April 1, 2024

Mr. James G. Scott
Director, Division of Program Operations
Medicaid and CHIP Operations Group
Centers for Medicare & Medicaid
Services 601 E. 12th St., Room 355
Kansas City, Missouri 64106

Attention: Fred Sebree, National Institutional Reimbursement Team

Dear Director Scott:

Please find enclosed the submission of Ohio Medicaid State Plan Amendment (SPA) Transmittal Number (TN) 24-004, "Payment for Services: Nursing Facility Private Rooms Payment Increase".

The Ohio Department of Medicaid (ODM) is requesting approval from the Centers for Medicare and Medicaid Services (CMS) to amend Attachments 3.1-A, 4.19-C Supplement 1, and 4.19-D Supplement 1 to bring them into alignment with legislation adopted by the Ohio General Assembly.

Ohio's 2024-2025 biennium budget authorized ODM to reimburse a higher daily rate for private rooms at qualifying nursing facilities. The Ohio Revised Code included a process by which nursing facilities could apply to be approved higher reimbursement for a certain number of private rooms if the facility and beds met specific criteria. Most Medicaid nursing facilities submitted applications in early January for private room approval. Those applications are under review and are being held, pending CMS approval, as stipulated in the applicable Revised Code. Upon CMS approval, ODM will begin to issue individual facility approvals up to the annual funding limit of $160 million per state fiscal year (SFY) beginning with SFY 2025. The recently-enacted state legislation mandates that the private room incentive program is to be effective beginning six months following CMS approval or on the effective date of the applicable rules, whichever is later, but not sooner than April 1, 2024. Therefore, ODM is tentatively seeking a SPA effective date of October 1, 2024.

The State will submit the required upper payment limit (UPL) demonstration in the MACFin system.

If you have any questions or require additional information, please contact Rebecca Jackson at rebecca.jackson@medicaid.ohio.gov; or Jesse Wyatt at jesse.wyatt@medicaid.ohio.gov.

Sincerely,

Maureen M. Corcoran, Director

Enclosures:

1. Ohio Medicaid SPA TN 24-004
2. SPA TN 24-004 Changes – Redline version
3. Legal Notices
4. State Responses to Funding Questions

cc: Christine Davidson, CMS Ohio State Program Representative
Rebecca Jackson, Ohio Department of Medicaid
Jesse Wyatt, Ohio Department of Medicaid
Fred Sebree, NIRT Lead

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0004

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
1902(a)(30)(A) and 1905(a)(4)(A) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 54,884,160
b. FFY 2026 $ 54,884,160

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Atch 3.1-A, Item 4-a, Page 1 of 1
Atch 4.19-C, Suppl. 1, Sec. 001.1, Page 1 of 1
Atch 4.19-D, Suppl. 1, Sec. 001.4, pages 1-2 of 2

Atch 4.19-D, Suppl. 1, Sec. 001.20.6, pages 1-2 of 2 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Atch 3.1-A, Item 4-a, Page 1 of 1 (TN 19-011)
Atch 4.19-C, Suppl. 1, Sec. 001.1, Page 1 of 1 (TN 17-024)
Atch 4.19-D, Suppl. 1, Sec. 001.4, pages 1-2 of 2 (TN 19-011)

9. SUBJECT OF AMENDMENT

Payment for Services: Nursing Facility Private Rooms Payment Increase

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL
Maureen M. Corcoran

12. TYPED NAME
MAUREEN M. CORCORAN

13. TITLE
STATE MEDICAID DIRECTOR

14. DATE SUBMITTED
April 1, 2024

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

4-a. Nursing facility services (other than services in an institution of mental diseases) for individuals 21 years of age or older.

Included in the nursing facility per diem rate is room and board, including a private room if medically necessary, such as the need for infection control. Eligible facilities may also receive approval to receive an increased daily rate under the private room program.

The services included and not included in the nursing facility per diem rate are specified in Section 001.4 of Attachment 4.19-D, Supplement 1.

Leave Days

The Ohio Department of Medicaid will make payments to reserve a bed for a recipient during temporary absence for hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the facility when the resident's plan of care provides for the absence for up to 30 days in a calendar year. Payment will equal 50% of the nursing facility's per diem if the nursing facility's occupancy exceeded 95% in the preceding calendar year and 18% of the nursing facility's per diem if the nursing facility's occupancy did not exceed 95% in the preceding calendar year.

Leave Day payments to reserve a bed will be no different than the routine leave day payment rate regardless of the facility's approval status for providing ventilator services or private rooms.

Relation to Other Services

The nursing facility per diem rate is a comprehensive rate that includes many items and services for which the provider is not paid directly by the Medicaid program. The following items and services are included in the nursing facility per diem rate:

1) Personal hygiene services provided by facility staff or contracted personnel;
2) The purchase and administration of tuberculin tests;
3) Drawing specimens and forwarding specimens to a laboratory;
4) Medical supplies, defined as items with a very limited life expectancy (e.g., atomizers, nebulizers, bed pans, catheters, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits);
5) Needed medical equipment, defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility (e.g., hospital beds, wheelchairs other than custom wheelchairs, and intermittent positive-pressure breathing machines). For dates of service on and after January 1, 2014, custom wheelchairs are not included in the nursing facility rate and are covered on a fee for service basis;
6) Emergency oxygen;
7) Over the counter drugs and nutritional supplements;
8) Physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants;
9) Respiratory therapy services, including physician ordered administration of aerosol therapy rendered by a licensed respiratory care professional;
10) Resident transportation other than medically necessary transportation by ambulance or wheelchair van. Medically necessary transportation of residents who do not require an ambulance or wheelchair van is paid through the NF per diem rate;
11) Private rooms, which will be reimbursed in accordance with Section 001.20.6 of Attachment 4.19-D.

The following items and services are not included in the nursing facility per diem rate but are paid directly to the provider by the Medicaid program:

1) Covered dental services provided by licensed dentists;
2) Laboratory and x-ray procedures covered under the Medicaid program;
3) Ventilators;
4) Prostheses and orthoses;
5) Pharmaceuticals, subject to the following conditions:
   a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient;
   b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years;

c) A receipt for drugs delivered to a NF must be signed by the facility representative at the time of delivery; a copy must be maintained by the pharmacy.

6) Behavioral health services;
7) Physician services;
8) Podiatry services;
9) Vision care services;
10) Custom wheelchairs;
11) Non-emergency oxygen;
12) Medically necessary resident transportation by ambulance or wheelchair van;
13) Acupuncture services in accordance with Attachment 3.1-A.

Private Rooms

Private Rooms may be provided due to a resident's medical necessity or for any resident in an approved private room in an eligible facility approved to participate in the private room program. Reimbursement is different based on these scenarios.

For all Nursing Facilities:

Private rooms may be provided by any facility to a resident due to medical necessity such as the need for infection control, or when semiprivate or ward accommodations are not available. In both cases, the Medicaid per diem payment is considered payment in full, and no supplemental payment may be requested or accepted from a resident, or from the resident's authorized representative or family. If semiprivate or ward accommodation are available but the resident or resident's representative makes a written request for a private room, the private room is considered a non-covered service for which the facility may seek supplemental payment from the resident or resident's representative. The supplemental payment amount shall be no more than the difference between the charge to private pay residents for a semi-private room and the charge to private pay residents for a private room.

For Approved Nursing Facilities:

Facilities who apply, meet specified eligibility requirements and are approved by Medicaid to participate in the private room program will receive an increased per diem rate for the provision of services in those private rooms approved by Medicaid.

1) Reimbursement:
    a. For Category One private rooms, meaning the room has unshared access to a toilet and sink, the facility's per diem payment rate will be increased by $30 per day.
    b. For Category Two private rooms, meaning the room has shared access to a toilet and sink, the facility's per diem payment rate will be increased by $20 per day.

2) Eligibility Criteria:
    a. Private rooms that are in existence on July 1, 2023, in facilities where all of the licensed beds are in service on the application date.
    b. Private rooms created by surrendering licensed beds from its licensed capacity, or, if the facility does not hold a license, surrendering licensed beds that have been certified by CMS. A nursing facility where the beds are owned by a county and the facility is operated by a person other than the county may satisfy this requirement by removing beds from service.
    c. Private rooms created by adding space to the nursing facility or renovating non-bedroom space, without increasing the total licensed bed capacity.
    d. For a nursing facility licensed after July1, 2023, all licensed beds are in service on the application date or private rooms were created by surrendering licensed beds from its licensed capacity.

3) Provider Exclusions:
    Facilities will not be approved if any of the following circumstances apply:
    a. The rooms do not meet the above definitions of a Category One or Category Two private room.
    b. The above eligibility criteria is not met.

c. The facility created private rooms by reducing the number of available beds without surrendering the beds, and surrender of the beds is required.
d. Approval of the room would cause projected expenditures for private room payments for the state fiscal year to exceed one hundred sixty million dollars in fiscal year 2025 or subsequent fiscal years.
e. On the application date, the nursing facility is listed on table A or table D of the Special Focus Facility list or is designated as having a one-star overall rating in the CMS nursing facility five-star rating system, Care Compare.

4) Ongoing Requirements:
Beginning July 1, 2025, to retain eligibility for private room rates, a nursing facility must do both of the following:
a. Have a policy in place to prioritize placement in a private room based on the medical and psychosocial needs of the resident; and
b. Participate in Ohio's annual resident or family satisfaction survey.

5) Appeal Rights:
Facilities may request reconsideration if their application to participate in the private room program and receive the increased per diem rate is denied.

4-a. Nursing facility services (other than services in an institution of mental diseases) for individuals 21 years of age or older.

Included in the nursing facility per diem rate is room and board, including a private room if medically necessary, such as the need for infection control. Eligible facilities may also receive approval to receive an increased daily rate under the private room program.

The services included and not included in the nursing facility per diem rate are specified in Section 001.4 of Attachment 4.19-D, Supplement 1.

Leave Days

The Ohio Department of Medicaid will make payments to reserve a bed for a recipient during temporary absence for hospitalization for an acute condition, visits with relatives and friends, and participation in therapeutic programs outside the facility when the resident's plan of care provides for the absence for up to ~~thirty~~ 30 days in a calendar year. ~~During calendar year 2011, the payment will equal fifty percent of the nursing facility's per diem. During calendar year 2012 and thereafter, the~~ ~~p~~Payment will equal ~~fifty percent~~ 50% of the nursing facility's per diem if the nursing facility's occupancy exceeded ~~ninety-five percent~~95% in the preceding calendar year and ~~eighteen percent~~18% of the nursing facility's per diem if the nursing facility's occupancy did not exceed ~~ninety-five percent~~95% in the preceding calendar year.

Leave Day payments to reserve a bed will be no different than the routine leave day payment rate regardless of the facility's approval status for providing ventilator services or private rooms.

Relation to Other Services

The nursing facility per diem rate is a comprehensive rate that includes many items and services for which the provider is not paid directly by the Medicaid program. The following items and services are included in the nursing facility per diem rate:

1) Personal hygiene services provided by facility staff or contracted personnel;
2) The purchase and administration of tuberculin tests;
3) Drawing specimens and forwarding specimens to a laboratory;
4) Medical supplies, defined as items with a very limited life expectancy (e.g., atomizers, nebulizers, bed pans, catheters, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits);
5) Needed medical equipment, defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility (e.g., hospital beds, wheelchairs other than custom wheelchairs, and intermittent positive-pressure breathing machines). For dates of service on and after January 1, 2014, custom wheelchairs are not included in the nursing facility rate and are covered on a fee for service basis;
6) Emergency oxygen;
7) Over the counter drugs and nutritional supplements;
8) Physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants;
9) Respiratory therapy services, including physician ordered administration of aerosol therapy rendered by a licensed respiratory care professional;
10) Resident transportation other than medically necessary transportation by ambulance or wheelchair van. Medically necessary transportation of residents who do not require an ambulance or wheelchair van is paid through the NF per diem rate;
11) Private rooms, ~~when residents require one due to medical necessity such as the need for infection control, or when semiprivate or ward accommodations are not available. In both cases, Medicaid payment is considered payment in full, and no supplemental payment may be requested or accepted from a resident, or from a resident's authorized representative or family. If semiprivate or ward accommodations are available but the resident or resident's representative makes a written request for a private room, the private room is considered a non-covered service for which the facility may seek supplemental payment from the resident or resident's representative. The supplemental payment amount shall be no more than the difference between the charge to private pay residents for a semiprivate room and the charge to private pay residents for a private room.~~ which will be reimbursed in accordance with Section 001.20.6 of Attachment 4.19-D.

The following items and services are not included in the nursing facility per diem rate but are paid directly to the provider by the Medicaid program:

1) Covered dental services provided by licensed dentists;
2) Laboratory and x-ray procedures covered under the Medicaid program;

3) Ventilators;
4) Prostheses and orthoses;
5) Pharmaceuticals, subject to the following conditions:
   a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient;
   b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years;
   c) A receipt for drugs delivered to a NF must be signed by the facility representative at the time of delivery; a copy must be maintained by the pharmacy.
6) Behavioral health services;
7) Physician services;
8) Podiatry services;
9) Vision care services;
10) Custom wheelchairs;
11) Non-emergency oxygen;
12) Medically necessary resident transportation by ambulance or wheelchair van;
13) Acupuncture services in accordance with Attachment 3.1-A.

LEGAL NOTICE
STATE OF OHIO
OHIO DEPARTMENT OF MEDICAID
COLUMBUS, OHIO

Pursuant to section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205, the Director of the Ohio Department of Medicaid (department) gives notice of the department's intent to modify provisions relating to the reimbursement of nursing facilities participating in the Medicaid program.

The modifications are amendments to the Ohio Revised Code that will impact the way nursing facilities are reimbursed for services rendered to Medicaid recipients in state fiscal years 2024, 2025, and beyond.

The proposed amendments are included in legislation being considered by the Ohio General Assembly for the fiscal year 2024 and 2025 state of Ohio budget. With this notice, the department is initiating a public input process thereon.

CHANGE IN REIMBURSEMENT METHODOLOGY FOR NURSING FACILITY SERVICES

Changes to the way nursing facilities are reimbursed for services provided to Medicaid eligible recipients are included in the proposed amendments to the Ohio Revised Code. These changes are intended to recognize changes in provider spending, assure stability in provider rates, balance state resources among competing demands, and continue to assure access to care. The following amendments are being considered by the Ohio General Assembly:

Per Medicaid Day Payment Rate

The proposed amendments modify the formula used to calculate the Medicaid payment amount to nursing facilities for Medicaid residents by removing a $1.79 deduction, considering a deduction for low occupancy under certain circumstances, increasing the add-on to the initial rate for new nursing facilities, and removing inflationary adjustments for the direct care and ancillary and support cost centers.

Quality Incentive Payments

The proposed amendments extend the quality incentive payments which were only in effect through FY 2023. The proposed amendments eliminate some exclusions from the quality incentive payment found in current law for facilities that meet certain criteria and permit new nursing facilities and, under certain circumstances, a facility that undergoes a change of operator, to receive a quality incentive payment. The proposed amendments also add to the calculation of the total amount to be spent on quality incentive payments an additional component based on 60% of the amount certain cost centers changed as a result of the FY 2024 rebasing. The proposed amendments add additional quality incentive metrics beginning in FY 2025 and cap the total amount to be spent on quality incentive payments each fiscal year.

Rebasing

The proposed amendment provides that costs be measured from the calendar year immediately before the start of the fiscal year in which a rebasing is conducted, instead of two calendar years before. In addition, in calculating a facility's FY 2024 and FY 2025 base rates, any increases in the direct care cost center from the most recent rebasing are limited to 40% of the increase. Finally, the proposed amendments eliminate the requirement that nursing facilities spend additional money received as a result of the FY 2022 rebasing on direct care, ancillary and support, and tax cost centers only.

Private Room Incentive Payment

Additional funding is being considered by the General Assembly for a private room incentive payment for eligible nursing facilities with private rooms, subject to requirements that are approved by CMS. The rate would be based on whether the private room has shared access to a bathroom. Nursing facilities with private rooms must apply to the department for the incentive payment. The department may deny applications that don't meet the definition of a private room or the specified criteria, or where beds were not surrendered if required.

IMPACT ON ANNUAL AGGREGATE EXPENDITURES

Implementation of these changes in the methods and standards for setting payment rates is expected to increase annual aggregate expenditures for nursing facility services by between $301 million and $627.6 million in SFY 2024 and between $301 million and $747.6 million in SFY 2025.

PUBLIC INPUT PROCESS

Any person may examine and obtain a copy of the amendments, without charge, at the following locations:

Ohio Department of Medicaid, 50 West Town Street, Suite 400, Columbus, Ohio 43215;

Any county department of job and family services; or

On the internet at House Bill 33 | 135th General Assembly | Ohio Legislature.

Written comments on the amendments may be submitted in person to the department at the address above and may be reviewed at the same location*. Comments may also be provided by e-mail to the following address: NFPolicy@medicaid.ohio.gov. Comments must be submitted no later than close of business on June 29, 2023.

ODM is committed to providing access and inclusion and reasonable accommodation in its services, activities, programs, and employment opportunities in accordance with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act, and other applicable laws. To request an interpreter, written information in a language other than English or in other formats (large print, audio, accessible electronic formats, other formats), or a reasonable accommodation due to a disability, please contact ODM's Civil Rights/ADA Coordinator at 614-995-9981/TTY 711, Fax 1-614-644-1434, or Email: ODM_EEO_EmployeeRelations@medicaid.ohio.gov. If

you believe ODM has failed to provide these services or discriminated in another way, you can file a grievance with ODM's Civil Rights Coordinator and/or file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Further information on these processes and ODM's compliance with civil rights and other applicable laws can be found here: Notice of Nondiscrimination | Medicaid (ohio.gov).

*If you would like to review the amendments or written comments in person at the department or county, please contact the department or county first to schedule an appointment, as office hours may be limited or revised from the usual schedule due to COVID-19.

LEGAL NOTICE
STATE OF OHIO
OHIO DEPARTMENT OF MEDICAID
COLUMBUS, OHIO

Pursuant to section 1902(a)(13)(A) of the Social Security Act, the Director of the Ohio Department of Medicaid (department) gives final notice of the department's modification of provisions relating to the reimbursement of nursing facilities participating in the Medicaid program.

An initial notice was issued in June 2023 to inform the public of proposed changes in reimbursement to nursing facilities for Medicaid services. This final notice reflects the result of the public and legislative processes.

CHANGE IN REIMBURSEMENT METHODOLOGY FOR NURSING FACILITY SERVICES

The following changes are intended to recognize changes in provider spending, assure stability in provider rates, balance state resources among competing demands, and continue to assure access to care:

Per Medicaid Day Payment Rate

The formula used to calculate the Medicaid payment amount to nursing facilities for Medicaid residents has been modified by removing a $1.79 deduction, including a deduction for nursing facilities with a low occupancy rate, increasing the add-on to the initial rate for new nursing facilities, and removing inflationary adjustments for the direct care and ancillary and support cost centers.

Quality Incentive Payments

The quality incentive payments which were only in effect through FY 2023 have been extended. New nursing facilities and, under certain circumstances, facilities that undergo a change of operator will be eligible for a quality incentive payment. The calculation of the total amount to be spent on quality incentive payments will include an additional component based on 60% of the amount the direct care cost center changed as a result of rebasing. Additional quality incentive metrics will be added beginning in FY 2025 and the total amount to be spent on quality incentive payments each fiscal year is limited. Some exclusions from the quality incentive payment found in current law for facilities that meet certain criteria have been eliminated.

Rebasing

Costs will be measured from the calendar year immediately before the start of the fiscal year in which a rebasing is conducted, instead of two calendar years before. In addition, in calculating a facility's base rates, any increases in the direct care cost center from the most recent rebasing are limited to 40% of the increase. Finally, the requirement that nursing facilities spend additional money received as a result of the FY 2022 rebasing on direct care, ancillary and support, and tax cost centers only has been removed.

Private Room Incentive Payment

Additional funding is available for a private room incentive payment for eligible nursing facilities with private rooms, subject to requirements that are approved by the Centers for Medicare and Medicaid Services. The amount of the incentive payment will be determined by whether the private room has shared access to a bathroom. Facilities with private rooms must apply to the department for the incentive payment. The department may deny applications that do not meet the definition of a private room or specified criteria, or where the beds are not surrendered if required.

If, as an interested party, you need further clarification regarding the rates for a specific nursing facility under these methodologies, you may contact NFPolicy@medicaid.ohio.gov.

ODM is committed to providing access and inclusion and reasonable accommodation in its services, activities, programs, and employment opportunities in accordance with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act, and other applicable laws. To request an interpreter, written information in a language other than English or in other formats (large print, audio, accessible electronic formats, other formats), or a reasonable accommodation due to a disability, please contact ODM's Civil Rights/ADA Coordinator at 614-995-9981/TTY 711, Fax 1-614-644-1434, or Email: ODM_EEO_EmployeeRelations@medicaid.ohio.gov. If you believe ODM has failed to provide these services or discriminated in another way, you can file a grievance with ODM's Civil Rights Coordinator and/or file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Further information on these processes and ODM's compliance with civil rights and other applicable laws can be found here: Notice of Nondiscrimination | Medicaid (ohio.gov)

State: OHIO

Medicaid Funding Questions

1905(a) Service: Nursing Facility Services

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved plan. Do providers receive and retain the Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payment, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in the response a full description of the repayment process. Include in the response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

   Response: NF providers under Attachment 4.19-D of the State Plan retain 100% of payments received from Medicaid for NF services and return no portion of the Medicaid payments to the State or any other entity.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either and IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and the state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   i. a complete list of the names of entities transferring or certifying funds;
   ii. the operational nature of the entity (state, county, city, other);
   iii. the total amounts transferred or certified by entity;
   iv. clarify whether the transferring or certifying entity has general taxing authority; and,
   v. whether the certifying or transferring entity received appropriations (identify the level of appropriations).

Response: The state share for the NF provider reimbursement approved under Attachment 4.19-D is funded by the state legislature (general revenue fund) and portions of the franchise permit fee. The NF providers under Attachment 4.19-D do not receive supplemental or enhanced payments. The funds paid to NFs under Attachment 4.19-D are retained 100% by those providers.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1902(a)(1) provides for federal financial participation to states for expenditures for services under an approved state plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   Response: NF provider reimbursement approved under Attachment 4.19-D does not include supplemental or enhanced payments. Payments received by participating NFs are retained by the providers and not returned to ODM.

4. For clinic or outpatient hospital services, please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

   Response: N/A

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

   Response: The State does not pay any group of public providers under Attachment 4.19-D more than the UPL. No additional funding beyond the reimbursement approved under Attachment 4.19-D is paid to a public provider or in fact to any provider. All NF provider reimbursement approved under Attachment 4.19-D is treated uniformly on a prospective basis.