Ohio Administrative Code

Rule 5160-28-07.1 Cost-based clinics: alternate payment method (APM) for determining FQHC payment.

Effective: October 1, 2016

(A) This rule describes an alternate payment method (APM) that may be selected, with approval from the department, by a government-operated federally qualified health center (FQHC). Under this APM, a government-operated FQHC may receive payment in addition to amounts established under the prospective payment system (PPS) described in rule 5160-28-05.1 of the Administrative Code. To qualify for additional payment under this APM, a government-operated FQHC must submit both a preliminary cost report and a fully audited cost report for every cost-reporting period. For purposes of this rule, a cost-reporting period is the fiscal year used by the government-operated FQHC. For a government-operated FQHC new to the APM described in this rule, the department may agree to an initial cost-reporting period covering not less than six months nor more than seventeen months.

(B) The APM involves three steps:

(1) Submission of a preliminary cost report. Within one hundred twenty days after the close of each cost-reporting period, the government-operated FQHC compiles and submits a preliminary cost report of all FQHC services rendered during that cost-reporting period. A government-operated FQHC that has more than one service site compiles and submits separate cost reports for the individual sites. When it submits a preliminary cost report, the government-operated FQHC must certify to the department that its costs were an expenditure of public funds not derived from a federal funding source and not otherwise used as a state or local match for federal funds.

(2) Calculation of an APM payment. After it receives a complete and accurate cost report and certification, the department performs a desk audit of the cost report and determines the amount for which the government-operated FQHC is eligible to receive payment, in the form of federal matching funds, in addition to amounts established under the PPS. The cost report is not used in any way to alter amounts established under the PPS.

(a) No additional limitation, test of reasonableness, or ceiling described in rule 5160-28-06.1 of the

Administrative Code is applied to the cost report. The resulting figures represent the total actual allowable costs during the cost-reporting period.

(b) From these figures, the "average cost per visit" for each FQHC service offered at the site is obtained by dividing the total actual allowable costs for the service by the total number of visits.

(c) For each FQHC service, the "total allowable medicaid cost" for the cost-reporting period is the product of the average cost per visit and the number of visits made by medicaid-eligible individuals.

(d) The "total medicaid payment" for an FQHC service during the cost-reporting period is the sum of the per-visit payment amounts (PVPAs) paid to an FQHC under the prospective payment system (PPS), payments made by medicaid managed care plans, and supplemental payments.

(e) The "total medicaid variance" for an FQHC service is the difference obtained by subtracting the total medicaid payment from the total allowable medicaid cost. If this difference is positive, the department calculates the federal share of the difference by applying the appropriate federal match percentage and then remits this amount to the government-operated FQHC.

(3) Submission of a fully audited cost report. Within five hundred days after the close of each cost-reporting period, the government-operated FQHC submits a fully audited cost report of all services rendered during that cost-reporting period. A government-operated FQHC that has more than one service site submits separate cost reports for the individual sites. From the audited cost report, the department follows the procedure described in paragraph (B)(2) of this rule to calculate the federal share of the total medicaid variance for each FQHC service offered by the government-operated FQHC. If the total medicaid variance derived from the fully audited cost report differs from the total medicaid variance derived from the preliminary cost report, then the difference in the federal share must be remitted appropriately; amounts owed to the department must be paid within thirty days. For payment purposes, the federal share amounts for the various FQHC services offered at a single site may be aggregated.