanced imaging procedure is performed by the same provider or provider group for an individual patient in the same session. Payment is made for the primary procedure at 100%, payment for each additional technical component is made at 50%, and payment for each additional professional component is made at 95%. This payment provision took effect on January 1, 2017.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new laboratory or x-ray services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the laboratory services or MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's laboratory services fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

By-report services require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate, or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

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

Clinical Diagnostic Lab (CDL) rates attestation

The state attests that it complies with section 1903(i)(7) of the Social Security Act and limits Medicaid payments for clinical diagnostic lab services to the amounts paid by Medicare for those services on a per-test basis (or per billing code basis for a bundled/panel of tests).

TN: 20-003

Supersedes:

TN: 19-004

Approval Date: 04/17/20

Effective Date: 01/01/2020

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.

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 whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

Unless otherwise specified, the maximum payment amount for a physicians' service is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For dates of service on or after July 1, 2017, when a physician acts as an assistant-at-surgery for a covered primary surgical procedure, the maximum payment amount for the physician is the lesser of the provider's submitted charges or 25% of the Medicaid maximum specified in the agency's physician fee schedule found on the MSRIAP fee schedule.

For dates of service on or after July 1, 2017, when a surgical procedure is performed by two co-surgeons, the maximum payment amount for each co-surgeon is the lesser of the provider's submitted charges or 62.5% of the Medicaid maximum specified in the agency's physician fee schedule found on the MSRIAP 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 listed on the agency's MSRIAP fee schedule is set at 80% of the Medicare allowed amount.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

For dates of service on or after January 1, 2017, payment for anesthesia services furnished by an anesthesiologist is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by the following formula:

$$\text{Maximum payment amount} = (\text{Base unit value} + \text{Time unit value}) \times \text{Conversion factor} \times \text{Multiplier}$$

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. The conversion factor and multiplier are effective for dates of service on or after January 1, 2018, and are listed on the agency's Anesthesia fee schedule at <https://medicaid.ohio.gov/ProvidersFeeScheduleandRates.aspx>.

TN: 20-003

Supersedes:

TN: 17-027

Approval Date: 04/17/20

Effective Date: 01/01/2020

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

Optometrists' services

Optometrists' services are subject to a co-payment, explained in Attachment 4.18-A of the plan.

The agency's rates for dispensing of ophthalmic materials such as contact lenses, low vision aids, etc. are on the eye care services fee schedule published on the agency's website at <https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx>. These rates were set as of May 1, 2016, and are effective for services provided on or after that date.

The agency's physicians' rates found on the MSRIAP fee schedule were set as of January 1, 2020, and are effective for services provided on or after that date.

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

Services Provided in a Community Behavioral Health Agency

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

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

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

Supplemental Payments for Qualifying OSU Physician and Professional Services

1. Qualifying Criteria

Supplemental payments will be made for services provided to Medicaid recipients by eligible Ohio State University (OSU) physicians and other professional service practitioners. To be a 'Qualifying Provider' for purposes of the supplemental payment, eligible physicians and other professional service practitioners must:

- a. Be one of the following provider types;
 - i. Physicians;
 - ii. Physician Assistants;
 - iii. Advanced Practice Registered Nurses (APRNs);
 - iv. Certified Registered Nurse Anesthetists (CRNAs);
 - v. Certified Nurse Midwives (CNMs);
 - vi. Clinical Social Workers (CSWs);
 - vii. Clinical Psychologists;
 - viii. Optometrists; or
 - ix. Dentists
- b. Be licensed by the State of Ohio;
- c. Have an Ohio Medicaid provider agreement; and,
- d. Be employed by or affiliated with The Ohio State University Wexner Medical Center

2. Payment Methodology for non-dental services

The supplemental payment will be calculated to ensure total payments for these services are equal to OSU's average commercial rate. The average commercial rate is defined as the rates paid by the five largest commercial payers for the same service.

The specific methodology to be used in establishing the supplemental payment for professional services is as follows:

- a. Calculation of the Medicare equivalent of the average commercial rate.
 - i. For services provided by Qualifying Providers, the State will collect from OSU its current commercial professional fees by CPT code for the providers' top five commercial payers by volume.
 - ii. The State will calculate the average commercial fee for each CPT code for Qualifying Providers. For CPT codes for which there are at least one but fewer than five commercial payers for the year, the average of the available payers will be used.
 - iii. The State will extract from its paid claims history file for the preceding fiscal year all Medicaid claims paid to the Qualifying Providers. For each CPT

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

code, the State will align the average commercial fee as determined in Section 2.a.ii to the Qualifying Providers' paid Medicaid claims and calculate the total amount payable for those claims using the average commercial fee.

- iv. The State will also align the same paid Medicaid claims for the Qualifying Providers with the Medicare fee for each CPT code and calculate the total amount payable for those claims using the Medicare fee schedule. The Medicare fee schedule will be the most currently available national non-facility fees geographically adjusted for Ohio.
- v. The State will then calculate an overall Commercial to Medicare Conversion Factor by dividing the total amount of the average commercial payments for the claims determined under Section 2.a.iii by the total Medicare payments for the claims determined under Section 2.a.iv. The Commercial to Medicare Conversion Factor will be re-determined at least every three years.

b. Calculation of the Supplemental Payment

- i. Each quarter the State will query its MMIS system for paid Medicaid claims for Qualifying Providers for the preceding quarter.
- ii. The State will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees geographically adjusted for Ohio.
- iii. The total amount that Medicare would have paid for those claims will then be multiplied by the Commercial to Medicare Conversion Factor determined under Section 2.a.v.
- iv. The amount Medicaid actually paid for the prior quarter claims identified in Section 2.b.i will be subtracted from the commercial equivalent amount determined in Section 2.b.iii to establish the total allowable supplemental payment amount for the Qualifying Providers for the prior quarter.

Supplemental Payments for Qualifying Physician and Professional Services

1. Qualifying Criteria

Supplemental payments will be made for services provided to Medicaid recipients by eligible physicians and other professional service practitioners. To qualify for the supplemental payment, eligible physicians and other professional service practitioners must:

- a. Be one of the following provider types;
 - i. Physicians;
 - ii. Physician Assistants;
 - iii. Nurse Practitioner (NPs);
 - iv. Clinical Nurse Specialist (CNSs);
 - v. Certified Registered Nurse Anesthetists (CRNAs);
 - vi. Certified Nurse Midwives (CNMs);
 - vii. Clinical Social Workers (CSWs);
 - viii. Clinical Psychologists;
 - ix. Optometrists; and
 - x. Dentists
- b. Be licensed by the State of Ohio;
- c. Have an Ohio Medicaid provider agreement; and,
- d. Be employed by or affiliated with a participating agency. Participating agencies are defined as a nonprofit hospital that is affiliated with a state university or a public hospital agency consistent with the Care Innovation and Community Improvement Program as enacted in Ohio's 2018-2019 biennium budget. Participating Agencies that qualify under this subsection are:
 - i. The MetroHealth System
 - ii. UC Health
 - iii. University of Toledo Medical Center

2. Payment Methodology

The supplemental payment will be calculated to ensure total payments for these services are equal to the average commercial rate for each participating agency. The average commercial rate is defined as the rates paid by the five largest commercial payers for the same service for each participating agency.

Under the methodology described below, the terms "physician" and "physician services" includes services provided by all qualifying providers listed in Section 1.a. above.

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

- a. Calculation of the Medicare equivalent of the average commercial rate.
 - i. For services provided by physicians meeting the criteria as set forth in Section 1. above, the state will collect from the providers its current commercial physician fees by CPT code for the provider's top five commercial payers by volume.

TN: 17-045

Supersedes:

TN: New

Approval Date: 6/5/18

Effective Date: 10/20/2017

- ii. The state will calculate the average commercial fee for each CPT code for qualifying provider types that are eligible in Section 1. a. above.
 - iii. The state will extract from its paid claims history file for the preceding fiscal year all paid claims for those qualifying provider types, as defined in Section 1. above, who qualify for a supplemental payment. For each CPT code, the state will align the average commercial fee as determined in Section 2. a. ii. above to Medicaid payments for qualifying provider types, as defined in Section 1. above and calculate the average commercial payments for the claims.
 - iv. The state will also align the same paid Medicaid claims with the Medicare fees for each CPT code for each qualifying provider type, as defined under 2. above and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees geographically adjusted for Ohio.
 - v. The state will then calculate an overall commercial to Medicare conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio will be re-determined at least every three years.
- b. Calculation of the Supplemental Payment
- i. Each quarter the state will query its MMIS system for paid Medicaid claims for qualifying providers, as defined in Section 1. above for the preceding quarter.
 - ii. The state will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees geographically adjusted for Ohio.
 - iii. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare equivalent of the average commercial rate.
 - iv. The amount Medicaid actually paid for those claims is subtracted from Section 2. b. iii. above to establish the total allowable supplemental payment amount for the physician or physician practice plan for that quarter.

5. a. Physicians' services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

--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 agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new podiatry code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020 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.

TN: 20-003
Supersedes:
TN: 19-004

Approval Date: 04/17/20
Effective Date: 01/01/2020

The following payment scenarios also exist:

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

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

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

TN: 19-004
Supersedes:
TN: 13-036

Approval Date: 3/26/19
Effective Date: 01/01/2019

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.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

TN: 19-003
Supersedes:
TN: New

Approval Date: APR 15 2019

Effective Date: 01/01/2019

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.

The agency's chiropractors' services fee schedule rate was set as of January 1, 2018, 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: 18-001

Supersedes:

TN: 16-016

Approval Date: 3/1/18

Effective Date: 01/01/2018

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.

c. Chiropractors' services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

TN: 19-003
Supersedes:
TN: New

Approval Date: APR 15 2019

Effective Date: 01/01/2019

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.

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.

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

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

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

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

- Psychologists

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

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

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

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

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

d. Other Licensed practitioners' services, continued.

(2) Non-Physician Licensed Behavioral Health Practitioners

- 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 practitioners requiring general supervision at 85% of the rate of their supervising practitioner:

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

If a Medicare fee exists for a defined covered procedure code, the State will pay the following practitioners under direct supervision at the rate of their supervising practitioner:

- Registered counselor trainees;
- Registered chemical dependency counselor assistants and trainees;
- Registered social work trainees;
- Registered marriage and family therapist trainees; and
- Board-registered psychology assistant who are under the supervision of a licensed psychologist.

The State will pay 100% of the Medicaid maximum fee for psychological testing and structured screening and brief intervention for substance use regardless of the eligible mental health professional providing the service.

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

TN: 17-044

Supersedes:

TN: 17-037

Approval Date: 1/19/18

Effective Date: 01/01/2018

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 paid an administration fee for the administration of seasonal and pandemic influenza vaccines and the administration of drugs by injection.

The administration fee is the same for both governmental and private providers.

When a provider administers a seasonal or pandemic influenza vaccine or drug by injection in a pharmacy, the administration fee is the lesser of the provider's charge or the Medicaid maximum allowable payment of \$19.35. This amount is effective for services provided on or after April 1, 2017.

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

d. Other practitioners' services

(5) Physician assistants' services

Payment for physician assistants' services is the lesser of the billed charge or 85% of the Medicaid maximum for the physicians' service specified in the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial Medicaid maximum payment amount is set at 80% of the Medicare allowed amount. Each new physician assistants' code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at

<https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at

<https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

The following payment scenarios apply:

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

Payment rates for evaluation and management services rendered by physician assistants operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after August 1, 2019, the payment for behavioral health evaluation and management services rendered by physician assistants practicing in a community behavioral health agency will be 100% of the rates Ohio pays to physicians practicing in a community behavioral health agency, as described in Item 5-a of this Attachment.

By-report services require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate, or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed. Physician assistants are reimbursed the lesser of billed charges or 85% of the established price established through this manual review pricing process.

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

TN: 20-003

Supersedes:

TN: 19-021

Approval Date: 04/17/20

Effective Date: 01/01/2020

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.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

TN: 19-003
Supersedes:
TN: New

Approval Date: APR 15 2019
Effective Date: 01/01/2019

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' (APNs') services, other than described elsewhere in this plan.

For dates of service on or after January 1, 2018, payment for anesthesia services furnished by a certified registered nurse anesthetist (CRNA) is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by the following formula:

$$\text{Maximum payment amount} = (\text{Base unit value} + \text{Time unit value}) \times \text{Conversion factor} \times \text{Multiplier}$$

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. Effective for dates of service on or after January 1, 2018, the conversion factor and multiplier are listed on the agency's Anesthesia fee schedule at <http://medicaid.ohio.gov/ProvidersFeeScheduleandRates.aspx>.

Unless otherwise specified, the maximum payment amount for a service furnished by a clinical nurse specialist (CNS) or certified nurse practitioner (CNP) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum for physicians' services as listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNS or CNP will be made to the hospital.

Payment rates for evaluation and management services rendered by nurse practitioners and clinical nurse specialists operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after August 1, 2019, the payment for behavioral health evaluation and management services rendered by nurse practitioners and clinical nurse specialists practicing in a community behavioral health agency will be 100% of the rates Ohio pays to physicians practicing in a community behavioral health agency, as described in Item 5-a of this Attachment.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum for surgical procedures as listed on the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

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

d. Other practitioners' services.

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

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new APNs' services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx>.

The agency's Anesthesia fee schedule was set as of January 1, 2018, and is effective for services provided on or after that date.

The agency's MSRIAP fee schedule was set as of January 1, 2020, and is effective for services provided on or after that date.

Additional codes for certain services provided by CRNAs (i.e., trigger-point injections) are located on the State's MSRIAP fee schedule.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

TN: 20-003

Supersedes:

TN: 19-018

Approval Date: 04/17/20

Effective Date: 01/01/2020

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.

For clinical nurse specialists' (CNS) services and certified nurse practitioners' (CNP) services, other than certified pediatric or family nurse practitioners' services, there may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

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.

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.

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

(8) Anesthesiologist Assistants' services.

Payment for an anesthesia service furnished by an Anesthesiologist Assistant is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by the following formula:

$$\text{Maximum payment amount} = (\text{Base unit value} + \text{Time unit value}) \times \text{Conversion factor} \times \text{Multiplier}$$

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. The conversion factor and multiplier are effective for dates of service on or after January 1, 2018 and are listed on the agency's Anesthesia fee schedule, which is published on the agency's website at <https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx>.

The services of an Anesthesiologist Assistant employed by a hospital are considered to be hospital services, payment for which is made to the hospital.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new anesthesia code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the Anesthesia fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx>.

The agency's Anesthesia fee schedule was set as of January 1, 2018, and is effective for services provided on or after that date.

Additional codes for certain services provided by Anesthesiologist Assistants (i.e., trigger-point injections) are located on the State's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

TN: 20-003

Supersedes:

TN: 17-012

Approval Date: 04/17/20

Effective Date: 01/01/2020

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

(9) Acupuncturists' services

Payment for acupuncturists' services is the lesser of the submitted charge or the Medicaid maximum payment amount listed on Ohio Medicaid's Medicine, Surgery, Radiology and Imaging, and Additional Procedures payment schedule. The payment amounts were set as of January 1, 2018 and are effective for acupuncturists' services provided on or after that date.

Payment schedules are published on Ohio Medicaid's website at:

<http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/SchedulesandRates.aspx>.

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

TN: 18-001

Supersedes:

TN: New

Approval Date: 3/1/18

Effective Date: 01/01/2018

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.

The agency's home health intermittent or part-time nursing services fee schedule was set as of January 1, 2017, 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.

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

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

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

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

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

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

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

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new DMEPOS code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the DMEPOS fee schedule.

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

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

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

TN: 18-017
Supersedes
TN: 18-007

Approval Date: 11/9/18
Effective Date: 07/16/2018

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.

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.

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.

The agency's private duty nursing fee schedule was set as of January 1, 2017, 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: 17-007

Supersedes:

TN: 15-007

Approval Date: 4/14/17

Effective Date: 01/01/2017

9. Clinic services.

a. Service-Based Ambulatory Health Care Clinic (AHCC) Services.

i. End-Stage Renal Disease (ESRD) Dialysis Clinics

Payment for covered dialysis services rendered by an ESRD dialysis clinic is made as an all-inclusive composite amount per visit. This composite amount includes all related services, tests, equipment, supplies, and training furnished on the same date.

The Medicaid maximum composite payment amount for a covered dialysis service is the product of two figures: (a) The calendar year 2016 ESRD prospective payment system (PPS) base rate published by the Centers for Medicare and Medicaid services (CMS), which can be found on the CMS website at <https://www.cms.gov>; and (b) The applicable percentage from the following list: (i) chronic maintenance dialysis performed in an ESRD dialysis clinic – fifty-eight and three quarters per cent; (ii) chronic maintenance dialysis performed in a home setting – three sevenths of the percentage for chronic maintenance dialysis performed in an ESRD dialysis clinic; (iii) dialysis support services – thirty-three and three quarters per cent; or (iv) dialysis with self-care training – sixty-seven and three quarters per cent.

Separate payment may be made to an ESRD dialysis clinic for covered professional services of a medical practitioner and for covered laboratory services and pharmaceuticals that are not directly related to dialysis treatment. Payment methods and amounts for such items and services are determined in accordance with paragraph (9)(a)(ii) of this attachment.

ii. All Other Service-Based AHCCs

Medicaid makes a separate payment for each service or item provided at a service-based AHCC.

Unless otherwise specified, the maximum payment amount for an AHCC service is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new AHCC services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes

TN: 20-003
Supersedes:
TN: 17-020

Approval Date: 04/17/20

Effective Date: 01/01/2020

9-a Clinic services, Service-Based Ambulatory Health Care Clinic (AHCC) Services,
continued.

payment schedule at
<https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates/#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is
moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's
website at
<https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020, and is
effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff.
Payment for these services is determined on a case-by-case basis. The
specific method used depends on the service; examples include comparison
with a similar service that has an established maximum payment rate and
application of a percentage of charges.

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

TN: 20-003
Supersedes:
TN: 19-018

Approval Date: 04/17/20

Effective Date: 01/01/2020

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

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

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 2/1/90

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

317

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.

INS# 90-38
SUPERSEDE
INS# 84-9

ISSUANCE 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: 09-035Approval Date: 08/14/2014Effective Date: 01/01/2012 2013 *ed*

9. b. Outpatient health facilities (OHFs).

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

9. Clinic services, continued.

c. Ambulatory surgery centers (ASCs).

Payment for ASCs' services is the Medicaid maximum for the service. The Medicaid maximum is an amount based on the Enhanced Ambulatory Patient Group (EAPG) and any discounting, consolidation or packaging factors assigned by 3M's EAPG software. These factors are defined in Attachment 4.19-B, Item 2-a, section E. Payment for laboratory and radiology services is the lesser of billed charges or the payment calculated under EAPG. Payment for all laboratory services will be no more than the Medicare fee schedule amount.

For each date of service every CPT/HCPCS code on a claim is assigned an EAPG. An EAPG groups together services that are similar in nature, have similar costs and utilizes similar material. For each EAPG there is a relative weight, which reflects the cost of the services in that EAPG. The payment for the detail is the product of the EAPG relative weight and the ASC base rate. All ASC are assigned the same base rate. Payment for EAPG 00233 is increased by 145% and EAPG 00485 is increased by 233%.

The following services are paid outside of EAPG and are paid as specified below:

- Payment for pharmaceuticals is the lesser of the billed charge or the amount in the provider administered pharmaceutical fee schedule.
- Payment for durable medical equipment (DME) is the lesser of the billed charge or the amount in the DME fee schedule.
- Payment for claims assigned to a dental service EAPG type will be \$953.60.
- Pharmaceutical, DME and dental are paid outside of the EAPG but are subject to discounting, consolidation and packaging factors as determined by the EAPG software.

ASCs may only bill for the technical component of laboratory, radiology, and diagnostic and therapeutic services.

The relative weights that apply to ASC services are the same ones developed for outpatient hospital services, which are described in Attachment 4.19-B, Item 2-a, section I. The ASC base rate is 90% of the outpatient base rate which is described in Attachment 4.19-B, Item 2-a, section G. The ASC base rates and relative weights were set as of January 2, 2020 and are effective for services provided on or after that date. The ASC base rate, relative weights, pharmaceutical fee schedule and DME fee schedule are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

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

TN: 20-010
Supersedes:
TN: 19-006

Approval Date: 6/8/2020

Effective Date: 03/14/2020

9. c. Ambulatory surgery centers (ASCs).

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

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:

<https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's dental services fee schedule was set as of January 1, 2020 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.

TN: 20-005

Supersedes:

TN: 19-004

Approval Date: 03/10/2020

Effective Date: 01/01/2020

10. Dental services.

Supplemental Payments for Qualifying OSU Dental Services

1. Qualifying Criteria

Supplemental payments will be made for services provided on or after January 1, 2018 to Medicaid recipients by eligible Ohio State University (OSU) dentists. To be a 'Qualifying Provider' for purposes of the supplemental payment, eligible dentists must:

- a. Be licensed by the State of Ohio;
- b. Have an Ohio Medicaid provider agreement; and,
- c. Be employed by or affiliated with The Ohio State University Wexner Medical Center

2. Payment Methodology for dental services

The supplemental payment will be calculated to ensure total payments for dental services are equal to OSU's commercial rate. The commercial rate is defined as the rate paid by OSU's largest commercial payer, for the same services.

The specific methodology to be used in establishing the supplemental payment for dental services is as follows:

- a. Calculation of the Medicaid equivalent of the commercial rate:
 - i. For services provided by qualifying providers, the State will collect from OSU its current commercial fees by CDT code for the providers' top commercial payer by volume.
 - ii. The State will extract from its paid claims history file for the preceding fiscal year all Medicaid claims paid to the Qualifying Providers. For each CDT code, the State will align the commercial fee as determined in 2.a.i to the Qualifying Providers' paid Medicaid claims and calculate the total amount payable for those claims using the commercial fee.
 - iii. The State will then calculate an overall Commercial to Medicaid Conversion Factor by dividing the total amount of the commercial payments for the claims determined under Section 2.a.ii by the total Medicaid payments for the claims determined under Section 2.a.ii. The Commercial to Medicaid Conversion Factor will be re-determined annually.
- b. Calculation of the Supplemental Payment
 - i. Each quarter the State will query its MMIS system for paid Medicaid claims for Qualifying Providers for the preceding quarter.
 - ii. The total amount that Medicaid paid for those claims will then be multiplied by the Commercial to Medicaid Conversion Factor determined under Section 2.a.iii.
 - iii. The amount Medicaid actually paid for the prior quarter claims identified in Section 2.b.i. will be subtracted from the commercial equivalent amount determined in Section 2.b.ii. to establish the total allowable supplemental amount for the Qualifying Providers for the prior quarter.
 - iv. The supplemental payment will be distributed to The Ohio State Wexner Medical Center not later than six months after the end of the quarter from which the calculation was based.

TN: 18-009-B

Supersedes:

TN: NewApproval Date: 10/5/18Effective Date: 01/01/2018

10. Dental services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

TN: 19-003
Supersedes:
TN: New

Approval Date: APR 15 2019
Effective Date: 01/01/2019

--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 (PT) 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 PT services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new PT code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020 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 PT services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG-exempt.

Payment for PT services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

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

TN: 20-003
Supersedes:
TN: 19-004

Approval Date: 04/17/20
Effective Date: 01/01/2020

11. Physical therapy and related services, continued.

b. Occupational therapy.

Occupational therapy (OT) 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 OT services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new OT code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020 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 OT services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for OT services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

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

TN: 20-003
Supersedes:
TN: 19-004

Approval Date: 04/17/20
Effective Date: 01/01/2020

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 SLPA services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new SLPA code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

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

Payment for SLPA services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for SLPA services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

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

TN: 20-003

Supersedes:

TN: 19-004

Approval Date: 04/17/20

Effective Date: 01/01/2020

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

A. Payment for the following prescribed drugs will be in accordance with the Actual Acquisition Cost (AAC) definition at 42 CFR 447.512.

1. Brand name and generic drugs and other drugs/products meeting the definition of covered outpatient drug in 42 CFR 447.502 including covered over-the-counter medications will be paid at ingredient cost based on AAC, plus professional dispensing fee.

a. AAC is defined as the lesser of:

- National Average Drug Acquisition Cost (NADAC) plus professional dispensing fee, or
- The provider's usual and customary charge.

b. If NADAC is unavailable, AAC is the lesser of:

- Wholesale Acquisition Cost (WAC+0%) plus professional dispensing fee, or
- State Maximum Allowable Cost (SMAC) plus professional dispensing fee, or
- The provider's usual and customary charge

SMAC means the maximum amount to be paid for an equivalent generic drug group based on an estimate of the statewide AAC.

c. Professional Dispensing Fees are determined on the basis of surveys conducted of pharmacy operational and overhead costs. The fees are reviewed periodically for reasonableness. A survey of each Medicaid-enrolled pharmacy provider every other year documents prescription volume and determines the tier under which the pharmacy will be paid.

- i. The professional dispensing fee tiers including fees for compounded drugs that are not sterile compound or total parenteral nutrition compound claims are as follows:
 - Less than 49,999 prescriptions per year = \$13.64
 - Between 50,000 and 74,999 prescriptions per year = \$10.80
 - Between 75,000 and 99,999 prescriptions per year = \$9.51
 - 100,000 or more prescriptions per year = \$8.30
- ii. Sterile compound claims will receive a dispensing fee of \$10 per day supplied, with a maximum dispensing fee of \$70 per claim.
- iii. Total parenteral nutrition compound claims will receive a professional dispensing fee of \$15 per day supplied, with a maximum dispensing fee of \$150 per claim.

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)
 2. Drugs purchased by 340B covered entities through the federal 340B drug price program will be paid at ingredient cost based on 340B AAC, plus professional dispensing fee.
 3. Drugs purchased by 340B covered entities outside of the federal 340B drug price program will be paid at the same AAC methodology used for providers that are not 340B covered entities described in Section A.1.a. through A.1.b. of Item 12-a, page 1, plus the professional dispensing fee assigned as described in Section A.1.c. of Item 12-a, page 1.
 4. Drugs acquired through the federal 340B drug price program and dispensed by 340B contract pharmacies are not covered.
 5. Drugs acquired through the Federal Supply Schedule (FSS) will be paid at the FSS actual acquisition cost, plus the professional dispensing fee.
 6. Drugs acquired at nominal price, (outside of 340B or FSS) will be paid at the actual acquisition cost, plus the professional dispensing fee.
 - B. Payment for the following prescribed drugs are not required to be paid based on AAC.
 1. Federally Qualified Health Centers will be paid for drugs dispensed to patients for use in their personal residence according to the AAC methodology described in Section A. of Item 12-a, pages 1-2, plus the professional dispensing fee.
 2. Specialty drugs not dispensed by a retail community pharmacy including drugs dispensed primarily through the mail (but not in institutions or long term care) will be paid at the same AAC calculated allowable methodology described in Section A.1 of Item 12-a, page 1, plus the professional dispensing fee.
 3. Clotting factor and other blood products used to treat hemophilia and other blood disorders will be paid at the lesser of:
 - The payment limit shown in the current Medicare part B drug pricing file, minus the furnishing fee assigned by Medicare part B, plus the professional dispensing fee assigned to the provider in Section A.1.c. of Item 12-a, page 1, or
 - The provider's usual and customary charge.

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)

4. Drugs dispensed through institutions or long-term care that are not included as part of an inpatient stay will be paid at the same AAC calculated allowable methodology described in Section A.1 of Item 12-a, page 1.

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.

5. Coverage for investigational drugs is subject to prior authorization and must be determined to be medically necessary. Payment for investigational drugs is the cost actually paid by the provider plus the provider's cost to dispense.

C. Federal Upper Limits (FUL)

1. The aggregate payment of drugs subject to the FUL will not exceed the FUL based on the NADAC for ingredient cost payment for multiple source drugs.
2. Compliance with the FUL in the aggregate will be ensured on an annual basis.

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.

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

- (1) The state maximum allowable cost (MAC);
- (2) The payment limit shown in the current Medicare part B drug pricing file;
- (3) 107% of the wholesale acquisition cost (WAC); or
- (4) 85.6% of the average wholesale price (AWP).

All maximum payment amounts are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx. Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

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

b. Dentures.

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

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

The agency's dentures fee schedule was set as of January 1, 2019, and is effective for services provided on or after that date.

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

11/25/14

TN: 19-004
Supersedes:
TN: 13-019

Approval Date: 3/26/19

Effective Date: 01/01/2019

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

c. Prosthetic devices.

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

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new prosthetic device code can be found on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the DMEPOS fee schedule.

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

The agency's DMEPOS fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date.

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

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

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

d. Eyeglasses.

Eyeglass services, including lenses, frames, fitting and dispensing of ophthalmic materials, are also provided by enrolled retail optical establishments or self-employed ophthalmic dispensers (opticians).

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

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

The agency's eyeglasses fees were set as of July 1, 2018, and are effective for services provided on or after that date.

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

Ohio meets the certification requirements of Section 1902(a)(23) of the Social Security Act to permit the selection of one or more providers, through a competitive bidding process, to deliver eyeglasses on a statewide basis under the authority of Section 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d).

TN: 18-016

Supersedes:

TN: 17-025

Approval Date: 08/27/2018

Effective Date: July 1, 2018

--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.

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. Mental Health Rehabilitative services.

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

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

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

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

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

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

TN: 19-021
Supersedes
TN: 19-004

Approval Date: 12/16/19

Effective Date: 08/01/2019

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

d. Rehabilitative services

The fee development methodology is based upon provider cost modeling, which is composed of Ohio provider compensation studies, cost data, and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages of the practitioner delivering the direct care using the Bureau of Labor Statistics wage data for Ohio.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates were developed as the ratio of total annual modeled provider costs to the estimated annual billable units with the following exceptions noted below:

- Therapeutic Behavioral Services (TBS) provided by high school practitioners with three years of experience were set at the same rate as TBS provided by practitioners with a Bachelor's Degree. Rates for TBS provided by unlicensed Bachelor's and Master's degree level practitioners were set using the Bureau of Labor Statistics wage data for Ohio for that level of practitioner. Rates for TBS provided by licensed practitioners were set the same as for a Master's degree level practitioner.
- All TBS and PSR rates for practitioners on Assertive Community Treatment (ACT) teams were set using the respective high school, Bachelor's or Master's Bureau of Labor Statistics wage data for Ohio and indirect cost assumptions for an ACT team of seventy-five individuals (medium team).

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

d. Rehabilitative services

2. Substance use disorder (SUD) services.

Outpatient and Residential Substance Use Disorder services as outlined in Attachment 3.1-A are paid based upon a Medicaid fee schedule established by the single state agency. Payment for rehabilitative services as described in Attachment 3.1-A shall be the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule. No payments for residents of Institutions for Mental Disease will be made under the Rehabilitation section of the State Plan.

These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200 regarding payments, and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

Direct outpatient services by licensed practitioners are paid according to the fee schedule established under the physician, nurse practitioner and non-physician licensed behavioral health practitioner sections of the state plan in Attachment 4.19-B, Items 5, 6 and 23.

Where Medicare fees do not exist for a covered procedure code, fee development methodology for rates will use each component of provider costs as outlined below.

TN: 17-013

Supersedes:

TN: 14-010

Approval Date: 2/22/18

Effective Date: 01/01/2018

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

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

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

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

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

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

TN: 19-021
Supersedes:
TN: 19-004

Approval Date: 12/16/19

Effective Date: 08/01/2019

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

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.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse-midwife (CNM) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNM will be made to the hospital.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new nurse-midwife code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020, and is effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

TN: 20-003

Supersedes:

TN: 17-010

Approval Date: 04/17/20

Effective Date: 01/01/2020

17. Nurse-midwife services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

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.aspx> 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: OhioMHAS (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 Medicaid (ODM). ODM will process the claims and reimburse the providers at 100%.

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.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse practitioner (CNP) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNP will be made to the hospital.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new CNPs' services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at <https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes> until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

The agency's MSRIAP fee schedule was set as of July 1, 2020, and is effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends

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

on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

23. Certified pediatric and family nurse practitioners' services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

TN: 19-003
Supersedes:
TN: New

Approval Date: APR 15 2019
Effective Date: 01/01/2019

--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 on a claim is the lesser of the submitted 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.

The agency's transportation fee schedule was set as of January 1, 2020, 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.

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

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.

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.

Transmittal Number 09-010

Supersedes

Transmittal Number 90-45

Approval Date:

SEP 28 2011

Effective Date: 8/1/09

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

24. e. Emergency hospital services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 2 to Attachment 4.19-B.

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. Telehealth

Payment Methodology:

The payment amount for a health care service or an evaluation and management service delivered through the use of telehealth is the same as it would be if the service were provided face to face: the lesser of the submitted charge or the maximum amount shown in the professional fee schedule for the date of service.

Payment Limitations:

The practitioner site may submit a professional claim for the health care service delivered through the use of telehealth. All appropriate codes and modifiers must be reported in addition to the “GT” modifier to identify the service as telehealth.

The rendering practitioner must be one of the following: medical doctor, doctor of osteopathic medicine, podiatrist, licensed psychologist, physician assistant, clinical nurse specialist, certified nurse midwife, certified nurse practitioner, licensed independent social worker, licensed independent marriage and family therapist, licensed professional clinical counselor, or a licensed independent chemical dependency counselor. The rendering provider must be reported on a professional claim for any service rendered through the use of telehealth.

TN: 19-019
Supersedes
TN: 14-022

Approval Date 10/21/19
Effective Date 08/08/2019

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

Payment for FBC facility services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

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

All Medicaid payment schedules and rates are published on the agency's website at <https://medicaid.ohio.gov/PROVIDERS/FeeSchedulesandRates.aspx>.

The agency's MSRIAP fee schedule was set as of January 1, 2020, 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, an 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. An FBC will not be reimbursed separately for the professional component of such services.

TN: 20-003

Supersedes:

TN: 19-004

Approval Date: 04/17/20

Effective Date: 01/01/2020

Comprehensive Primary Care (CPC) Program, Payment Adjustment.

Payment for PCMH services can include two types of payments for enrolled PCMHs: (1) per-member-per-month (PMPM) payments; and (2) shared savings payments. All enrolled PCMHs are eligible for PMPM payments, and some may be eligible for shared savings payments. PMPM payments and shared savings payments are distributed to enrolled PCMHs directly by ODM and the Medicaid managed care plans.

Definitions and key calculations applicable to all payment

- A **Patient Centered Medical Home (PCMH)** is a team-based care delivery model led by primary care practitioners (PCPs) who comprehensively manage the health needs of individuals. Provider enrollment in the Ohio Department of Medicaid (ODM) PCMH program is voluntary. A PCMH may be a single practice or a practice partnership.
- The **CPC for Kids** program is a voluntary enhancement to the PCMH program focused on pediatric members under twenty-one years of age.
- A **Practice Partnership** is a group of practices participating as a PCMH whose performance will be evaluated as a whole. The practice partnership must meet the following requirements: (a) each member practice must have an active Medicaid provider agreement in accordance with rule 5160-1-17.2; (b) each member practice must have a minimum of one hundred fifty attributed Medicaid individuals determined using claims-only data; (c) member practices must have a combined total of five hundred or more attributed individuals determined using claims-only data at each attribution period; (d) member practices must have a single designated convener that has participated as a PCMH for at least one year; (e) each member practice must acknowledge to ODM its participation in the partnership; and (f) each member practice must agree that summary-level practice information will be shared by ODM among practices within the partnership.
- A **Convener** is the practice responsible for acting as the point of contact for ODM and the practices that form a practice partnership.
- A **Member practice** is a practice participating in a practice partnership.
- The **Performance period** is the 12-month calendar year period of participation in the PCMH program by an enrolled PCMH. An enrolled PCMH's first performance period begins January 1st after their enrollment in the program.
- A **Baseline year** is the twelve-month calendar year two years preceding the performance period.

Attribution:

- i **Member exclusions:** All Medicaid beneficiaries are included in the Ohio PCMH program and therefore included in the attribution process, except for the following excluded populations:
 - a. Dual-eligible beneficiaries (i.e., MyCare Ohio);
 - b. Beneficiaries with limited benefits;
 - c. Beneficiaries in transition;

- d. All other beneficiaries with third-party liability medical coverage except for those with exclusively dental or vision coverage.
- ii **Methodology:** ODM will attribute all non-excluded fee-for-service and managed care members to a PCMH that meets the provider type and specialty requirements. Attribution of PCMH members occurs quarterly using retrospective data. PCMH members will only be attributed to one PCMH at a time, and only one enrolled PCMH will receive PMPM payments for PCMH services per attributed beneficiary. Attribution will be done using a hierarchical process as follows:
 - a. PCMH member choice when expressed directly (i.e., communicated explicitly via contact with ODM or an MCP);
 - b. Individuals who do not express member choice explicitly will be attributed to a practice based on their claims history;
 - c. For individuals who do not express member choice and do not have any claims history, non-claims factors including but not limited to geographic proximity will be used for attribution.

Risk scoring:

- i **Methodology:** ODM will score all members attributed to a PCMH (or attributed to a member practice for practice partnerships) based on health status using an evidence-based proprietary risk scoring methodology. Risk scoring will be done using 24 months of available Medicaid data plus at least six months of run-out. Members without Medicaid history will be assigned to the healthiest risk status, and will be reassigned once there is sufficient claims data to update the risk status.
- ii **Relationship to payment:** The risk score is used both to determine PCMH PMPM payment amounts on a quarterly basis, and as an adjustment in the calculation of shared savings payments on an annual basis. The relationship to both payment streams is described in more detail below.

Clinical quality and efficiency metrics required for PMPM and shared savings payments

An enrolled PCMH must meet all of the effective activity requirements described above and in Attachment 3.1-A, in addition to clinical quality metrics and efficiency metrics described below, in order to receive any PMPM or shared savings payments. Enrolled PCMHs must meet the required clinical quality and efficiency metric thresholds for each program year (calendar year) in which they participate.

PCMHs that participate in the CPC for Kids program described above and in Attachment 3.1-A must meet additional clinical quality of care metric for each participating program year to receive additional PMPM or shared savings or bonus payments.

An enrolled PCMH must meet specific numerical thresholds on their performance on clinical quality and efficiency metrics. Enrolled PCMHs either pass or fail each clinical quality and efficiency metric, depending where their performance on the calculated metric falls relative to the

specific metric threshold value. It is not possible to partially pass a metric. The state will notify an enrolled PCMH of the full set of metrics and thresholds by publishing them on the ODM website.

Effective January 1st of each program year, the clinical quality and efficiency measures and thresholds are in effect for that performance year, and can be found at the following link:

<http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx>. Clinical quality metrics are only applicable to an enrolled PCMH if the patient volume in the metric denominator is sufficient for the measured metric to be statistically valid. Clinical quality and efficiency metrics will be evaluated for each enrolled PCMH at the end of each performance period using claims from the performance period across Medicaid FFS and managed care plans for all members attributed to the enrolled PCMH.

Clinical quality metrics: The set of clinical quality metrics includes adult health measures, behavioral health measures, pediatric measures, and women's health measures. Specific information regarding these requirements can be found at the link to the Payment Innovation website referenced in the paragraph above. An enrolled PCMH must pass at least 50% of applicable metrics. Clinical quality metrics are evaluated annually based on performance through the performance period plus at least six months of claims run-out.

In addition to the above clinical quality metrics, a PCMH participating in the CPC for Kids program must pass at least 50% of applicable metrics specific to members under the age of twenty-one. In addition, the participating PCMH must pass at least one of the following measures: lead screening in children, childhood immunization status, or immunizations for adolescents.

Efficiency metrics: Efficiency metrics are measures of health system utilization and efficiency. The full set of efficiency metrics can be found at the link to the Payment Innovation website referenced in the paragraph above. An enrolled PCMH must pass at least 50% of efficiency metrics. Efficiency metrics are evaluated annually based on performance through the performance period plus at least six months of claims run-out.

Per-member-per-month (PMPM) payments

Definition: The PMPM payment is a prospective payment that is both paid and risk-adjusted quarterly, and that supports the activities required by the PCMH and CPC for Kids programs. The unit of service is quarterly. PMPM payments begin in the first month of an enrolled PCMH's first performance period. Payment for PCMH services under Ohio's PCMH program will not duplicate payments made for the same services under other program authorities or under the Medicare CPC+ program for this same purpose. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that PCMH participants are not receiving similar services through other Medicaid-funded programs. Enrolled PCMHs must meet the effective program requirements described above in order to receive PMPM payments. Failing an activity requirement results in PMPM payment suspension. Failing to pass 50% of either clinical quality metrics or efficiency metrics as described above results in a warning; two consecutive warnings result in PMPM payment suspension. A payment suspension will be lifted

once an enrolled PCMH passes all activity requirements and 50% of both clinical quality and efficiency metrics.

Risk tiers: Members attributed to enrolled PCMHs are placed in the following risk tiers with associated PMPMs for each tier:

- i Healthy members including those with history of disease (\$1.80 PMPM);
- ii Members with minor or significant chronic diseases (\$8.55 PMPM);
- iii Members with severe chronic conditions across multiple organ systems (\$22 PMPM)

All members under the age of 21 who are attributed to a PCMH participating in CPC for Kids will have an additional associated PMPM of \$1.

PMPM amounts may be updated no more frequently than annually.

Calculation: The quarterly PMPM payment for an enrolled PCMH is calculated as follows: The final multiplication is to accommodate the three months in the quarter.

Quarterly PMPM payment for an enrolled PCMH

$$= [(number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 1 * PMPM\ amount\ for\ tier\ 1) + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 2 * PMPM\ amount\ for\ tier\ 2) + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 3 * PMPM\ amount\ for\ tier\ 3)] * 3$$

Quarterly PMPM payment for an enrolled PCMH also participating in the CPC for Kids program

$$= [(number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 1 * PMPM\ amount\ for\ tier\ 1) + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 2 * PMPM\ amount\ for\ tier\ 2) + (number\ of\ patients\ on\ the\ practice's\ panel\ attributed\ to\ tier\ 3 * PMPM\ amount\ for\ tier\ 3) + (number\ of\ patients\ under\ the\ age\ of\ twenty-one\ on\ the\ practice's\ panel\ attributed\ under\ CPC\ for\ Kids * PMPM\ amount\ for\ PCMH\ attributed\ members)] * 3$$

Shared savings payments

Total cost of care (TCOC).

- i Definition: Total cost of care for an enrolled PCMH is defined as the sum of all non-excluded payments made by ODM or MCPs for the Medicaid members attributed to that enrolled PCMH. Details of the calculation are below.
- ii Calculation of non-risk-adjusted TCOC: The TCOC for the baseline year and the performance period will be calculated by ODM retrospectively, using fee-for-service claims data and encounter data from the managed care plans. Total cost of care is calculated by summing the total Medicaid fee-for-service claims and managed care plan encounters for the enrolled PCMH's attributed members during the relevant period (i.e.,

baseline year or performance period). The total cost of care in the baseline year and performance period will include the accountable expenditures defined below for the members attributed to the enrolled PCMH, in addition to PMPM payments made as part of the Ohio PCMH program. The types of services included in the TCOC measurement for the baseline year and performance period will be identical.

- iii Calculation of risk-adjusted TCOC: Risk-adjusted TCOC for an enrolled PCMH is calculated by dividing the enrolled PCMH's TCOC by the average risk score of the members attributed to the enrolled PCMH, as determined by the evidence-based proprietary risk scoring methodology described above in Risk Scoring: Methodology.
- iv Excluded expenditures: Expenditures not included in the base year or performance period TCOC are:
 - a. Waiver services;
 - b. Currently underutilized services as determined by the state (initially to include dental, vision, and transportation);
 - c. All expenditures for the first year of life for members with a Neonatal Intensive Care Unit (NICU) day (Nursery 3 and 4);
 - d. All expenditures for member outliers within each risk band (top and bottom 1%); and
 - e. All expenditures for members with at least 90 consecutive days of LTC claims.
- v Accountable expenditures: All Medicaid-covered medical, prescription, and other expenditures that are not explicitly excluded above are considered accountable expenditures and are included in calculation of total cost of care.

Shared savings payments.

There are three types of shared savings payments: payment based on self-improvement, payment for practices with the lowest TCOC, and bonus payment under the CPC for Kids program. All enrolled PCMHs must meet the effective activity requirements, clinical quality and efficiency metrics described above and in Attachment 3.1-A in order for the enrolled PCMH to be eligible for any type of shared savings payment. Enrolled PCMHs may receive shared savings payments based on either self-improvement or on having the lowest TCOC, or both. PCMHs that participate in the CPC for Kids program are eligible for an additional bonus payment if the prescribed requirements are met.

Enrolled PCMHs must have at least 60,000 Medicaid member months over the performance period to be eligible for either type of shared savings payment, counting only members who were attributed to the practice for at least six months during the performance year and who were not excluded during those months due to Ohio CPC exclusion criteria. Full exclusion criteria are:

- (1) Members excluded from Ohio CPC attribution:
 - a. Dual-eligible beneficiaries (i.e., MyCare Ohio);
 - b. Beneficiaries with limited benefits;
 - c. Beneficiaries in transition; and
 - d. All other beneficiaries with third-party liability medical coverage except for those with exclusively dental or vision coverage.

- (2) Attributed members who receive specific services, including:
 - a. Neonatal Intensive Care Unit (NICU) members who utilize nursery level 3 or 4 services during first year of life;
 - b. Members with a nursing home stay spanning more than 90 consecutive days within the 12-month reporting or performance period;
 - c. Members with at least one Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) visit within the 12-month reporting or performance period; and
 - d. Members in the top or bottom one percent of total cost of care within each Clinical Risk Group (CRG) category where there exists a high degree of cost variation across members.

i Payment based on self-improvement

- a. Definition: Shared savings payments are annual retrospective payments that may be made to an enrolled PCMH for saving on the TCOC of their attributed members. The components of this calculation are outlined below.
- b. Calculation of savings percentage: The savings percentage for an enrolled PCMH is as follows:

$$\begin{aligned}
 & \text{Savings percentage} = \\
 & \left(\begin{array}{l} \text{average risk-adjusted TCOC} \\ \text{for the members} \\ \text{attributed to the enrolled PCMH} \\ \text{in the baseline year, with} \\ \text{adjustments for programmatic changes} \\ \text{and drug price increases} \end{array} \right) - \left(\begin{array}{l} \text{average risk-adjusted TCOC for the} \\ \text{members attributed to the enrolled PCMH} \\ \text{in the performance period} \end{array} \right) \\
 & \hline
 & \text{average risk-adjusted TCOC for the members} \\
 & \text{attributed to the enrolled PCMH in the baseline year, with adjustments for programmatic changes} \\
 & \text{and drug price increases}
 \end{aligned}$$

If the savings percentage is less than 1%, no payment based on self-improvement will be made.

c. Calculation of savings amount:

- i. The savings amount is calculated as follows for enrolled PCMHs composed of one practice participating individually:

$$\begin{aligned}
 & \text{Savings amount} \\
 & = [\text{savings percentage}] \\
 & * [\text{enrolled PCMH's non risk-adjusted TCOC in the baseline year}]
 \end{aligned}$$

- ii. The savings amount is calculated as follows for each member practice participating in a practice partnership:

Savings amount

$$= [\text{savings percentage}]$$

$$* [\text{enrolled PCMH's non risk-adjusted TCOC in the baseline year}]$$

$$* [\text{member practice's proportional share of risk} - \text{adjusted member months}]$$

- d. Calculation of gainsharing percentage: If the savings amount, as calculated above, is positive, the enrolled PCMH receives a percentage of this savings amount as a lump-sum payment. This percentage is called the gainsharing percentage, and is determined as follows:
- i. The individually-enrolled PCMH: The enrolled PCMH receives 65% of the savings amount for their practice (as calculated above) if they either have an average risk-adjusted TCOC below a specific threshold set to identify the lowest-cost PCMHs, and/or if the PCMH is a participant in CPC+ Track 2. Practices will be notified of qualification for 65% shared savings when final TCOC calculations are completed. Thresholds for 65% shared savings will be set utilizing data from the baseline year, identifying those that represent 10% of enrolled PCMHs with the lowest total cost of care. Thresholds will be effective for each performance year. This information will be shared with all enrolled PCMHs no later than July 31st of the performance year.
 - ii. Practice Partnerships enrolled as a PCMH: A member practice receives 65% of the savings amount for their enrolled PCMH (as calculated above) if the enrolled PCMH has an average risk-adjusted TCOC below a specific threshold set to identify the lowest-cost enrolled PCMHs, and/or if the member practice is a participant in CPC+ Track 2. Practices will be notified of qualification for 65% shared savings when final TCOC calculations are completed. Thresholds for 65% shared savings will be set utilizing data from the baseline year, identifying those that represent 10% of enrolled PCMHs with the lowest total cost of care. Thresholds will be effective for each performance year. This information will be shared with all enrolled PCMHs no later than July 31st of the performance year.
 - iii. All other individually-enrolled PCMHs and member practices in partnerships receive 50% of the total savings amount for their practice (as calculated above).
- e. Overall calculation of shared savings amount paid to enrolled PCMHs: The shared savings payment is calculated as follows:

Shared savings payment

$$= [\text{enrolled PCMH's savings amount}] * [\text{gainsharing percentage}]$$

This calculation is conducted annually for each enrolled PCMH's performance over the performance period. One payment is then made to the enrolled PCMH for each year-long performance period. For practice partnerships, payment will be made separately to each member practice. Payment will be based on the proportion of the

member practice's attributed members that made up the patient panel used in the TCOC calculation. This means that if the average risk-adjusted TCOC in the performance period is lower than the average risk-adjusted TCOC in the baseline year, and the savings percentage is greater than or equal to 1%, an enrolled PCMH may receive a lump-sum payment based on this difference.

- f. Timing of payments: Shared savings payments will be made no more than 12 months after the end of the performance period when all necessary data is received in final form.
- g. Payments made by ODM: While the determination of the shared savings amount paid to enrolled PCMHs includes both fee-for-service and managed care members, the payment that ODM makes to enrolled PCMHs for its fee-for-service patients will be the share of the shared savings payment described above, pro-rated based on risk-adjusted member months for FFS members.

Payment for enrolled PCMHs with the lowest TCOC: The 10% of enrolled PCMHs with the lowest average risk-adjusted TCOC will receive a bonus payment from ODM. This payment will be a lump sum amount calculated and paid annually, no more than 12 months after the end of the performance period when all necessary data is received in final form. Payment amounts to practices will be based on a \$5 per member per year bonus, with a practice's member count calculated as the total annualized attributed member months that made up the patient panel used in the TCOC calculation.

For payments for PCMHs with the lowest TCOC, the performance pool for each performance year is capped at \$1,000,000. If the sum of all calculated payments for enrolled PCMHs with the lowest TCOC across all Ohio CPC practices during a performance year exceeds \$1,000,000, each practice's payment is scaled down proportionally until total outlays equal \$1,000,000.

For practice partnerships, payment will be made separately to each member practice. Payment will be based on the proportion of the member practice's annualized attributed member months that made up the patient panel used in the TCOC calculation.

- ii Bonus payment under CPC for Kids: The highest-performing PCMHs participating in the CPC for Kids program that meet quality and efficiency outcomes and perform additional bonus activities focused on improving pediatric care will be eligible for an annual retrospective bonus payment. This annual lump-sum payment will be contingent upon risk-adjusted entity performance on the bonus payment scorecard for CPC for Kids.

The performance pool for each performance year is capped at a total of \$2,000,000. The bonus pool will be awarded to the thirteen highest-performing CPC for Kids entities: the top performer will receive \$500,000; two entities will each be awarded \$250,000; and ten entities will each be awarded \$100,000. For practice partnerships, payment will be made separately to each member practice. Payment will be based on the proportion of the member practice's annualized attributed member months that made up the quality metric panel.

Monitoring and Reporting

ODM will collect data from and monitor enrolled PCMHs in the following ways: 1) Upon enrollment, enrolled PCMHs will attest to activity requirements as specified in the “Practice Characteristics” section. The PCMH activity requirements will be confirmed one year after enrollment and annually thereafter; 2) the state, or its designee, will monitor enrolled PCMHs to verify and document that activity requirements are being met.

To be eligible for the CPC for Kids bonus payment, the PCMH must be a high-performing PCMH relative to other PCMHs participating in the CPC for Kids program based on performance of risk-adjusted scoring of specific pediatric bonus activities, which will be determined by ODM and evaluated annually during each performance period. These activities include: additional supports for children in foster care; behavioral health linkages; school-based health care linkages; transitions of care; and select wellness activities including lead testing capabilities, community services and supports screening, tobacco cessation, fluoride varnish, and breastfeeding support.

Specific information can be found on the ODM website at <https://medicaid.ohio.gov/>.

In addition, ODM will provide enrolled PCMHs with quarterly progress reports which include efficiency and clinical quality metrics.

Further, ODM, or its designee, will evaluate the program to demonstrate improvement against past performance using cost and clinical quality data to determine whether the payment methodology has achieved or needs revisions to achieve the goals of improving health, increasing quality and lowering the growth of health care costs. With regard to methodological changes and continued movement toward value-based purchasing, ODM will reflect in its annual updates any changes to the measures being used to assess program performance and/or determine payment eligibility and distribution.

Ohio will:

- Review the payment methodology as part of the evaluation; and,
- Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment updates.

--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. 05W 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. now EFFECTIVE DATE: 7/1/05