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State Territory Name: OHIO

State Plan Amendment (SPA) #: 24-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

June 18, 2024

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: TN 24-0007

Dear Director Corcoran:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-B 24-0007, which was submitted to CMS on May 13, 2024. This plan amendment increases rates for Federally Qualified Health Centers (FQHCs).

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Debi Benson at 312-886-0360 or via email at Deborah.Benson@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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: 24 — 0007

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, 2024

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 2024 $ 5,573,196
b. FFY 2025 $ 20,435,052

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Item 2-c, Pages 1-3
Attachment 4.19-B, Item 2-c, Pages 4, 5 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Item 2-c, Pages 1 - 3 of 3 (TN 22-017)

9. SUBJECT OF AMENDMENT
Payment for Services: Federally Qualified Health Care Center (FQHC) Rate Increase

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
May 13, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
May 13, 2024

17. DATE APPROVED
June 18, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

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.

(1) 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.

(2) 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 60th percentile for either urban or rural FQHCs. If no current PVPA at the applicable statewide 60th 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 60th 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.

Except for transportation services, a ceiling is established for each FQHC PPS service at 120% of the statewide 60th percentile PVPA for the respective PPS service. The final PVPA for an FQHC PPS service except transportation services is the lesser of the allowed cost, the limit, or the ceiling; for transportation services, the final PVPA is the initial PVPA (described above).

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.

(3) Alternative Payment Methodology (APM) – Payments in Addition to Existing FQHC PVPAs (PPS Rates) Paid Under the PPS

In accordance with State legislation, a new APM is developed, effective July 1, 2024, to increase FQHC PVPAs (PPS rates) by the amounts set forth in state statute. The FQHC payments made pursuant to this section are considered an APM and are made in addition to already established FQHC PVPAs for each FQHC PPS service.

Each FQHC must agree to the APM and will receive payments in addition to existing PPS rates (i.e., payment amounts that are above the already established PVPAs paid under the PPS). For FQHCs not participating in the APM, payment will remain at least equal to or greater than PVPAs (PPS rates) established under the PPS.

FQHC PPS rates that were in effect October 1, 2023, are increased in the aggregate by $31,170,000 for state fiscal year (SFY) 2025. In SFY 2026 and thereafter, the annual aggregate payment increase is $20,780,000. These figures represent an average increase in PVPAs of 10.8% in SFY 2025 and 7.2% in SFY 2026 and thereafter. Because each FQHC site has a different PVPA for each PPS service it offers, the increase ("FQHC PVPA add-on amount") is expressed in fixed amounts (dollars and cents) by FQHC PPS service.

For services rendered on or after July 1, 2024, the following "FQHC PVPA add-on amounts" are added to each base FQHC PVPA for the respective FQHC PPS service:

(a) Medical, $15.80;
(b) Dental, $16.50;

(c) Behavioral health, $18.20;
(d) Physical therapy or occupational therapy, $9.70;
(e) Speech pathology and audiology, $15.20;
(f) Podiatry, $6.60;
(g) Vision, $10.50;
(h) Chiropractic, $9.20;
(i) Transportation, $2.50.

For services rendered on or after July 1, 2025, the "FQHC PVPA add-on amounts" are the following amounts:
(a) Medical, $10.50;
(b) Dental, $11.00;
(c) Behavioral health, $12.20;
(d) Physical therapy or occupational therapy, $6.40;
(e) Speech pathology and audiology, $10.20;
(f) Podiatry, $4.40;
(g) Vision, $7.00;
(h) Chiropractic, $6.20;
(i) Transportation, $0.80.

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 Government-Operated FQHC Payment*

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 and submit a fully audited cost report for every cost-reporting period. The government-operated FQHC may also submit an optional preliminary cost report for each 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 the following steps:

(1) Submission of at least one cost report each cost-reporting period:

(a) Within 120 days after the close of a cost-reporting period, the government-operated FQHC site may submit an optional preliminary cost report of all PPS services rendered during that cost-reporting period.

(b) Within 500 days after the close of a cost-reporting period, the government-operated FQHC site submits a fully audited cost report. Government-operated FQHC sites of the same parent organization compile and submit separate cost reports. When it submits a cost report, a government-operated FQHC site certifies 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 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. The "aggregate add-on" is the sum of the products of the "FQHC PVPA add-on amount" for each PPS service and the number of visits for each PPS service. The "matchable expenditure" is the sum of the total Medicaid variance and the aggregate add-on. ODM calculates the federal share of the matchable expenditure by applying the appropriate federal match percentage and then remits this amount to the government-operated FQHC site.

(f) When a government-operated FQHC site submits an optional preliminary cost report, the payment is reconciled. If the total expenditure derived from the fully audited cost report differs from the total expenditure derived from the optional preliminary cost report, then the difference in the federal share is remitted to the FQHC (initial underpayment upon submission of the optional preliminary cost report) or to ODM (initial overpayment upon submission of the optional preliminary cost report), as appropriate.

(g) For government-operated FQHCs who do not submit an optional preliminary cost report, payment is made using the fully-audited cost report as described in section (C)(2).