Ohio Administrative Code

Rule 5160-28-07.1 FQHC and RHC services: alternate payment method (APM) for determining payment for government-operated FQHCs.

Effective: July 1, 2022

(A) This rule describes an alternate payment method (APM) that may be selected, with approval from the Ohio department of medicaid (ODM), by a government-operated federally qualified health center (FQHC) such as a public health department. Under this APM, a government-operated FQHC may receive payment in addition to amounts established under the prospective payment system (PPS) method described in rule 5160-28-05 of the Administrative Code. To qualify for additional payment under this APM, a government-operated FQHC site submits 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 that has newly selected the APM, ODM may agree to an initial cost-reporting period covering not less than six months nor more than seventeen months.

(B) The APM involves two steps:

(1) Submission of an annual cost report. Within one hundred twenty days after the close of its fiscal year, the government-operated FQHC site compiles and submits a fully audited cost report of all PPS services rendered during that cost-reporting period. Government-operated FQHC sites of the same parent organization compile and submit separate cost reports. When it submits its annual cost report, the government-operated FQHC site attests 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 an audited cost report and certification, ODM performs a desk review of the cost report and determines the amount for which the government-operated FQHC site 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 PPS 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 PPS 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 a PPS service during the cost-reporting period is the sum of the per-visit payment amounts (PVPAs) paid to an FQHC site under the prospective payment system (PPS), payments made by MCEs, and medicaid wraparound payments.

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

(C) For payment purposes, the federal share amounts for the various PPS services offered at an FQHC site may be aggregated.