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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 16-033

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

March 17, 2017

Barbara R. Sears, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 16-033

Dear Ms. Sears:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #16-033
- Coverage & limitations, and payment: Federally Qualified Health Center and Rural Health Clinic services
- Effective Date: October 1, 2016

If you have any questions regarding this State Plan Amendment, please have a member of your staff contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sarah Curtin, ODM
Carolyn Humphrey, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **16-033 Revised**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2016**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Sections 1902(bb) and 1905(a) of the Social Security Act Section 330 of the Public Health Service Act	7. FEDERAL BUDGET IMPACT: a. FFY 2017 $0 thousands b. FFY 2018 $0 thousands
8. 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 1 Attachment 4.19-B, Item 2-c, pages 1-4 of 4	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ATTACHMENT 3.1-A, PRE-PRINT PAGE 1, ITEM 2, PAGE 2 OF 2 (TN 90-38) ATTACHMENT 3.1-A, FROM PRE-PRINT PAGE 1, ITEM 2-C, PAGE 1 of 1 (TN 06-003) Attachment 4.19-B, Item 2-b, page 1 of 1 (TN 11-027) ATTACHMENT 4.19-B, REFERENCE PRE-PRINT PAGE 1 OF ATTACHMENT 3.1-A, ITEM 2-C, PAGES 1-5 of 6 (TN 06-003) ATTACHMENT 4.19-B, ITEM 2-C, PAGES 6 and 6-a of 6 (TN 10-014)

10. SUBJECT OF AMENDMENT: Coverage/Limitations and Payment for Services: Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **BARBARA R. SEARS**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: December 22, 2016 ~~March 14, 2017~~	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 22, 2016	18. DATE APPROVED: March 17, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Associate Regional Administrator

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

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 Section 1861(aa)(1) of the Social Security Act:

1. Services that are rendered by a physician, physician assistant, or advanced practice registered nurse employed by or otherwise compensated by the RHC;

2. Mental or behavioral health services, including therapy and testing;

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

4. Visiting nurse services.

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 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, or advanced practice registered nurse, except for mental or 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. Mental health services,
5. Speech pathology and audiology services,
6. Podiatry services,
7. Vision services,
8. Chiropractic services, and
9. Transportation services.

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. RHC Prospective Payment System (PPS)

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. 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).

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 establish a new PVPA based on a cost report that reflects the incremental change in rate due to the change in scope of service.

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 sixtieth 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.

The cost report used by the State for RHCs is the CMS-222-92, "Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report". 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. Supplemental Payments and Medicaid Managed Care Plans (MCPs)

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

“Supplemental payment" or "wraparound payment" is an amount, equal to the MCP payment gap (any positive difference obtained when the MCP 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 MCP payment. The wraparound payment amount equals the difference between the MCP payment and the payment that the RHC would have received under PPS.

The State pays valid claims for supplemental (wraparound) payments on a claim-by-claim basis as they are submitted. The supplemental payment is therefore made no less than every four months.

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

A. FQHC Prospective Payment System (PPS)

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. The state-calculated FQHC rates comply with the statutory requirements for the payment of FQHC services for Medicaid in Section 1902(bb) of the Social Security Act (the Act).

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 establish a new PVPA based on a cost report that reflects the incremental change in rate due to the change in scope of service.

For an FQHC that is enrolling as a new Medicaid provider or is adding new FQHC 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 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. 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 sixtieth 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 sixtieth 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 service. The current sixtieth percentile PVPAs for the FQHC service are determined for all rural FQHCs and urban FQHCs respectively. An urban wage adjustment factor is calculated as the quotient of two figures published in the Federal Register for the relevant year: the overall wage index for Ohio divided by the rural wage index for Ohio. For each FQHC service provided at a rural FQHC service site, the ceiling is the statewide rural sixtieth percentile PVPA. For each FQHC service provided at an urban FQHC service site, the ceiling is the product of the statewide urban sixtieth

percentile PVPA and the UWAF for the relevant year. The final PVPA for an FQHC service is the least 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 one-hundred twenty days of receiving a clean cost report.
Co-payments may apply to services rendered by an FQHC.

B. Supplemental Payments and Medicaid Managed Care Plans (MCPs)

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

"Supplemental payment" or "wraparound payment" is an amount, equal to the MCP payment gap (any positive difference obtained when the MCP 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 MCP payment. The supplemental (wraparound) payment amount equals the difference between the MCP payment and the payment that the FQHC would have received under PPS.

The State pays valid claims for supplemental (wraparound) payments on a claim-by-claim basis as they are submitted. The supplemental payment is therefore made no less than every four months.

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

An FQHC operated by a State or local governmental agency may request payment using an alternate payment methodology (APM) administered in accordance with Section 1902(bb)(6) of the Act. Under the APM, a government-operated FQHC receives payment in addition to amounts established under the FQHC PPS.

The APM makes interim payments to FQHCs at the PPS rates and annually reconciles cost to the interim PPS rates. In accordance with Section 1902(bb)(6)(B) of the Act, the FQHCs will be paid APM rates that are at least equal to the amounts paid under PPS. Annually, the State reimburses eligible FQHCs for any reconciled cost that exceed PPS rate payments, regardless of whether the interim payment is made by the State or a Medicaid managed care plan.

Under federal requirements in section 1902(bb)(5)(B) of the Act, the State will continue to make managed care supplemental (wraparound) payments that equal the difference between PPS and the managed care payment. The State pays valid claims for supplemental

(wraparound) payments on a claim-by-claim basis as they are submitted. The supplemental payment is therefore made no less than every four months.

At the end of the settlement period, the State will pay the FQHC for services paid under the APM an additional amount equal to the difference between its actual incurred allowable Medicaid cost and the following sums:

1. Interim PPS-based rates,
2. Payments made by Medicaid managed care plans, and
3. Supplemental (wraparound) payments that must be made by the State to the FQHC that equal the difference between the payments made by Medicaid managed care plans and the PPS-based rate.

A. Interim payments

Interim payment(s) is the PPS rate per visit based on a face-to-face encounters/visits between a patient and FQHC provider of the following Medicaid services:

1. Medical services
2. Dental services
3. Physical therapy services and occupational therapy services
4. Mental health services
5. Speech pathology and audiology services
6. Podiatry services
7. Vision services
8. Chiropractic services

Multiple visits on the same day are allowable if the visits are with different provider types that are distinct centers for direct and indirect cost allocation purposes, for the services listed in Item A. 1-8. The visits must involve different cost-based clinic services; or the services rendered must be for different purposes, illnesses, injuries, conditions, or complaints or for additional diagnosis and treatment.

B. Cost reports

Cost reports are submitted annually within one hundred twenty (120) days after the close of the FQHC's fiscal year. Each service site of a government-operated FQHC uses the State's FQHC cost report (ODM Form 03421, "Federally Qualified Health Center / Outpatient Health Facility Cost Report") to compile and submit a cost report that identifies the total actual incurred allowable Medicaid costs for the service site during FQHC's fiscal year.

C. Settlement

The State reconciles the filed cost report to final payments to the FQHC within one hundred twenty (120) days of receiving a clean cost report.

An average cost per visit for each of the types of visits paid on an interim basis is calculated for each FQHC service, regardless of payer, offered at the site by dividing the total allowable actual incurred cost for the service by the total number of all face-to-face encounters/visits.

For each FQHC service, the total allowable actual incurred Medicaid cost for the fiscal year is the product of the average cost per encounter/visit and the number of face-to-face encounters/visits made by Medicaid-eligible individuals.

If total allowable actual incurred Medicaid reconciled cost for the fiscal year exceeds all interim payments for the fiscal year, then within two years of the end of the fiscal year for which cost was reported, the State will pay the difference between total allowable actual incurred Medicaid reconciled cost and all interim payments.

If all interim payments for FQHC services for the fiscal year exceed the APM, then the State recovers the excess payment. Excess payment to an FQHC will be recovered by the State within sixty (60) days.