# Ohio Administrative Code

## Rule 5160-28-05 FQHC and RHC services: prospective payment system (PPS) method for determining payment.

Effective: July 1, 2022

(A) A discrete, all-inclusive per-visit payment amount (PVPA) is established for each FQHC PPS service provided at an FQHC or related off-site location and for an RHC PPS service provided at an RHC or related off-site location.

(1) For all FQHC or RHC sites that are already enrolled as medicaid providers, ODM establishes new PVPAs equal to the current PVPAs revised to reflect the latest available medicare economic index (MEI) percentage. The new PVPAs are established by October first of each year and are in effect from October first through the following September thirtieth.

(2) When an enrolled FQHC or RHC site requests adjustment of a PVPA, ODM may establish a new PVPA based on a cost report in accordance with rule 5160-28-04 of the Administrative Code.

(3) For an FQHC or RHC site that is enrolling as a new medicaid provider or an FQHC site that is adding a new FQHC PPS service, ODM establishes an initial PVPA in accordance with the following procedure:

(a) First, the initial PVPA is set equal to the corresponding PVPA of other FQHC or RHC sites in the immediate area that are similar in size, caseload, and scope of services. If no such FQHC or RHC site exists, then the initial PVPA is set equal to the current PVPA at the applicable statewide sixtieth percentile for the appropriate FQHC or RHC classification (FQHC or RHC).

(b) This initial PVPA remains in effect until a new PVPA is established.

(c) After the initial PVPA is set, the FQHC or RHC site submits a cost report in accordance with rule 5160-28-04 of the Administrative Code. A new PVPA is established on the basis of the cost report and is revised to reflect any changes in the MEI that have occurred since the cost report was submitted.

(d) Thereafter, the PVPA is revised in accordance with paragraph (A)(1) of this rule.

(4) For an FQHC PPS service only, if no current PVPA at the applicable statewide sixtieth percentile is available, then the initial PVPA, 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 FQHC sites; or

(ii) The current PVPA for medical services at the particular FQHC site.

(b) S is the medicaid maximum payment amount (or the median 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 calendar month after ODM 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 revised to reflect the applicable MEI. No retroactive establishment or adjustment will be made for a PVPA.

(C) A PVPA is specific to an FQHC or RHC site. No FQHC or RHC site may submit claims based on the PVPAs of another FQHC or RHC site.

(D) Decisions of ODM with respect to the establishment or adjustment of a PVPA are not subject to Chapter 119. of the Revised Code.