Ohio Administrative Code

Rule 5160-28-05.1 Cost-based clinics: prospective payment system (PPS) method for determining FQHC payment.

Effective: October 1, 2016

This rule addresses how the department complieswith provisions set forth in Section 702 of the Medicare, Medicaid and SCHIPBenefits Improvement and Protection Act of 2000 (BIPA) that require states toestablish a medicaid prospective payment system (PPS) for federally qualifiedhealth center (FQHC) services.

(A) A separate all-inclusive per-visit payment amount (PVPA) is established for each FQHC service provided at an FQHC service site.

(1) For every FQHC service site that is already enrolled as a medicaid provider, the department establishes new PVPAs equal to the current PVPAs adjusted by the percentage of the latest available medicare economic index (MEI). The new PVPAs are established by October first of each year and are in effect from October first through the following September thirtieth.

(2) For an existing FQHC that requests an adjustment based on a change in scope, the department may establish new PVPAs based on a cost report in accordance with rule 5160-28-04.1 of the Administrative Code.

(3) For an FQHC that is enrolling as a new medicaid provider or is adding new FQHC services, the department establishes initial PVPAs in accordance with the following procedure:

(a) First, the initial PVPAs are set 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 in accordance with paragraph (A)(4) of this rule. These initial PVPAs remain in effect until new PVPAs are established.

(b) After the initial PVPAs are set, the FQHC submits a cost report in accordance with rule 5160-28-

04.1 of the Administrative Code. 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.

(c) Thereafter, PVPAs are adjusted in accordance with paragraph (A)(1) of this rule.

(4) 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 (S / E), rounded up to the next whole dollar.

(a) 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.

(b) 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.

(c) E is the medicaid maximum non-facility payment amount for a mid-level evaluation and management service (office visit) for an established patient.

(B) A PVPA based on a cost report is effective from the first day of the first full month after the department has established or adjusted the PVPA through the following September thirtieth. A PVPA that is established or adjusted before September thirtieth and becomes effective on or after October first is then further adjusted by the appropriate MEI. No retroactive establishment or adjustment will be made for a PVPA.

(C) PVPAs are specific to an FQHC service site. No FQHC service site may submit claims based on the PVPAs of another service site.

(D) Decisions of the department with respect to the establishment or adjustment of a PVPA are not

subject to Chapter 119. of the Revised Code.