Table of Contents

State/Territory Name: Ohio

State Plan Amendment (SPA) #: 22-0017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

August 4, 2023

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

Re: Ohio State Plan Amendment (SPA) Transmittal Number 22-0017

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 22-0017. This amendment proposes to add transportation as an allowable rural health clinic service and dietician services as allowable rural health clinic and federally qualified health center services.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Ohio Medicaid SPA 22-0017 was approved on August 3, 2023, with an effective date of July 1, 2022.

If you have any questions, please contact Christine Davidson at (312) 886-3642 or via email at Christine.davidson@cms.hhs.gov.

Sincerely,

[redacted]

Sophia Hinojosa, Acting Director
Division of Program Operations

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Michele Weller, CMCS
Brandon Smith, CMCS
Deborah Benson, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0017

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
SSA 1902(bb) & 1905(a); Section 330 Public Health Service Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 23,000
b. FFY 2023 $ 82,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A, Item 2-b, page 1 of 1
Attachment 3.1-A, Item 2-c, page 1 of 1
Attachment 4.19-B, Item 2-b, page 1 of 2
Attachment 4.19-B, Item 2-b, page 2 of 2 (new)
Attachment 4.19-B, Item 2-c, pages 1-3 of 3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A, Item 2-b, page 1 of 1 (TN 21-009)
Attachment 3.1-A, Item 2-c, page 1 of 1 (TN 21-009)
Attachment 4.19-B, Item 2-b, page 1 of 1 (TN 16-033)

Attachment 4.19-B, Item 2-c, pages 1-4 of 4 (TN 16-033)

9. SUBJECT OF AMENDMENT

Coverage/Limitations and Payment for Services: Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME: **MAUREEN M. CORCORAN**

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED: June 22, 2022

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED: June 22, 2022

17. DATE APPROVED: **08/03/2023**

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL: Sophia Hinojosa

21. TITLE OF APPROVING OFFICIAL: Acting Director, Division of Program Operations

22. REMARKS

2-b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

An eligible provider of rural health clinic (RHC) services is an entity that meets the definition of an RHC set forth in 42 CFR 491.2 and has been certified as an RHC under Medicare.

The following RHC services are covered by the Ohio Department of Medicaid in accordance with Sections 1905(a)(2)(B), 1905(l), and 1861(aa)(1) of the Social Security Act:

1. Medical services that are rendered by a physician, physician assistant, advanced practice registered nurse (e.g., nurse practitioner, certified nurse midwife), dietitian, or pharmacist employed by or otherwise compensated by the RHC;

2. Behavioral health services, including therapy and testing, rendered by, but not limited to, a clinical psychologist or a clinical social worker; and

3. Services provided under supervision that would be covered if they were rendered by a physician or an advanced practice registered nurse;

4. Visiting nurse services; and

5. Transportation services.

Other ambulatory services included in the state plan and services and supplies furnished as "incident to the professional services" by an RHC are also covered services.

2-c. Federally-Qualified Health Center (FQHC) Services

An eligible provider of FQHC services is an entity that has been determined by the Federal Health Resources and Services Administration to meet all requirements under Section 330 of the Public Health Service Act (PHSA) and that has entered into an agreement with CMS to meet Medicare program requirements.

FQHC covered services under Medicaid are defined under Section 1905(l)(2) of the Social Security Act. FQHC services are listed in Section 1861(aa)(1)(A), (B) and (C) of the Act, and include drugs and biologicals referenced in 1861(s)(10)(A) and (B) of the Act.

The following FQHC services are covered and paid under the Prospective Payment System (PPS) by the Ohio Department of Medicaid in accordance with Section 1905(a)(2)(C) of the Social Security Act:

1. Medical services, which may comprise any of the following services or items:
    a. All services referenced at 42 USC 1395x(aa)(3);
    b. Professional services furnished by a physician, physician assistant, advanced practice registered nurse (e.g., nurse practitioner, certified nurse-midwife), dietitian, or pharmacist, except for behavioral health services provided by an advanced practice registered nurse;
    c. Services and supplies incident to the professional services of a physician, physician assistant, advanced practice registered nurse, clinical social worker, or psychologist for which no separate payment is made;
    d. Services of a registered nurse acting under the direct supervision of a physician unless provided incident to a professional service; or
    e. Visiting nurse services,
2. Dental services,
3. Physical therapy services and occupational therapy services,
4. Behavioral health services, rendered by, but not limited to, a clinical psychologist or a clinical social worker;
5. Speech pathology and audiology services,
6. Podiatry services,
7. Vision services,
8. Chiropractic services, and
9. Transportation services.

Other ambulatory services included in the state plan and services and supplies furnished as "incident to the professional services" by an FQHC are also covered services.

2-b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

A. Rural Health Clinic (RHC) Prospective Payment System (PPS)

Starting January 1, 2001, all RHCs are paid on a PPS basis as required by the provisions of the Benefits Improvement and Protection Act (BIPA) of 2000. The state-calculated RHC rates comply with the statutory requirements for the payment of RHC services for Medicaid in Section 1902(bb) of the Social Security Act (the Act).

In the RHC PPS, a separate all-inclusive per-visit payment amount (PVPA) (encounter) is established for RHC services (see Attachment 3.1-A, Item 2-b, Page 1 of 1) provided at an RHC service site (one PVPA for all services).

A PVPA is specific to an RHC service site.

Method for Establishing PVPAs at an Existing RHC

For every RHC service site already enrolled as a Medicaid provider, the State establishes a new PVPA equal to the current PVPA adjusted by the percentage of the latest available Medicare Economic Index (MEI). For an existing RHC that requests an adjustment based on a change in scope, the State may have their PVPA adjusted based on a cost report that reflects the incremental change in rate due to the change in scope of service.

Method for Establishing PVPAs at a New RHC

For an RHC that is enrolling as a new Medicaid provider, the State establishes an initial PVPA by setting it equal to the PVPAs of other RHCs in the immediate area that are similar in size, caseload, and scope of services. If no such RHC exists, then the initial PVPA is set equal to the current PVPA at the statewide 60th percentile for RHCs. This initial PVPA remains in effect until a new PVPA is established. After the initial PVPA is set, the RHC submits a cost report. A new PVPA is established on the basis of the cost report and is adjusted by any changes in the MEI that have occurred since the cost report was submitted.

For purposes of establishing RHC per-visit payment amounts, the State uses the appropriate Medicare form, either CMS-222-17, "Independent Rural Health Clinic Cost Report" (rev. 5/2018) or CMS 2552-10, "Hospital and Hospital Health Care Complex Cost Report Certification and Settlement Summary" (rev. 4/2020). When required, the State reconciles the annual cost report to final payments to the RHC within 120 days of receiving a clean cost report.

Co-payments may apply to services rendered by an RHC.

B. Wraparound Payments and Medicaid Managed Care Entities (MCEs)

An RHC receiving payment from an MCE for an RHC service is eligible to receive a wraparound payment from the State if the amount the RHC was paid by the MCE is less than the amount the RHC would have received under the PPS.

"Wraparound payment" is an amount, equal to the MCE payment gap (any positive difference obtained when the MCE payment is subtracted from the amount that would have been paid to the cost-based clinic under PPS) that is paid by the department to augment the MCE payment. The wraparound payment amount equals the difference between the MCE payment and the payment that the RHC would have received under PPS.

The State reconciles and pays valid claims for wraparound payments on a claim-by-claim basis as they are submitted, and no less often than every four months. Claim-by-claim reconciliation and payment, which is performed at least once a year, ensures that the MCE payment plus the state's wraparound payment to an RHC is equal to the amount calculated under the BIPA methodology.

2-c. Federally Qualified Health Center (FQHC) Services

A. FQHC Prospective Payment System (PPS)

For services rendered on or after January 1, 2001, all FQHCs are paid on a PPS basis as required by the provisions of the Benefits Improvement and Protection Act of 2000. The state-calculated FQHC rates comply with the statutory requirements for the payment of FQHC PPS services for Medicaid in Section 1902(bb) of the Social Security Act (the Act).

In the FQHC PPS, a separate all-inclusive per-visit payment amount (PVPA) (encounter) is established for each FQHC service (see Attachment 3.1-A, Item 2-c, page 1 of 1) provided at an FQHC service site (multiple PVPAs for services).

A PVPA is specific to an FQHC service site.

Method for Establishing PVPAs at an Existing FQHC

For every FQHC service site that is already enrolled as a Medicaid provider, the State establishes new PVPAs equal to the current PVPAs adjusted by the percentage of the latest available Medicare Economic Index (MEI). For an existing FQHC that requests an adjustment based on a change in scope, the State may have their PVPA adjusted based on a cost report that reflects the incremental change in rate due to the change in scope of service.

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 30th. A PVPA that is established or adjusted before September 30th and becomes effective on or after October 1st is then further revised to reflect the applicable MEI. No retroactive establishment or adjustment is made for a PVPA.

Method for Establishing PVPAs at a New FQHC

For an FQHC that is enrolling as a new Medicaid provider or is adding new FQHC PPS services, the State establishes initial PVPAs by setting them 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 60^{th} percentile for either urban or rural FQHCs. If no current PVPA at the applicable statewide 60^{th} percentile is available, then the initial PVPA for the service is developed. These initial PVPAs remain in effect until new PVPAs are established. After the initial PVPAs are set, the FQHC submits a cost report. 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.

If no current PVPA at the applicable statewide 60^{th} percentile is available, then the initial PVPA for a service, P, is obtained by the formula $P = M \times (S / E)$, rounded up to the next whole dollar. M is the greater of two figures: (i) The current PVPA for medical services at

the applicable statewide 60th percentile for urban FQHCs; or (ii) The current PVPA for medical services at the particular FQHC. 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. E is the Medicaid maximum non-facility payment amount for a mid-level evaluation and management service (office visit) for an established patient.

A ceiling is established for each FQHC PPS service. The ceiling is established for each PPS service at 120% of the statewide 60th percentile PVPA. The final PVPA for an FQHC PPS service is the lesser of the allowed cost, the limit, or the ceiling.

The cost report used by the State for FQHCs is ODM Form 03421, "Federally Qualified Health Center / Outpatient Health Facility Cost Report." When required, the State reconciles the annual cost report to final payments to the FQHC within 120 days of receiving a clean cost report.

Co-payments may apply to services rendered by an FQHC.

B. Wraparound Payments and Medicaid Managed Care Entities (MCEs)

An FQHC receiving payment from an MCE for FQHC PPS services is eligible to receive a wraparound payment from the State if the amount the FQHC was paid by the MCE is less than the amount the FQHC would have received under the PPS.

"Wraparound payment" is an amount, equal to the MCE payment gap (any positive difference obtained when the MCE payment is subtracted from the amount that would have been paid to the FQHC under the PPS) that is paid by the department to augment the MCE payment. The wraparound payment amount equals the difference between the MCE payment and the payment that the FQHC would have received under PPS.

The State reconciles and pays valid claims for wraparound payments on a claim-by-claim basis as they are submitted, and no less often than every four months. Claim-by-claim reconciliation and payment, which is performed at least once a year, ensures that the managed care organization payment plus the state's wraparound payment to an FQHC is equal to the amount calculated under the BIPA methodology.

C. ***Alternative Payment Method (APM) for Determining FQHC Payment***

Effective October 1, 2011 (TN 10-014, Attachment 4.19-B, Item 2-C, Page 6 of 6), with approval from the State, a government-operated FQHC such as a public health department may request the APM for determining payment. Under this APM, a government-operated FQHC may receive payment in addition to amounts established under the prospective payment system (PPS). To qualify for additional payment under this APM, a government-operated FQHC site must request the APM; it then submits both a preliminary cost report and a fully audited cost report for every cost-reporting period. A cost-reporting period is

the fiscal year used by the government-operated FQHC. The amount paid under the APM is at least equal to the total PPS payment. 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 17 months.

The APM involves two steps:

(1) Submission of an annual cost report: Within 120 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, the State performs a desk review of the cost report and determines the amount for which the government-operated FQHC site is eligible to receive a supplemental payment 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 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 calculated from the cost report and the number of visits made by Medicaid-eligible individuals for that service.
(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.
(f) If the total Medicaid variance is positive, the supplemental payment is calculated by ODM and the appropriate amount is remitted to the government-operated FQHC site.