Ohio Administrative Code

Rule 5160-28-04.3 Cost-based clinics: submission of an RHC cost report.

Effective: October 1, 2016

(A) A rural health clinic (RHC) must submit a cost report in either of the following circumstances:

(1) An RHC newly enrolled as a medicaid provider must submit a cost report covering the twelve-month period beginning on the first day of the first full month after enrollment.

(2) An RHC that requests an adjustment in a per-visit payment amount (PVPA) based on a change in scope must submit two cost reports for that service, one covering the twelve-month period ending on the last day of the last full month before the change in scope and one covering the twelve-month period beginning on the first day of the first full month after the change in scope. If the adjustment is granted, the adjustment amount is the difference (positive, negative, or zero) obtained when the PVPA derived from the first cost report is subtracted from the PVPA derived from the second cost report. The new PVPA is the sum of the current PVPA and the adjustment amount.

(B) No extension will be granted for submission of cost reports. If an RHC fails to submit a complete, accurate, and timely cost report, then the department may choose to take either or both of two courses of action:

(1) It may decline to make any adjustments to the PVPAs established for the RHC.

(2) It may impose a penalty of not more than five hundred dollars for each business day on which the cost report is late.

(C) The department has sole discretion over whether to grant a request for an adjustment in a PVPA based on a change in scope.

(D) A request for an adjustment in a PVPA based on a change in scope must be made in writing. In making such a request, an RHC must include the following information:

(1) It must specify that the basis for the request is a change in scope.

(2) It must demonstrate that all reasonable attempts were made to address cost changes outside of the adjustment process.

(3) It must demonstrate that an adjustment is warranted by providing detailed evidence derived from a community needs assessment based on population demographics, a completed business plan, or other similar documents.

(4) It must specify which cost centers have been affected and why.

(5) If the change in scope is attributable to a change in the intensity of services provided, then the RHC must demonstrate the direct connection. It may do so, for example, by providing evidence that a shift in the distribution of diagnoses has changed the acuity of care or by showing that the relative-value components of the services provided have changed.

(E) The department must respond in writing within sixty days after it receives a request for an adjustment in a PVPA based on a change in scope or after it receives additional information needed to determine whether an adjustment is warranted.

(F) The following conditions apply to any adjustment in a PVPA based on a change in scope:

(1) Such an adjustment can be granted only once for a particular circumstance for a particular RHC service site.

(2) No adjustment will be made if the percentage of change represented by the calculated PVPA for the service is not at least twice the medicare economic index (MEI) for the relevant year.

(3) No adjusted PVPA may exceed any limit, ceiling, or other maximum set forth in agency 5160 of the Administrative Code.