Common Sense Initiative

**Mike DeWine**, Governor
**Jon Husted**, Lt. Governor

**Sean McCullough**, Director

# Business Impact Analysis

**Agency, Board, or Commission Name:** **Ohio Department of Medicaid (ODM)**

**Rule Contact Name and Contact Information:**

**Tommi Potter, 614-752-3877, tommi.potter@medicaid.ohio.gov**

**Regulation/Package Title (a general description of the rules' substantive content):**

**Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Outpatient Health Facility (OHF) Services**

**Rule Number(s):**

**To Be Rescinded:** 5160-28-02, 5160-28-04.1, 5160-28-04.2, 5160-28-04.3, 5160-28-05.1, 5160-28-05.2, 5160-28-05.3, 5160-28-07.1

**New:** 5160-28-02, 5160-28-04, 5160-28-07.1, 5160-28-13

**For Informational Purposes Only:** 5160-28-01 (R), 5160-28-03.1(R), 5160-28-03.2(R), 5160-28-03.3(R), 5160-28-06.1(R), 5160-28-06.2(R), 5160-28-08.1(R), 5160-28-08.3(R), 5160-28-01(N), 5160-28-03 (N), 5160-28-05 (N), 5160-28-06.1 (N)

**Date of Submission for CSI Review:** **2/14/2022**

**Public Comment Period End Date:** **2/21/2022**

**Rule Type/Number of Rules:**

**New/_8_ rules**

**Amended/____ rules (FYR? ___)**

**No Change/____ rules (FYR? ___)**

**Rescinded/__16_ rules (FYR? _Yes_)**

**The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common**

**Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.**

## Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   **Which adverse impact(s) to businesses has the agency determined the rule(s) create?**

   **The rule(s):**

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

## Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   ***Please include the key provisions of the regulation as well as any proposed amendments.***

   Chapter 5160-28 of the Ohio Administrative Code sets forth coverage and payment for the delivery of services by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Outpatient Health Facilities (OHFs).

   As a result of this review, a number of changes are being made to the rules, mostly for the purpose of clarification. On the whole, the intent remains the same. Changes include:

   - Am. Sub. H. B. 166 (133rd G. A.) lists six terms that cause a rule to be deemed to contain regulatory restrictions: 'shall', 'shall not', 'must', 'may not', 'require', and 'prohibit'. All of these terms are being removed from these rules, and the passages in

which they appear are recast.

- The text of the rules is being reorganized and streamlined.
    - Existing rules 5160-28-01, 5160-28-02, 5160-28-06.1, and 5160-28-07.1 are being rescinded and replaced with new rules of the same number.
    - Existing rules 5160-28-03.1 and 5160-28-03.3 are being consolidated into one new rule 5160-28-03.
    - Existing rules 5160-28-04.1 and 5160-28-04.3 are being consolidated into one new rule 5160-28-04.
    - Existing rules 5160-28-05.1 and 5160-28-05.3 are being consolidated into one new rule 5160-28-05.
    - Existing rules 5160-28-08.1 and 5160-28-08.3 are being consolidated into one new rule 5160-28-08.
    - Existing rules 5160-28-03.2, 5160-28-04.2, 5160-28-05.2, and 5160-28-06.2 are consolidated into one new rule 5160-28-13.
- Throughout Chapter 5160-28, the term 'cost-based clinic' is being replaced with FQHC, RHC, and OHF.
- Managed care entity (MCE) is the new terminology that will be used in Chapter 5160-26 of the Administrative Code starting July 1, 2022. All references to managed care (e.g., managed care organization, MCO, MyCare plan) were updated to MCE.
- All OHF provisions are being moved into one new rule, 5160-28-13.
- In new rule 5160-28-02, the title of the rule is being changed to better describe the content of the rule. The new rule also specifies the enrollment documentation needed and removes the provisions regarding outpatient health facilities and physician availability in rural health clinics.
- In new rule 5160-28-04 a statement is being added on the principles of reasonable cost reimbursement, gives ODM or its designee the ability to perform a field review or desk audit of any cost report submitted, and describes the process for requesting an adjustment to a per visit payment amount. Government-operated FQHCs submit cost reports; a paragraph was added stating this submission. A list of topics is being set forth to help the provider write this request for a change in scope of services.
- In new rule 5160-28-07.1, the tile of the rule is being changed to better describe the content of the rule. The new rule also eliminates the filing of a preliminary cost report and instead only requires the submission of a fully audited cost report within 120 days after the close of the fiscal year.
- ODM is making minor formatting changes to the FQHC cost report.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   All rules in the rule package are authorized by RC 5164.02.

   The statutes that amplify that authority are as follows:

   Rule 5160-28-02 (N), 5160-28-04, 5160-28-4.1, 5160-28-4.3, 5160-28-5.1, 5160-28-5.3, 5160-28-7.1: 5164.02

   Rules 5160-28-02 (R), 5160-28-4.2, 5160-28-5.2, 5160-28-13: 5164.02, 5164.05

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   ***If yes, please briefly explain the source and substance of the federal requirement.***

   Under provisions of the Social Security Act, services provided by FQHCs and RHCs are mandatory Medicaid services. (OHFs were established by the Ohio General Assembly.) The proposed changes in the rules are not necessitated by federal law; they are being made in order to broaden service coverage, provide additional clarity, and to ease some restrictions placed on FQHCs, RHCs, and OHFs.

5. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not impose any conditions beyond what is required by the federal government.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment formulas or fee schedules for the use of providers and the general public. The administrative rules for FQHC, RHC and OHF services perform these functions, and no alternative is readily apparent.

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   To the extent that these rules involve internal operating procedures, they place no requirements on providers. Their success, therefore, can be measured by the extent to which operational updates to the claims payment system result in the correct payment of claims.

FQHC, RHC, and OHF payment, and in turn payment of claims, is based on an all-inclusive pre-established per-visit payment amount (PVPA). PVPAs can be verified both by internal staff and providers by logging onto the claims payment system web portal.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   ***If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.***
   Not Applicable.

## Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   ***If applicable, please include the date and medium by which the stakeholders were initially contacted.***

   During the pre-clearance period, ODM sent the draft rule language to the Ohio Association of Community Health Centers (OACHC, FQHCs) and the State Office of Rural Health (SORH, RHCs) by e-mail on April 2, 2020 and May 28, 2021. OACHC and SORH asked questions and responded by e-mail and telephone on multiple occasions after the initial contact. Currently, there are no actual OHF providers in Ohio.

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

    The following comments and questions were submitted by OACHC (and their members) and the SORH.

    *A.* ***Cost Reporting***

    Comment: Today, FQHCs submit an initial cost report to ODM, which is not required to be audited. We have strong concerns and objections to requiring annual cost reports, and furthermore, requiring that they be audited. Requiring annual reports to also be audited will result in significant administrative and financial burdens for FQHCs who are already stretching scarce resources. FQHCs today do not submit Medicare cost reports to ODM. While they do submit annual cost reports to CMS, they are not required to be audited and can be submitted by FQHC organization and not site by site. Comparatively, at the state level for Medicaid, FQHCs are often viewed by site, and not as an organization, and that includes the existing cost report policies. The provisions in the rule package would require all 400+ sites to submit annual and audited cost reports. We are extremely

sympathetic to the existing capacity, or lack thereof, within ODM to timely process the current one-time cost reports that are submitted today to set rates etc. We believe in addition to an increasing burden on FQHCs, this would be a significant increase in ODM's workload too, and require additional staffing and resources. And finally, cost principles for Medicaid (state) and Medicare (federal) are different, and as such, we would caution any comparisons between the two.

Response: ODM removed the proposed annual cost reporting provision from the new rules.

***B. FQHCs that are also enrolled with Medicaid as Community Mental Health Centers (CMHCs) at the same location***

Comment: The Behavioral Health stakeholder community prefers that ODM continue allowing FQHCs to also enroll as CMHC providers at the same location rather than having all services being required to be billed under the FQHC or RHC.

ODM Response: ODM removed the proposed provision from the new rule that would require all services rendered at an FQHC or RHC to be billed under the FQHC or RHC.

***C. RHC services***

Comment: Possibly list RHC services out like they are for FQHCs.

ODM Response: ODM expanded the RHC section to list out allowable and coverable RHC services.

**11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

Utilization and expenditure data drawn from ODM's Quality Decision Support System were used in projecting the fiscal impact.

**12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

The agency considered adding an annual cost report requirement. This proposed regulation was removed because stakeholders expressed concern about the cost to FQHCs and the possibility that these reports would not be processed timely.

**13. Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

The concept of performance-based rule-making does not apply when payment, by federal law, is based on cost.

**14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

ODM policy and legal staff reviewed the regulations to ensure they are not duplicative of existing Ohio regulations. There are no regulations in these rules that is also found elsewhere in agency 5160. Any provision of another rule that applies specifically to these services is incorporated by reference.

**15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

The policies set forth in these rules will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the rules. They therefore will be applied by ODM's electronic claim-payment system automatically and consistently whenever an appropriate provider submits a claim for an applicable service. Stakeholders will also be informed of changes via a transmittal letter, meetings, and e-mails.

**Adverse Impact to Business**

**16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

**a. Identify the scope of the impacted business community; and**

**b. Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and**

**c. Quantify the expected adverse impact from the regulation.**
***The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.***

a. These rules apply to FQHCs, RHCs, OHFs. (There are currently no OHF providers enrolled in the Medicaid program in Ohio.)

b. The nature of the adverse impact for all rules with an adverse impact is employee time to submit required information.

c. The adverse impact has been quantified for each new regulation separately as follows:

- Rule 5160-28-02 - When it enrolls, an FQHC must submit to ODM a copy of the Notice of Grant Award Authorization or Notice of Look-Alike Designation it has received from the federal Health Resources and Services Administration (HRSA). FQHCs normally forward this already obtained information to ODM via the portal or by e-mail. The cost to forward this information is estimated to be immaterial and would be determined by the time to locate and submit the information multiplied by an employee's rate of pay.
- Rule 5160-28-02 - Any permanent decrease in scope must be reported to ODM. Reporting a decrease in scope would entail the submission of a cost report with an expenditure of about $2,500.
- 5160-28-04 - A provision in this rule enables (but does not require) the imposition of a penalty of not more than $500 per business day if an FQHC or RHC fails to submit a cost report in a complete, accurate, and timely manner.
- 5160-28-04 - This rule requires the submission of a cost report by newly enrolled FQHCs or RHCS, by FQHCs and RHCs reporting a change in scope of services, and by government-operated FQHCs that request the alternate payment method (APM). The actual adverse impact on providers is expected to be limited to the submission of a required cost report, which for most providers entails a one-time expenditure of about $2,500. Those FQHCs participating in the APM submit annual cost reports amounting to approximately $2,500 per year.
- 5160-28-04 – The rule allows an FQHC or RHC to request an adjustment of a PVPA and submit supporting documentation. The cost to put together and submit supporting documentation would be determined by the time it takes the employee to put together the information multiplied by the employee's rate of pay. This expenditure is estimated to be $200 (4 hours multiplied by $50).
- 5160-28-07.1 - This rule requires the report of information (submission of cost reports). The actual adverse impact on providers is expected to be limited to the submission of a required cost report, which for most providers participating in the APM entails an expenditure of about $2,500 per year.
- 5160-28-13 - This rule requires a submission of a cost report. The adverse impact on OHFs is expected to be limited to the submission of a required cost report, which for most OHFs entails a one-time expenditure of about $2,500.

The rules to be rescinded require submission of a cost report or notification to enroll, for changes in scope of services, and to request payment adjustments. The cost would be the same as noted above for these submissions. Also 5160-28-4.1 and 5160-28-4.3 enable (but do not require) the imposition of a penalty of not more than $500 per business day if an FQHC or RHC fails to submit a cost report in a complete, accurate, and timely manner.

**17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

It ensures correct payment.

## Regulatory Flexibility

**18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

There can be no exemption from nor alternative to submitting timely cost reports. Base payment amounts must be established.

**19. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

Fines and penalties for paperwork violations by first-time offenders will not be waived. Pursuant to RC 119.14(C)(1), not submitting timely cost reports has the potential to cause serious harm to the public interest as determined by a state agency because cost reports are essential to the establishment of initial base payments for payment under the prospective payment system.

**20. What resources are available to assist small businesses with compliance of the regulation?**

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau, at noninstitutional_policy@medicaid.ohio.gov.

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-28-02 **Cost-based clinics: medicaid provider requirements and limitations.**

(A) No provider may be simultaneously enrolled in medicaid as more than one type of cost-based clinic.

(B) Unless otherwise noted, any limitations or requirements specified in the Revised Code or in agency 5160 of the Administrative Code apply to services rendered by a cost-based clinic.

(C) Federally qualified health center (FQHC).

(1) An FQHC must submit to the department a copy of the notice of grant award authorization from the federal health resources and services administration (HRSA) confirming that its service sites meet FQHC requirements.

(2) An FQHC may be paid only for services provided on or after the date on which this notice is received by the department.

(3) Each FQHC service site must obtain and use its own medicaid provider number. No FQHC service site may use the provider number of another FQHC service site, even a service site within the same parent organization. Claims for services provided away from an FQHC service site (e.g., in an individual's home) must specify the FQHC service site responsible for providing the services.

(4) The responsibility of an FQHC to pay a health professional performing an FQHC medical service must be spelled out in a written agreement between the FQHC and the health professional.

(5) An FQHC must notify the department in writing not later than ninety days after any permanent decrease in its scope of service.

(D) Outpatient health facility (OHF).

(1) An entity that operates more than one service site may choose to enroll them under a single provider number if both of the following requirements are met:

(a) The entity provides written assurance that each service site independently meets all the requirements for an OHF.

(b) The entity has a single, central, uniform accounting and record-keeping system for all of its participating service sites.

(2) Any entity that is erroneously enrolled as both an OHF and another type of cost-based clinic must not submit claims as an OHF.

(E) Rural health clinic (RHC).

(1) A physician must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral.

(2) Extraordinary circumstances in which no physician is available must be documented in the records of the RHC.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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| Promulgated Under: | 119.03 |
| Statutory Authority: | 5164.02 |
| Rule Amplifies: | 5164.02, 5164.05 |
| Prior Effective Dates: | 04/01/1980, 11/10/1983, 10/01/1987, 04/18/1988, 04/10/1991, 06/01/1991, 07/01/2001, 08/01/2001, 10/25/2001, 11/01/2001, 03/01/2002, 05/01/2005, 07/01/2006, 07/01/2009, 10/01/2016 |

TO BE RESCINDED

**5160-28-04.1 Cost-based clinics: submission of an FQHC cost report.**

(A) A federally qualified health center (FQHC) must submit a cost report in any of the following circumstances:

(1) An FQHC newly enrolled as a medicaid provider must submit a cost report covering the twelve-month period beginning on the first day of the first full month after enrollment.

(2) An FQHC that has chosen to provide an additional FQHC service must submit a cost report for that service covering the twelve-month period beginning on the first day of the first full month after addition of the service.

(3) An FQHC that requests an adjustment in a per-visit payment amount (PVPA) based on a change in scope of an existing FQHC service must submit two cost reports for that service: the first one covering the twelve-month period ending on the last day of the last full month before the change in scope, the second one covering the twelve-month period beginning on the first day of the first full month after the change in scope. If the adjustment is granted, the adjustment amount is the difference (positive, negative, or zero) obtained when the PVPA derived from the first cost report is subtracted from the PVPA derived from the second cost report. The new PVPA is the sum of the current PVPA and the adjustment amount.

(B) A government-operated FQHC that requests the alternate payment method (APM) described in rule 5160-28-07.1 of the Administrative Code must submit cost reports in accordance with that rule.

(C) No extension will be granted for submission of cost reports. If an FQHC fails to submit a complete and accurate cost report within ninety days after the end of a reporting period, the department may choose to take either or both of two courses of action:

(1) It may decline to make any adjustments to the PVPAs established for the FQHC.

(2) It may impose a penalty of not more than five hundred dollars for each business day on which the cost report is late.

(D) The department has sole discretion over whether to grant a request for an adjustment in a PVPA based on a change in scope.

(E) A request for an adjustment in a PVPA based on a change in scope must be made in writing. In making such a request, an FQHC must include the following information:

(1) It must specify that the basis for the request is a change in scope.

(2) It must demonstrate that all reasonable attempts were made to address cost changes outside of the adjustment process.

(3) It must demonstrate that an adjustment is warranted by providing detailed evidence derived from a community needs assessment based on population demographics, a completed business plan, or other similar documents.

(4) It must specify which cost centers have been affected and why.

(5) If the change in scope is attributable to a change in the intensity of services provided, then the FQHC must demonstrate the direct connection. It may do so, for example, by providing evidence that a shift in the distribution of diagnoses has changed the acuity of care or by showing that the relative-value components of the services provided have changed.

(F) The department must respond in writing within sixty days after it receives a request for an adjustment in a PVPA based on a change in scope or after it receives additional information needed to determine whether an adjustment is warranted.

(G) The following conditions apply to any adjustment in a PVPA based on a change in scope:

(1) Such an adjustment can be granted only once for a particular circumstance for a particular FQHC service site.

(2) No adjustment will be made if the percentage of change represented by the calculated PVPA for the service is not at least twice the medicare economic index (MEI) for the relevant year.

(3) No adjusted PVPA may exceed any limit, ceiling, or other maximum set forth in agency 5160 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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| Promulgated Under: | 119.03 |
| Statutory Authority: | 5164.02 |
| Rule Amplifies: | 5164.02 |
| Prior Effective Dates: | 10/25/2001, 07/01/2006, 10/01/2016 |

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-28-04.2 **Cost-based clinics: submission of an OHF cost report.**

(A) After its initial program year, each outpatient health facility (OHF) must submit a complete and adequate cost report by April first of each year for the preceding calendar year.

(B) An OHF's provider agreement will be terminated in either of two circumstances:

(1) The OHF fails to submit a cost report by May first.

(2) The OHF submits an incomplete or inadequate cost report by April first and does not correct it within forty-five days of notification of deficiency.

(C) Government institutions operating on a cash basis may use the cash method of accounting. All other OHFs must use the accrual method.

Effective:

Five Year Review (FYR) Dates:

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Date

Promulgated Under: 119.03
Statutory Authority: 5164.02
Rule Amplifies: 5164.02, 5164.05
Prior Effective Dates: 11/10/1983, 11/01/2001, 05/01/2005, 10/01/2016

TO BE RESCINDED

5160-28-04.3 **Cost-based clinics: submission of an RHC cost report.**

(A) A rural health clinic (RHC) must submit a cost report in either of the following circumstances:

(1) An RHC newly enrolled as a medicaid provider must submit a cost report covering the twelve-month period beginning on the first day of the first full month after enrollment.

(2) An RHC that requests an adjustment in a per-visit payment amount (PVPA) based on a change in scope must submit two cost reports for that service, one covering the twelve-month period ending on the last day of the last full month before the change in scope and one covering the twelve-month period beginning on the first day of the first full month after the change in scope. If the adjustment is granted, the adjustment amount is the difference (positive, negative, or zero) obtained when the PVPA derived from the first cost report is subtracted from the PVPA derived from the second cost report. The new PVPA is the sum of the current PVPA and the adjustment amount.

(B) No extension will be granted for submission of cost reports. If an RHC fails to submit a complete, accurate, and timely cost report, then the department may choose to take either or both of two courses of action:

(1) It may decline to make any adjustments to the PVPAs established for the RHC.

(2) It may impose a penalty of not more than five hundred dollars for each business day on which the cost report is late.

(C) The department has sole discretion over whether to grant a request for an adjustment in a PVPA based on a change in scope.

(D) A request for an adjustment in a PVPA based on a change in scope must be made in writing. In making such a request, an RHC must include the following information:

(1) It must specify that the basis for the request is a change in scope.

(2) It must demonstrate that all reasonable attempts were made to address cost changes outside of the adjustment process.

(3) It must demonstrate that an adjustment is warranted by providing detailed evidence derived from a community needs assessment based on population demographics, a completed business plan, or other similar documents.

(4) It must specify which cost centers have been affected and why.

(5) If the change in scope is attributable to a change in the intensity of services provided, then the RHC must demonstrate the direct connection. It may do so, for example, by providing evidence that a shift in the distribution of diagnoses has changed the acuity of care or by showing that the relative-value components of the services provided have changed.

(E) The department must respond in writing within sixty days after it receives a request for an adjustment in a PVPA based on a change in scope or after it receives additional information needed to determine whether an adjustment is warranted.

(F) The following conditions apply to any adjustment in a PVPA based on a change in scope:

(1) Such an adjustment can be granted only once for a particular circumstance for a particular RHC service site.

(2) No adjustment will be made if the percentage of change represented by the calculated PVPA for the service is not at least twice the medicare economic index (MEI) for the relevant year.

(3) No adjusted PVPA may exceed any limit, ceiling, or other maximum set forth in agency 5160 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Date

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|---|---|
| Promulgated Under: | 119.03 |
| Statutory Authority: | 5164.02 |
| Rule Amplifies: | 5164.02 |
| Prior Effective Dates: | 10/15/2001, 07/01/2006, 10/01/2016 |

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-28-05.1 **Cost-based clinics: prospective payment system (PPS) method for determining FQHC payment.**

This rule addresses how the department complies with provisions set forth in Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) that require states to establish a medicaid prospective payment system (PPS) for federally qualified health center (FQHC) services.

(A) A separate all-inclusive per-visit payment amount (PVPA) is established for each FQHC service provided at an FQHC service site.

(1) For every FQHC service site that is already enrolled as a medicaid provider, the department establishes new PVPAs equal to the current PVPAs adjusted by the percentage of the latest available medicare economic index (MEI). The new PVPAs are established by October first of each year and are in effect from October first through the following September thirtieth.

(2) For an existing FQHC that requests an adjustment based on a change in scope, the department may establish new PVPAs based on a cost report in accordance with rule 5160-28-04.1 of the Administrative Code.

(3) For an FQHC that is enrolling as a new medicaid provider or is adding new FQHC services, the department establishes initial PVPAs in accordance with the following procedure:

(a) First, the initial PVPAs are set 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 in accordance with paragraph (A)(4) of this rule. These initial PVPAs remain in effect until new PVPAs are established.

(b) After the initial PVPAs are set, the FQHC submits a cost report in accordance with rule 5160-28-04.1 of the Administrative Code. 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.

(c) Thereafter, PVPAs are adjusted in accordance with paragraph (A)(1) of this rule.

(4) 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.

(a) 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.

(b) 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.

(c) E is the medicaid maximum non-facility payment amount for a mid-level evaluation and management service (office visit) for an established patient.

(B) A PVPA based on a cost report is effective from the first day of the first full month after the department has established or adjusted the PVPA through the following September thirtieth. A PVPA that is established or adjusted before September thirtieth and becomes effective on or after October first is then further adjusted by the appropriate MEI. No retroactive establishment or adjustment will be made for a PVPA.

(C) PVPAs are specific to an FQHC service site. No FQHC service site may submit claims based on the PVPAs of another service site.

(D) Decisions of the department with respect to the establishment or adjustment of a PVPA are not subject to Chapter 119. of the Revised Code.

Effective:

Five Year Review (FYR) Dates:

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| Promulgated Under: | 119.03 |
| Statutory Authority: | 5164.02 |
| Rule Amplifies: | 5164.02 |
| Prior Effective Dates: | 10/25/2001, 07/01/2006, 10/01/2016 |

TO BE RESCINDED

**5160-28-05.2 Cost-based clinics: prospective payment system (PPS) method for determining OHF payment.**

(A) An all-inclusive per-visit payment amount (PVPA) is established for each outpatient health facility (OHF) service provided at an OHF service site.

(1) For every OHF newly enrolled as a medicaid provider, the department sets the PVPA for a service at the average PVPA for all participating OHFs.

(2) After the initial PVPAs are set, each OHF submits an annual cost report in accordance with rule 5160-28-04.2 of the Administrative Code. New PVPAs are established on the basis of the cost report, to which an inflation factor is applied.

(a) The inflation factor is the sum of the following figures:

(i) The actual inflation rate between the midpoint of the cost report year and the midpoint of the following year as established by the United States bureau of labor statistics; and

(ii) An estimated inflation rate from the midpoint of the preceding year to the midpoint of the year for which the PVPA is calculated based upon the preceding twelve-month average.

(b) Unless otherwise specified, an inflation factor is computed from monthly statistical data supplied by the United States bureau of labor statistics for the following cost areas:

(i) Non-physician-level personnel costs (e.g., nurses, administration, legal staff, accounting, management, data services, employee fringe benefits, medical records, operation and maintenance services, housekeeping, laundry);

(ii) Medical supplies countable as a separate expense;

(iii) Non-durable goods (e.g., office supplies, printing);

(iv) Fuel and utilities;

(v) Transportation services;

(vi) Physician-level medical personnel and rehabilitation professionals;

(vii) Insurance; and

(viii) Real estate taxes.

(B) Audits.

(1) The principal objective of an audit is to determine whether payments have been made or will be made in accordance with all applicable regulations, rules, and requirements.

(2) The department conducts two types of audits:

(a) A desk audit of cost reports; and

(b) An on-site (field) audit of a facility.

(3) Each on-site audit must be sufficiently comprehensive in scope to demonstrate, in all material respects, whether the costs reported and submitted by an OHF are true, correct, and representative to the best of the facility's ability.

(4) If reported costs exceed costs established by an on-site audit, then the difference is subject to recovery in full. All amounts owed must be repaid within thirty days after an audit has been made final.

(5) If an OHF fails to retain or provide required financial and statistical records, then it may be required to repay the aggregate difference between its PVPAs for the year in question and the lowest PVPAs for like services established for an OHF of similar size and structure.

(6) No further payment will be made to an OHF that refuses a request for an audit.

(C) Decisions of the department with respect to the establishment or adjustment of a PVPA are not subject to Chapter 119. of the Revised Code.

Effective:

Five Year Review (FYR) Dates:

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| Promulgated Under: | 119.03 |
| Statutory Authority: | 5164.02 |
| Rule Amplifies: | 5164.02, 5164.05 |
| Prior Effective Dates: | 11/10/1983, 11/01/2001, 05/01/2005, 10/01/2016 |

TO BE RESCINDED

5160-28-05.3 **Cost-based clinics: prospective payment system (PPS) method for determining RHC payment.**

This rule addresses how the department complies with provisions set forth in Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) that require states to establish a medicaid prospective payment system (PPS) for rural health clinic (RHC) services.

(A) An all-inclusive per-visit payment amount (PVPA) is established for an RHC service provided at an RHC service site.

(1) For every RHC service site already enrolled as a medicaid provider, the department establishes a new PVPA equal to the current PVPA adjusted by the percentage of the latest available medicare economic index (MEI). The new PVPA is established by October first of each year and is in effect from October first through the following September thirtieth.

(2) For an existing RHC that requests an adjustment based on a change in scope, the department may establish a new PVPA based on a cost report in accordance with rule 5160-28-04.3 of the Administrative Code.

(3) For an RHC that is enrolling as a new medicaid provider, the department establishes an initial PVPA in accordance with the following procedure:

(a) First, the initial PVPA is set 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.

(b) After the initial PVPA is set, the RHC submits a cost report in accordance with rule 5160-28-04.3 of the Administrative Code. 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.

(c) Thereafter, the PVPA is adjusted in accordance with paragraph (A)(1) of this rule.

(B) A PVPA based on a cost report is effective from the first day of the first full month after the department has established or adjusted the PVPA through the following

September thirtieth. A PVPA that is established or adjusted before September thirtieth and becomes effective on or after October first is then further adjusted by the appropriate MEI. No retroactive establishment or adjustment will be made for a PVPA.

(C) A PVPA is specific to an RHC service site. No RHC service site may submit claims based on the PVPA of another service site.

(D) Decisions of the department with respect to the establishment or adjustment of a PVPA are not subject to Chapter 119. of the Revised Code.

Effective:

Five Year Review (FYR) Dates:

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Promulgated Under: 119.03
Statutory Authority: 5164.02
Rule Amplifies: 5164.02
Prior Effective Dates: 10/15/2001, 07/01/2006, 10/01/2016

TO BE RESCINDED

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

(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.

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Five Year Review (FYR) Dates:

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| Promulgated Under: | 119.03 |
| Statutory Authority: | 5164.02 |
| Rule Amplifies: | 5164.02 |
| Prior Effective Dates: | 10/01/2012, 10/01/2016 |

*** DRAFT - NOT YET FILED ***

5160-28-02 **FQHC and RHC services: conditions affecting medicaid provider participation.**

(A) Unless otherwise noted, any stipulations or limitations specified in the Revised Code or in agency 5160 of the Administrative Code apply to services rendered by a federally qualified health center (FQHC) or rural health clinic (RHC). Provisions of other rules in agency 5160 of the Administrative Code that concern coordination of benefits apply to payment for FQHC and RHC services.

(B) Responsibilities of an FQHC.

(1) When it enrolls or changes its enrollment (e.g., adds a service), an FQHC submits to the Ohio department of medicaid (ODM) a copy of a notice of authorization or notice of look-alike designation it has received from the federal health resources and services administration (HRSA). In particular, two pieces of documentation are needed:

(a) Confirmation that the FQHC satisfies HRSA criteria for providing the PPS services it plans to render (either new services or services added through a change in scope); and

(b) A list of the services approved by HRSA for the FQHC to perform at any of its sites.

(2) Each FQHC site obtains and uses its own medicaid provider number. No FQHC site is allowed to use the provider number of another FQHC site, even if the two share the same parent organization.

(3) The responsibility of an FQHC to pay a health professional for performing a service is described in a written agreement between the FQHC and the health professional.

(4) An FQHC notifies ODM in writing not later than ninety days after any permanent decrease in its scope of service.

(C) Medicaid payment cannot be made before the date listed on the FQHC HRSA notice or before the RHC certification date.

(D) No provider can be simultaneously enrolled in medicaid as both an FQHC and an RHC.

Replaces: 5160-28-02

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under: 119.03
Statutory Authority: 5164.02
Rule Amplifies: 5164.02
Prior Effective Dates: 04/01/1980, 11/10/1983, 10/01/1987, 04/18/1988, 04/10/1991, 06/01/1991, 07/01/2001, 08/01/2001, 10/25/2001, 11/01/2001, 03/01/2002, 05/01/2005, 07/01/2006, 07/01/2009, 10/01/2016

## 5160-28-04 **FQHC and RHC services: submission of a cost report.**

(A) Data entered into a cost report should represent "reasonable and allowable costs," which are defined in "Principles of reasonable cost reimbursement," 42 C.F.R. part 413 (October 1, 2021).

(B) For purposes of payment determination, an FQHC or RHC submits a cost report in any of the following circumstances:

(1) An FQHC or RHC that is newly enrolled as a medicaid provider submits a cost report covering the twelve-month period beginning either on the first day of the first calendar month or on the first day of the first full fiscal year after enrollment.

(2) An FQHC or RHC that requests an adjustment of a per-visit payment amount (PVPA) based on a change in scope of an existing FQHC or RHC PPS service submits a cost report for that service covering the twelve-month period beginning either on the first day of the first calendar month or on the first day of the first full fiscal year after the change in scope. If the adjustment is granted, the PVPA derived from the cost report becomes the new PVPA.

(3) An FQHC or RHC that has chosen to provide an additional PPS service (other than transportation) submits a cost report for that service covering the twelve-month period beginning either on the first day of the first calendar month or on the first day of the first full fiscal year after addition of the service.

(4) A government-operated FQHC that requests the alternate payment method (APM) described in rule 5160-28-07.1 of the Administrative Code submits cost reports in accordance with that rule.

(C) The Ohio department of medicaid (ODM) or its designee may perform a desk review or conduct a field audit of any cost report submitted and may request any supporting documentation it deems necessary.

(D) No extension will be granted for submission of cost reports. If an FQHC or RHC fails to submit a complete and accurate cost report within one hundred twenty days after the end of a reporting period, ODM may choose to take either or both of two courses of action:

(1) It may decline to make any adjustments to the established PVPA or PVPAs.

(2) It may impose a penalty of not more than five hundred dollars for each business day on which the cost report is late.

(E) An FQHC or RHC may request adjustment of a PVPA.

(1) In its request, it addresses in writing the following topics:

(a) It specifies the basis for the request, such as a change in scope of an existing service or the addition of a new service.

(b) It specifies which cost centers have been affected and why.

(c) It describes the steps it took to arrive at the conclusion that an adjustment would be the most efficient means of responding to cost changes.

(d) It provides documentation to support its request, such as a community needs assessment or other analysis.

(e) If the change in scope is directly attributable to a change in the intensity of services provided, then the FQHC or RHC provides evidence such as a change in the acuity of care caused by a shift in the distribution of diagnoses or a change in the relative-value components of the services provided.

(f) An FQHC that is adding a PPS service submits to ODM a copy of the notice of grant award authorization from the federal health resources and services administration (HRSA) confirming that its sites satisfy HRSA criteria for providing the new PPS service it plans to render.

(2) ODM has sole discretion over whether to grant a request for adjustment of a PVPA.

(F) ODM will respond in writing within sixty days after it receives a request for an adjustment of a PVPA based on a change in scope or after it receives additional information needed to determine whether an adjustment is warranted.

(G) The following conditions apply to any adjustment of a PVPA based on a change in scope:

(1) Such an adjustment can be granted only once for a particular circumstance for a particular FQHC or RHC service site.

(2) No adjustment will be made if the percentage of change represented by the calculated PVPA for the service is not at least twice the medicare economic index (MEI) for the relevant year.

(3) No adjusted PVPA may exceed any limit, ceiling, or other maximum set forth in agency 5160 of the Administrative Code.

Replaces: 5160-28-04.1, 5160-28-04.3

Effective:

Five Year Review (FYR) Dates:

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Date

Promulgated Under: 119.03
Statutory Authority: 5164.02
Rule Amplifies: 5164.02
Prior Effective Dates: 10/25/2001, 07/01/2006, 10/01/2016

*** DRAFT - NOT YET FILED ***

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

(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 or RHC site may be aggregated.

Replaces: 5160-28-07.1

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Statutory Authority: 5164.02
Rule Amplifies: 5164.02
Prior Effective Dates: 10/01/2012, 10/01/2016

*** DRAFT - NOT YET FILED ***

5160-28-13 **Outpatient health facility (OHF) services**.

(A) "Outpatient health facility (OHF)" has the same meaning as in section 5164.05 of the Revised Code.

(B) Conditions affecting medicaid participation.

(1) Unless otherwise noted, any stipulations or limitations specified in the Revised Code or in agency 5160 of the Administrative Code apply to services rendered by an OHF.

(2) No OHF may enroll simultaneously in medicaid as FQHC or RHC.

(C) OHF covered services and limitations.

(1) Each OHF provides the following preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services, which are collectively termed, "comprehensive primary health services":

(a) Covered services provided on-site:

(i) Medical services, which may be divided into three categories:

*(a)* Services rendered by a physician or podiatrist;

*(b)* Services rendered by a physician assistant or advanced practice registered nurse; or

*(c)* Services rendered by a registered nurse or licensed practical nurse acting independently under standing orders of a physician or advanced practice registered nurse, under specific instructions from a previous visit, or under supervision of a physician or advanced practice registered nurse who has no direct contact with the patient during a visit (e.g., administration of an immunization or injection, change of dressing, removal of sutures, dispensing of hormonal contraceptives if vital signs are taken during the visit, follow-up evaluation and management after insertion of an intrauterine device);

(ii) Early and periodic screening, diagnostic, and treatment (EPSDT) services and other preventive health services, such as children's eye

and ear examinations, perinatal services, well-child services, and pregnancy prevention or contraceptive management;

(iii) Obstetrical care services, including a prenatal risk assessment for every woman receiving prenatal services, and at-risk pregnancy services for every woman diagnosed at risk of premature birth or poor pregnancy outcome;

(iv) Diagnostic laboratory services;

(v) Diagnostic radiological services; and

(b) Covered services provided on-site or arranged for by the OHF:

(i) Transportation services; and

(ii) Emergency medical services.

(2) In addition, an OHF may provide the following services:

(a) Medical services other than comprehensive primary health services:

(i) Services provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, a physician assistant, or an advanced practice registered nurse;

(ii) Services provided by a registered nurse or a licensed practical nurse, under supervision, that would be covered if they were rendered by a physician or an advanced practice registered nurse;

(iii) EPSDT services; and

(iv) Services for women who have been determined to be at risk of preterm birth or poor pregnancy outcome;

(b) Dental services;

(c) Mental or behavioral health services provided by a clinical psychologist or a clinical social worker;

(d) Vision services provided by a licensed optometrist, optician, or ocularist;

(e) Speech and hearing services provided by an audiologist or speech pathologist;

(f) Physical medicine services provided by a physician, podiatrist, physical therapist, or mechanotherapist;

(g) Laboratory services;

(h) Radiology services; and

(i) Transportation services, excluding ambulance and wheelchair van services addressed in Chapter 5160-15 of the Administrative Code, needed to transport a patient to or from the OHF or between the OHF and other medicaid providers with which the OHF has referral arrangements.

(3) No separate payment is made for medical supplies and drugs dispensed during a visit.

(4) An OHF that is enrolled separately in medicaid as another type of provider may be paid on a fee-for-service basis under its non-OHF medicaid provider number for providing any of the following services or supplies:

(a) Take-home drugs identified in Chapter 5160-9 of the Administrative Code; or

(b) Durable medical equipment (DME) and supplies for take-home use identified in Chapter 5160-10 of the Administrative Code.

(5) Claims for services provided off-site under contract are submitted separately to the Ohio Department of Medicaid (ODM). The contractor may submit such claims if it has a current medicaid provider number.

(6) With the following exceptions, limits on OHF services are specified in the chapter of the Administrative Code that addresses the type of service:

(a) For medical services, payment may be made for a maximum of twenty-four office visits per year. Physician visits listed in rule 5160-4-06 of the Administrative Code do not count toward this limit.

(b) For vision care services, payment may be made for one vision examination in a twelve-month period for patients younger than twenty-one or older than fifty-nine. Payment may be made for one vision examination in a twenty-four-month period for patients older than twenty and younger than sixty. Corrective eyewear is covered only if it is provided by one of ODM's contracted vision laboratories.

(D) Submission of an OHF cost report.

(1) After its initial program year, each OFH submits a complete and adequate cost report by April first of each year for the preceding calendar year.

(a) "Cost report" is a report of costs submitted to ODM together with all schedules, attachments, and supporting documentation, in accordance with the instructions specified for the form.

(b) For an OHF, the form is the ODM 03421,"Federally Qualified Health Center / Outpatient Health Facility Cost Report" (rev. 04/2022).

(2) An OHF's provider agreement may be terminated in either of two circumstances:

(a) The OHF fails to submit a cost report by May first.

(b) The OHF submits an incomplete or inadequate cost report by April first and does not correct it within forty-five days of notification of deficiency.

(3) Government institutions operating on a cash basis may use the cash method of accounting. All other OHFs use the accrual method.

(E) Prospective payment system (PPS) method for determining OHF payment.

(1) An all-inclusive per-visit payment amount (PVPA) is established for each OHF service provided at an OHF service site

(a) For every OHF newly enrolled as a medicaid provider, ODM sets the PVPA for a service at the average PVPA for all participating OHFs.

(b) After the initial PVPAs are set, each OHF submits an annual cost report in accordance with this rule. New PVPAs are established on the basis of the cost report, to which an inflation factor is applied.

(i) The inflation factor is the sum of the following figures:

*(a)* The actual inflation rate between the midpoint of the cost report year and the midpoint of the following year as established by the United States bureau of labor statistics; and

*(b)* An estimated inflation rate from the midpoint of the preceding year to the midpoint of the year for which the PVPA is calculated based upon the preceding twelve-month average.

(ii) Unless otherwise specified, an inflation factor is computed from monthly statistical data supplied by the United States bureau of labor statistics for the following cost areas:

*(a)* Non-physician-level personnel costs (e.g., nurses, administration, legal staff, accounting, management, data services, employee fringe benefits, medical records, operation and maintenance services, housekeeping, laundry);

*(b)* Medical supplies countable as a separate expense;

*(c)* Non-durable goods (e.g., office supplies, printing);

*(d)* Fuel and utilities;

*(e)* Transportation services;

*(f)* Physician-level medical personnel and rehabilitation professionals;

*(g)* Insurance; and

*(h)* Real estate taxes.

(2) Audits.

(a) ODM or its designee may perform a desk review or conduct a field audit of any cost report submitted and may request any supporting documentation it deems necessary.

(b) Decisions of ODM with respect to the establishment or adjustment of a PVPA are not subject to Chapter119. of the Revised Code.

(F) Determination of a PVPA for an OHF service on the basis of a medicaid cost report.

(1) Separate PVPAs are established for the following services:

(a) Medical services;

(b) Dental services;

(c) Mental or behavioral health services provided by a clinical psychologist or a clinical social worker;

(d) Vision services provided by a licensed optometrist, optician, or ocularist;

(e) Speech and hearing services provided by an audiologist or speech pathologist;

(f) Physical medicine services;

(g) Laboratory services;

(h) Radiology services; and

(i) Transportation services.

(2) Allowable costs are calculated in accordance with the instructions for the OHF cost report. Certain restrictions apply

(a) Costs related to patient care are not allowable.

(b) Procedures or items that are not OHF services are not allowable.

(c) The straight-line method of computing depreciation is used for all depreciable assets.

(d) The cost claimed for services, facilities, and supplies furnished by a related organization does not exceed the lesser of two figures:

(i) The cost to the related organization; or

(ii) The price of comparable services, facilities, or supplies generally available.

(e) Total allowable administrative and general overhead costs do not exceed fifteen per cent of the costs of the services to which they are applied.

(3) Tests of reasonableness are applied to the allowable costs to establish limits.

(a) PVPAs established for any of the indicated services are not to exceed the lesser of two numbers:

(i) The quotient obtained by dividing the reported allowable cost by the reported number of visits; or

(ii) The quotient obtained by dividing the reported allowable cost by the product of the actual number of direct hours worked by the professional and the applicable number of encounters per hour from the following list:

*(a)* Medical services 2.4;

*(b)* Dental services 1.85;

*(c)* Mental or behavioral health services 0.8;

*(d)* Vision services 2.3;

*(e)* Speech pathology and audiology services 1.8; and

*(f)* Physical medicine services 2.0.

(iii) Any adjustment is to be computed on an annualized base of thirty hours per week and does not exceed one hundred per cent.

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| Replaces: | Part of 5160-28-01, 5160-28-03.2, 5160-28-04.2, 5160-28-05.2, 5160-28-06.2 |

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TO BE RESCINDED

5160-28-01 **Cost-based clinics: definitions and explanations.**

The following definitions apply for purposes of this chapter. Policies governing fee-for-service clinics are set forth in Chapter 5160-13 of the Administrative Code.

(A) "Change in scope of service" is an alteration in aspects of a service such as the procedures or items that are furnished, the frequency with which they are furnished, and the personnel who furnish them.

(1) Factors that constitute a change in scope of service include but are not limited to the following examples:

(a) The addition of a service that has been mandated by a governmental entity such as the centers for medicare and medicaid services (CMS) in federal statute, rules, or policies;

(b) The addition of a higher-level staff member working at a service site (e.g., an obstetrical-gynecological physician or a nurse-midwife or other advanced practice registered nurse certified in obstetrical-gynecological services at a service site that did not previously offer obstetrical services, a dentist at a service site that previously did not employ a licensed dentist and did not offer the full scope of dental services but only the services of a dental hygienist); or

(c) An increase in the intensity of services provided.

(2) The following factors do not constitute a change in scope of service:

(a) Wage increases;

(b) Changes in negotiated union contracts;

(c) Renovations or other capital expenditures;

(d) The addition of a disease management program;

(e) An increase in the number of lower-level staff members working at a service site (e.g., a nurse practitioner at a site that employs a family physician, a dental hygienist at a site that employs a dentist, a physical therapy assistant at a site that employs a physical therapist);

(f) An increase in the number of social service staff members;

(g) An increase in office space that is not directly associated with an approved change in scope of service;

(h) An increase in equipment or supplies that is not directly associated with an approved change in scope of service;

(i) An increase in patient volume; or

(j) An increase in office hours.

(B) "Clinical social worker" is a collective term for either of two professionals:

(1) A licensed independent social worker working with or without supervision; or

(2) A licensed social worker working under the supervision of a licensed independent social worker, a psychologist, or a physician.

(C) "Cost-based clinic (CBC)" is a collective term for a federally qualified health center, an outpatient health facility, or a rural health clinic.

(1) "Federally qualified health center (FQHC)" is an entity that has been determined by the federal health resources and services administration (HRSA) 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.

(a) "PHSA grant-funded FQHC" is an FQHC that receives PHSA grant funding either directly or through a contract with a grant recipient.

(b) "FQHC look-alike" is an FQHC that does not receive PHSA grant funding.

(c) "Government-operated FQHC" is an FQHC operated by a state, county, or local government agency.

(2) "Outpatient health facility (OHF)" has the same meaning as in section 5164.05 of the Revised Code.

(3) "Rural health clinic (RHC)" is an entity for which both of the following criteria are satisfied:

(a) It meets the definition of rural health clinic set forth in 42 C.F.R. 491.2 (October 1, 2015).

(b) It has been certified as a rural health clinic under medicare.

(D) "Cost report" is a report of a cost-based clinic's costs submitted to the department together with all schedules, attachments, and supporting documentation, in accordance with the instructions specified for the form.

(1) For an FQHC, the form is the ODM 03421, "Federally Qualified Health Center / Outpatient Health Facility Cost Report" (rev. 07/2014).

(2) For an OHF, the form is the ODM 03421, "Federally Qualified Health Center / Outpatient Health Facility Cost Report" (rev. 07/2014).

(3) For an RHC, the form is the CMS-222-92, "Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report" (rev. 05/2013).

(E) "Homebound" means having a condition that restricts the ability to leave one's place of residence except with the aid of supportive devices, the use of specialized transportation, or the assistance of another person or that medically contraindicates departure from the home. A person may also be considered homebound if absences from the home are infrequent, are for periods of relatively short duration, or are attributable to the need to receive health care treatment.

(F) "Managed care plan (MCP)" has the same meaning as in Chapter 5160-26 of the Administrative Code.

(G) "MCP enrollee" is a medicaid-eligible individual enrolled in a managed care plan.

(H) "MCP payment" is the amount received by a cost-based clinic from an MCP (exclusive of any financial incentive payments) for a service provided to an MCP enrollee.

(I) "MCP payment gap" is any positive difference obtained when the MCP payment is subtracted from the amount that would have been paid to the cost-based clinic under the prospective payment system (PPS) payment method described in rule 5160-28-05.1, 5160-28-05.2, or 5160-28-05.3 of the Administrative Code.

(J) "Per-visit payment amount (PVPA)" is the amount of payment established for a cost-based clinic service.

(K) "Reasonable and allowable costs" (also called "costs that are reasonable and related to patient care") are defined in the following reference materials, listed in descending order of priority:

(1) "Principles of reasonable cost reimbursement," 42 C.F.R. part 413 (October 1, 2015);

(2) "Centers for Medicare and Medicaid Services (CMS) Publication 15-1, Provider Reimbursement Manual - Part 1" (October 1, 2015) or chapter 9 of "Centers for Medicare and Medicaid Services (CMS) Publication 100-04, Medicare Claims Processing Manual" (July 25, 2014), both of which are available at http://www.cms.gov; or

(3) "Statement on Auditing Standards (SAS) No. 91, Federal GAAP Hierarchy" (April 2000), which may be obtained at http://www.aicpa.org.

(L) "Related organization" is an organization that is related to a cost-based clinic by common ownership or control.

(M) "Related party" is a person who has, or has had within the previous five years, another business relationship with the owner or operator of the cost-based clinic, either directly or indirectly, or who is related by marriage or birth to the owner or operator of the cost-based clinic.

(N) "Supplemental payment" or "wraparound payment" is an amount, equal to the MCP payment gap that is paid by the department to augment the MCP payment.

(O) "Urban cost-based clinic" is a cost-based clinic located within a metropolitan statistical area (MSA); "rural cost-based clinic" is a cost-based clinic located outside an MSA. "Metropolitan statistical area (MSA)" has the same meaning as in 40 C.F.R. 58.1 (July 1, 2015).

(P) "Visit" is a single instance of service.

(1) For cost-based clinic services other than transportation, it is a face-to-face encounter between a patient and a provider of cost-based clinic services. For transportation services, it is one trip to or from a service site.

(2) Multiple encounters with one health professional or encounters with multiple health professionals (e.g., a nurse and a physician) constitute a single visit if all of the following conditions are satisfied:

(a) All encounters take place on the same day;

(b) All contact involves a single cost-based clinic service; and

(c) The service rendered is for a single purpose, illness, injury, condition, or complaint.

(3) Multiple encounters constitute separate visits if one of the following conditions is satisfied:

(a) The encounters involve different cost-based clinic services; or

(b) The services rendered are for different purposes, illnesses, injuries, conditions, or complaints or for additional diagnosis and treatment.

(4) A visit must take place at an approved service site, in a patient's home, at another appropriate location (e.g., an outpatient hospital setting used by a cost-based clinic for providing services to patients, the scene of an accident), or (for transportation) between a service site and another location.

(5) No service provided to anyone other than a patient may be claimed as a visit with that patient.

(6) The following activities are not visits:

(a) Participation in a meeting or group session at which no health service is provided (e.g., an orientation session for new patients, a health presentation to a community group such as a high school class or parent-teacher association, an informational presentation about the cost-based clinic program); and

(b) Provision of a health service as part of a community service program such as a mass immunization, a large group screening, or a health fair.

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TO BE RESCINDED

**5160-28-03.1 Cost-based clinics: FQHC services, co-payments, and limitations.**

(A) A federally qualified health center (FQHC) may be paid on a per-visit basis for providing any of the following FQHC services:

(1) Medical services, which may comprise any of five kinds of services or items:

(a) All services referenced at 42 U.S.C. 1395x(aa)(3) (current as of July 28, 2015);

(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 in accordance with paragraph (A)(4) of this rule;

(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 as described in paragraph (A)(1)(c) of this rule; or

(e) Visiting nurse services if four conditions are satisfied:

(i) The service site is located in an area in which the United States secretary of health and human services (HHS) has determined that there is a shortage of home health agencies;

(ii) The services are furnished by either a registered nurse or a licensed practical nurse employed by or under contract with the FQHC;

(iii) The services are furnished to a homebound individual; and

(iv) The services are furnished under a written plan of treatment that is established by a physician, physician assistant, or advanced practice registered nurse or by a supervising physician of the FQHC; is signed by a physician, physician assistant, or advanced practice registered nurse or by a supervising physician of the FQHC; and

is reviewed at least every sixty days by a supervising physician of the FQHC.

(2) Dental services, which are identified in Chapter 5160-5 of the Administrative Code;

(3) Physical therapy services or occupational therapy services, which are identified in Chapter 5160-8 of the Administrative Code;

(4) Mental health services, which are identified in rule 5160-8-05 of the Administrative Code;

(5) Speech pathology and audiology services, which are identified in Chapter 5160-8 of the Administrative Code;

(6) Podiatry services, which are identified in Chapter 5160-7 of the Administrative Code;

(7) Vision services, which are identified in Chapter 5160-6 of the Administrative Code, except for services rendered by a physician (e.g., an ophthalmologist);

(8) Chiropractic services, which are identified in Chapter 5160-8 of the Administrative Code; or

(9) Transportation services to or from an FQHC service site where a covered visit takes place on the same date.

(B) An FQHC may be required to enroll separately in medicaid as another type of provider and to use a non-FQHC medicaid provider number in order to receive separate payment for a service or supply that cannot be claimed as an FQHC service under paragraph (A) of this rule.

(C) Co-payments established in accordance with rule 5160-1-09 of the Administrative Code apply to services rendered by an FQHC. Co-payments for services rendered to managed care enrollees are applied in accordance with Chapter 5160-26 of the Administrative Code.

(D) For each set of dentures, an FQHC may submit one claim for providing the service and not more than two additional claims for follow-up encounters.

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TO BE RESCINDED

5160-28-03.2 **Cost-based clinics: OHF services, co-payments, and limitations.**

(A) Each outpatient health facility (OHF) must provide the following preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services, which are collectively termed "comprehensive primary health services":

(1) Covered services provided on-site:

(a) Medical services, which may be divided into three categories:

(i) Services rendered by a physician or podiatrist;

(ii) Services rendered by a physician assistant or advanced practice registered nurse; or

(iii) Services rendered by a registered nurse or licensed practical nurse acting independently under standing orders of a physician or advanced practice registered nurse, under specific instructions from a previous visit, or under supervision of a physician or advanced practice registered nurse who has no direct contact with the patient during a visit (e.g., administration of an immunization or injection, change of dressing, removal of sutures, dispensing of hormonal contraceptives if vital signs are taken during the visit, follow-up evaluation and management after insertion of an intrauterine device);

(b) Early and periodic screening, diagnostic, and treatment (EPSDT) services and other preventive health services, such as children's eye and ear examinations, perinatal services, well-child services, and pregnancy prevention or contraceptive management;

(c) Obstetrical care services, including a prenatal risk assessment for every woman receiving prenatal services, and at-risk pregnancy services for every woman diagnosed at risk of premature birth or poor pregnancy outcome;

(d) Diagnostic laboratory services including but not limited to the following procedures:

(i) Chemical examination of urine (including urine ketones) by test strip, tablet, or both methods;

(ii) Microscopic examination of urine sediment;

(iii) Hemoglobin test or hematocrit;

(iv) Blood sugar test;

(v) Gram stain;

(vi) Examination of stool specimens for occult blood;

(vii) Pregnancy test;

(viii) Primary culturing of a specimen for transmittal to a certified laboratory;

(ix) Test for pinworm; and

(x) Drawing blood for a lead poisoning screening;

(e) Diagnostic radiological services including but not limited to the following procedures:

(i) Chest x-ray; and

(ii) X-ray necessary to diagnose treatment of a broken foot, ankle, leg, arm, or hand; and

(2) Covered services provided on-site or arranged for by the OHF:

(a) Transportation services; and

(b) Emergency medical services.

(B) In addition, an OHF may provide the following services:

(1) Medical services other than comprehensive primary health services:

(a) Services provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, a physician assistant, or an advanced practice registered nurse;

(b) Services provided by a registered nurse or a licensed practical nurse, under supervision, that would be covered if they were rendered by a physician or an advanced practice registered nurse;

(c) EPSDT services; and

(d) Services for women who have been determined to be at risk of preterm birth or poor pregnancy outcome;

(2) Dental services;

(3) Mental or behavioral health services provided by a clinical psychologist or a clinical social worker;

(4) Vision services provided by a licensed optometrist, optician, or ocularist;

(5) Speech and hearing services provided by an audiologist or speech pathologist;

(6) Physical medicine services provided by a physician, podiatrist, physical therapist, or mechanotherapist;

(7) Laboratory services;

(8) Radiology services; and

(9) Transportation services, excluding ambulance and wheelchair van services addressed in Chapter 5160-15 of the Administrative Code, needed to transport a patient to or from the OHF or between the OHF and other medicaid providers with which the OHF has referral arrangements.

(C) No separate payment is made for medical supplies and drugs dispensed during a visit.

(D) An OHF that is enrolled separately in medicaid as another type of provider may be paid on a fee-for-service basis under its non-OHF medicaid provider number for providing any of the following services or supplies:

(1) Take-home drugs, which must be paid for in accordance with Chapter 5160-9 of the Administrative Code; or

(2) Durable medical equipment (DME) and supplies for take-home use, which must be paid for in accordance with Chapter 5160-10 of the Administrative Code.

(E) Claims for services provided off-site under contract must be submitted separately to the department. The contractor must submit such claims if it has a current medicaid provider number.

(F) With the following exceptions, limits on OHF services are specified in the chapter of the Administrative Code that addresses the type of service:

(1) For medical services, payment may be made for a maximum of twenty-four office visits per year. Physician visits listed in rule 5160-4-06 of the Administrative Code do not count toward this limit.

(2) For vision care services, payment may be made for one vision examination in a twelve-month period for patients younger than twenty-one or older than fifty-nine. Payment may be made for one vision examination in a twenty-four-month period for patients older than twenty and younger than sixty. Corrective eyewear is covered only if it is provided by one of the department's contracted vision laboratories.

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TO BE RESCINDED

5160-28-03.3 **Cost-based clinics: RHC services, co-payments, and limitations.**

(A) A rural health clinic (RHC) may be paid on a per-visit basis for providing any of the following services:

(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, that meet one of the following criteria:

(a) They are provided by a clinical psychologist or advanced practice registered nurse certified by a national organization in the specialty of psychiatry; or

(b) They are provided by a clinical social worker, professional counselor, or professional clinical counselor;

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

(4) Visiting nurse services if four conditions are satisfied:

(a) The service site is located in an area in which the United States secretary of health and human services (HHS) has determined that there is a shortage of home health agencies;

(b) The services are furnished by either a registered nurse or a licensed practical nurse employed by or under contract with the RHC;

(c) The services are furnished to a homebound individual; and

(d) The services are furnished under a written plan of treatment that is established by a supervising physician of the RHC or a physician, physician assistant, or advanced practice registered nurse, is signed by a supervising physician of the RHC or a physician, physician assistant, or advanced practice registered nurse, and is reviewed at least every sixty days by a supervising physician of the RHC.

(B) An RHC may be required to enroll separately in medicaid as another type of provider and to use a non-RHC medicaid provider number in order to receive separate payment

for a service or supply that cannot be claimed as an RHC service under paragraph (A) of this rule.

(C) Co-payments may be established in accordance with rule 5160-1-09 of the Administrative Code for services rendered by an RHC. Co-payments for services rendered to managed care enrollees are applied in accordance with Chapter 5160-26 of the Administrative Code.

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TO BE RESCINDED

5160-28-06.1 **Cost-based clinics: determination of a PVPA for an FQHC service on the basis of a medicaid cost report.**

(A) Allowable costs are calculated in accordance with the instructions for the FQHC cost report. Certain restrictions apply:

(1) Costs related to direct patient care are not allowable.

(2) Procedures or items that are not federally qualified health center (FQHC) services are not allowable.

(3) The straight-line method of computing depreciation must be used for all depreciable assets.

(4) The cost claimed for services, facilities, and supplies furnished by a related organization must not exceed the lesser of two figures:

(a) The cost to the related organization; or

(b) The price of comparable services, facilities, or supplies generally available.

(5) Total allowable administrative and general overhead costs must not exceed thirty-five per cent of the costs of the services to which they are applied.

(6) Not more than thirty thousand dollars in administrative and general overhead costs are allowable annually as recruitment cost incurred by a provider of FQHC medical service.

(B) Tests of reasonableness are applied to the allowable costs to establish limits.

(1) For each FQHC service except transportation, a limit is established by dividing the allowable cost by the greater of two figures:

(a) The number of allowable encounters; or

(b) The product of the actual number of direct hours worked by the professional and the applicable number of encounters per hour from the following list:

(i) Physician services, per physician – 2.4;

(ii) Physician assistant or advanced practice registered nurse services, per practitioner – 1.2;

(iii) Dental services – 1.8;

(iv) Physical therapy services – 2.0;

(v) Mental or behavioral health services – 0.7;

(vi) Speech pathology and audiology services — 1.8;

(vii) Podiatry services – 2.4;

(viii) Vision services – 1.9;

(ix) Chiropractor services – 2.4. and

(x) Occupational therapy services – 2.0;

(2) For transportation, a limit is established of twenty-five dollars per unit of service.

(C) A ceiling is established for each FQHC service.

(1) The current sixtieth percentile PVPAs for the FQHC service are determined for all rural FQHCs and urban FQHCs respectively.

(2) An urban wage adjustment factor (UWAF) 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.

(3) 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.

(D) The final PVPA for an FQHC service is the least of the allowed cost, the limit, or the ceiling.

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5160-28-06.2 **Cost-based clinics: determination of a PVPA for an OHF service on the basis of a medicaid cost report.**

(A) Separate PVPAs are established for the following services:

(1) Medical services;

(2) Dental services;

(3) Mental or behavioral health services provided by a clinical psychologist or a clinical social worker;

(4) Vision services provided by a licensed optometrist, optician, or ocularist;

(5) Speech and hearing services provided by an audiologist or speech pathologist;

(6) Physical medicine services;

(7) Laboratory services;

(8) Radiology services; and

(9) Transportation services.

(B) Allowable costs are calculated in accordance with the instructions for the OHF cost report. Certain restrictions apply:

(1) Costs related to patient care are not allowable.

(2) Procedures or items that are not outpatient health facility (OHF) services are not allowable.

(3) The straight-line method of computing depreciation must be used for all depreciable assets.

(4) The cost claimed for services, facilities, and supplies furnished by a related organization must not exceed the lesser of two figures:

(a) The cost to the related organization; or

(b) The price of comparable services, facilities, or supplies generally available.

(5) Total allowable administrative and general overhead costs must not exceed fifteen per cent of the costs of the services to which they are applied.

(C) Tests of reasonableness are applied to the allowable costs to establish limits.

(1) PVPAs established for any of the indicated services must not exceed the lesser of two numbers:

(a) The quotient obtained by dividing the reported allowable cost by the reported number of visits; or

(b) The quotient obtained by dividing the reported allowable cost by the product of the actual number of direct hours worked by the professional and the applicable number of encounters per hour from the following list:

(i) Medical services – 2.4;

(ii) Dental services – 1.85;

(iii) Mental or behavioral health services – 0.8;

(iv) Vision services – 2.3;

(v) Speech pathology and audiology services — 1.8; and

(vi) Physical medicine services – 2.0.

(2) Any adjustment is to be computed on an annualized base of thirty hours per week and must not exceed one hundred per cent.

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5160-28-08.1 **Cost-based clinics: submission and payment of FQHC claims.**

(A) Claims for services provided to managed care plan (MCP) enrollees, including requests for prior authorization by an MCP of a federally qualified health center (FQHC) service, must be submitted in accordance with Chapter 5160-26 of the Administrative Code.

(B) In claims submitted to the department for all other services, an FQHC must include the following data:

(1) The designated procedure code for an encounter;

(2) The appropriate modifier to specify the FQHC service; and

(3) Additional codes representing all procedures performed during the encounter, along with any required modifiers.

(C) In claims submitted to the department for supplemental payment for services provided to an MCP enrollee, an FQHC must also include the following data:

(1) The name of the MCP that paid for the FQHC service;

(2) The identification code of the MCP, assigned by the department;

(3) The MCP payment plus amounts received from any other third-party payers; and

(4) Any other information, such as an adjustment reason code, that is necessary for the coordination of benefits.

(D) The department must pay a valid claim for supplemental payment within four months. However, no supplemental payment will be made for a claim that is not submitted to the department within the limits specified in rule 5160-1-19 of the Administrative Code.

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TO BE RESCINDED

5160-28-08.3 **Cost-based clinics: submission and payment of RHC claims.**

(A) Claims for services provided to managed care plan (MCP) enrollees, including requests for prior authorization by an MCP of an RHC service, must be submitted in accordance with Chapter 5160-26 of the Administrative Code.

(B) In claims submitted to the department for all other services, an RHC must include the designated procedure code for an encounter.

(C) In claims submitted to the department for supplemental payment for services provided to an MCP enrollee, an RHC must also include the following data:

(1) The name of the MCP that paid for the RHC service;

(2) The identification code of the MCP, assigned by the department;

(3) The MCP payment plus amounts received from any other third-party payers; and

(4) Any other information, such as an adjustment reason code, that is necessary for the coordination of benefits.

(D) The department must pay a valid claim for supplemental payment within four months. However, no supplemental payment will be made for a claim that is not submitted to the department within the limits specified in rule 5160-1-19 of the Administrative Code.

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*** DRAFT - NOT YET FILED ***

5160-28-01 **Federally qualified health center (FQHC) and rural health clinic (RHC) services: definitions and explanations.**

(A) "Change in scope of service" is an alteration in aspects of a prospective payment system (PPS) service such as the procedures or items that are furnished, the frequency with which they are furnished, and the type of personnel who furnish them.

(1) A change in scope of service is characterized by such factors as are specified in the following non-exhaustive list:

(a) The addition or discontinuation of a PPS service;

(b) The addition or discontinuation of a procedure or class of procedures within a PPS service that involves the skills and training of a higher-level practitioner, such as the expansion of PPS medical service to include obstetrical-gynecological care provided by a physician or advanced practice registered nurse or the provision of a full range of dental procedures performed by a licensed dentist where previously only the services of a dental hygienist had been available; or

(c) A change in the distribution of procedures within a PPS service that materially affects the allocation of resources to that PPS service, such as a change in a medical service "case mix" from eighty per cent family practice and twenty per cent obstetrical-gynecological care to forty per cent family practice and sixty per cent obstetrical-gynecological care.

(2) The following factors do not constitute a change in scope of service:

(a) Wage increases;

(b) Changes in negotiated union contracts;

(c) Renovations or other capital expenditures;

(d) An increase in the number of lower-level staff members, such as a nurse practitioner at a site that employs a family physician, a dental hygienist at a site that employs a dentist, or a physical therapy assistant at a site that employs a physical therapist;

(e) An increase in the number of social service staff members;

(f) An increase in office space, such as the addition of square footage at an FQHC or RHC, a satellite office, a school location, or a mobile unit;

(g) An increase in equipment or supplies;

(h) An increase in patient volume;

(i) An increase in office hours;

(j) The addition of an adjunctive service such as a disease management program; or

(k) Provision of a PPS service by an FQHC or RHC practitioner at a related off-site location.

(B) "Cost report" is a report of FQHC or RHC costs together with all schedules, attachments, and supporting documentation, in accordance with the instructions specified for the form.

(1) For purposes of establishing FQHC per-visit payment amounts, the Ohio Department of Medicaid (ODM) uses form ODM 03421, "Federally Qualified Health Center Cost Report" (rev. 7/2022).

(2) For purposes of establishing RHC per-visit payment amounts, ODM 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).

(C) "Federally qualified health center (FQHC)" is an entity that meets the definition of FQHC set forth in 42 U.S.C. 1395x(aa)(4) (October 1, 2021).

(1) "FQHC look-alike" is an FQHC that does not receive Public Health Service Act (PHSA) grant funding.

(2) "Government-operated FQHC" is an FQHC operated by a state, county, or local government agency.

(D) "Managed care entity (MCE)" has the same meaning as in Chapter 5160-26 of the Administrative Code.

(E) "Medicaid wraparound payment" is an amount that is paid by ODM to augment the payment made by an MCE to an FQHC or RHC. It equals any positive difference

obtained when the MCE payment is subtracted from the per-visit payment amount (PVPA) for the visit.

(1) For purposes of determining timely filing in accordance with rule 5160-1-19 of the Administrative Code, an MCE is treated as a third-party payer.

(2) An FQHC or RHC may submit a claim to ODM for medicaid wraparound payment before the later of the following dates:

(a) One hundred eighty days after the date on which the MCE pays the original claim; or

(b) Three hundred sixty-five days after the date of service.

(3) ODM will pay a valid claim for medicaid wraparound payment within four months after submission.

(F) "Non-PPS service" is a service rendered at an FQHC or RHC for which payment is generally made in accordance with rules in agency 5160 of the Administrative Code outside of Chapter 5160-28.

(G) "PPS" means prospective payment system.

(H) "Per-visit payment amount (PVPA)" is the amount of medicaid payment established for a visit for which payment is made under the PPS method described in rule 5160-28-05 of the Administrative Code.

(I) "PPS payment" is payment that is made under the PPS method described in rule 5160-28-05 of the Administrative Code.

(J) "PPS service" is a service that is rendered during a visit for which PPS payment is made.

(K) "Related off-site location" is a place other than an FQHC or RHC site at which a service is performed, such as a school, a satellite office, a mobile unit, a long-term care facility, an outpatient hospital setting used by an FQHC or RHC for providing services to patients, or a practice location operated by an FQHC- or RHC-contracted practitioner. For reporting purposes, a service rendered at a related off-site location is attributed to the particular FQHC or RHC site whose personnel provided the service.

(L) "Related organization" is an organization that is related to an FQHC or RHC by common ownership or control.

(M) "Rural health clinic (RHC)" is an entity that meets the definition of RHC set forth in 42 U.S.C. 1395x(aa)(2) (October 1, 2021).

(N) "Services and supplies furnished incident to" other services has the same meaning as in chapter 13 of "Centers for Medicare and Medicaid Services (CMS) Publication 100-02, Medicare Benefit Policy Manual" (December 20, 2019), which is available at http://www.cms.gov.

(O) "Site," as used in this chapter of the Administrative Code, is a separate and distinct location operated by an FQHC or RHC at which healthcare services are rendered. An FQHC or RHC may have several sites.

(P) "Visit."

(1) For PPS services other than transportation, a visit is one face-to-face (person-to-person) encounter between a patient and a provider; for medicaid payment purposes, a covered service rendered through telehealth by an FQHC or RHC practitioner is a face-to-face encounter. For transportation services, a visit is a one-way trip provided to or from a site on the same day as a non-transportation PPS service.

(a) Multiple encounters with one health professional or encounters with multiple health professionals constitute a single visit if all of the following conditions are satisfied:

(i) All encounters take place on the same day;

(ii) All contact involves a single PPS service; and

(iii) The service rendered is for a single purpose, illness, injury, condition, or complaint.

(b) Multiple encounters constitute separate visits if one of the following conditions is satisfied:

(i) The encounters involve different PPS services; or

(ii) The services rendered are for different purposes, illnesses, injuries, conditions, or complaints or for additional diagnosis and treatment.

(2) A visit may take place at an FQHC or RHC site, in a patient's home, at a related off-site location, or (for transportation) between an FQHC or RHC site and a patient's home or a related off-site location.

(3) A visit may be conducted through telehealth if the service is rendered in accordance with rule 5160-1-18 of the Administrative Code.

(4) No service provided to anyone other than a patient may be claimed as a visit with that patient.

(5) The following activities are not visits:

(a) Participation in a meeting or group session at which no health service is provided, such as an orientation session for new patients, a health presentation to a community group, or an informational presentation about a program managed by an FQHC or RHC;

(b) Provision of a health service as part of a community service program such as a mass immunization, a large group screening, or a health fair;

(c) A service rendered by a practitioner who is not employed by nor under contract with an FQHC or RHC; and

(d) A non-PPS service.

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5160-28-03 **FQHC and RHC services: covered services, limitations, and copayments.**

(A) A federally qualified health center (FQHC) may receive prospective payment system (PPS) payment for providing any of the following FQHC PPS services:

(1) In accordance with section 330 of the Public Health Services Act, 42 U.S.C. chapter 6A (October 1, 2021), medical services, which comprise any of four types of services:

(a) Services referenced at 42 U.S.C. 1395x(aa)(3) (October 1, 2021), including but not limited to an evaluation and management (E&M) service, another medical or surgical procedure, or the administration of a vaccine or other provider-administered pharmaceutical;

(b) Professional services (including the administration of a vaccine) furnished by a qualified healthcare practitioner (physician, physician assistant, advanced practice registered nurse, dietitian, pharmacist, registered nurse working under supervision), along with any services or supplies furnished incident to the professional services on the same date;

(c) Professional services and related supplies provided at a later date as necessary follow-up to a medical services visit, even if the same services and supplies were also provided as part of (or incident to) the original medical services visit; or

(d) Visiting nurse services if the following three conditions are satisfied:

(i) The services are furnished by either a registered nurse or a licensed practical nurse employed by or under contract with the FQHC;

(ii) The FQHC is located in an area determined by the Centers for Medicare and Medicaid Services (CMS) to have a shortage of home health agencies; and

(iii) The services are furnished under a written plan of treatment that is established by a physician, physician assistant, or advanced practice registered nurse or by a supervising physician of the FQHC; is signed by a physician, physician assistant, or advanced practice registered nurse or by a supervising physician of the FQHC; and is reviewed at least every sixty days by a supervising physician of the FQHC.

(2) Dental services, which are identified in Chapter 5160-5 of the Administrative Code and to which the following conditions apply:

(a) An FQHC reports every dental procedure or service, in the appropriate claim format, as a PPS service; and

(b) For each set of dentures, an FQHC may submit one claim for providing the service and not more than two additional claims for follow-up visits;

(3) Physical therapy services or occupational therapy services, which are identified in Chapter 5160-8 of the Administrative Code;

(4) Behavioral health services identified in rule 5160-8-05 of the Administrative Code;

(5) Speech pathology and audiology services, which are identified in Chapter 5160-8 of the Administrative Code;

(6) Podiatry services, which are identified in Chapter 5160-7 of the Administrative Code;

(7) Vision services, which are identified in Chapter 5160-6 of the Administrative Code, that are rendered by a non-physician;

(8) Chiropractic services, which are identified in Chapter 5160-8 of the Administrative Code; or

(9) Transportation services that enable an individual to make up to four trips to or from an FQHC site (or related location) where a covered service is rendered on the same date.

(B) A rural health clinic (RHC) may receive PPS payment for providing any of the following RHC PPS services:

(1) Medical services, which comprise any of three types of services:

(a) All services referenced at 42 U.S.C. 1395x(aa)(1) (October 1, 2021), including but not limited to an evaluation and management (E&M) service, another medical or surgical procedure, or the administration of a vaccine or other provider-administered pharmaceutical;

(b) Professional services (including the administration of a vaccine) furnished by a qualified healthcare practitioner (e.g., physician, physician assistant, advanced practice registered nurse, dietitian, pharmacist, registered nurse

working under supervision), along with any services or supplies furnished incident to the professional services on the same date;

(c) Professional services and related supplies provided at a later date as necessary follow-up to a medical services visit, even if the same services and supplies were also provided as part of (or incident to) the original medical services visit;

(2) Behavioral health services identified in rule 5160-8-05 of the Administrative Code; or

(3) Transportation services that enable an individual to make up to four trips to or from an RHC (or related location) where a covered service is rendered on the same date.

(C) An FQHC or RHC may structure its enrollment in medicaid such that it can submit a claim and receive separate payment for a covered service or supply that cannot be claimed as a PPS service under paragraphs (A) and (B) of this rule.

(1) No PPS service may be claimed as a non-PPS service. Payment for a covered non-PPS service is made in accordance with the rule or chapter of the Administrative Code that applies to the service.

(2) The following non-exhaustive list specifies covered medically necessary services and supplies that may be claimed as non-PPS services:

(a) Group therapy;

(b) Remote patient monitoring;

(c) Acupuncture rendered by an acupuncturist;

(d) Inpatient hospital services;

(e) Take-home medications;

(f) Hemophilia clotting factor drugs;

(g) Long-acting reversible contraception (LARC);

(h) Durable medical equipment for take-home use;

(i) The technical component of a procedure comprising both a professional and a technical component, such as radiography or other imaging;

(j) Clinical diagnostic laboratory services other than the following procedures:

(i) Venipuncture;

(ii) Chemical examination of urine by stick or tablet method or both;

(iii) Hematocrit or hemoglobin analysis;

(iv) Blood sugar analysis;

(v) Examination of stool specimens for occult blood;

(vi) Pregnancy tests; and

(vii) Primary culturing for transmittal to a certified laboratory;

(k) Eyeglass lenses and frames;

(l) Topical fluoride varnish furnished by a non-dental practitioner in accordance with rule 5160-4-33 of the Administrative Code;

(m) A vaccine administered as part of a mass immunization;

(n) A report of a pregnancy that is diagnosed in conjunction with a PPS service, described in rule 5160-21-04 of the Administrative Code;

(o) A pregnancy risk assessment, described in rule 5160-21-04 of the Administrative Code; and

(p) Behavioral health services and substance use disorder services identified in Chapter 5160-27 of the Administrative Code that meet the following criteria:

(i) They cannot be claimed as PPS services; and

(ii) They are rendered by certified behavioral health practitioners in accordance with Chapter 5160-27 of the Administrative Code and federal and state law.

(3) The provision of a covered non-PPS service on the same date as a covered PPS service does not preclude payment for either service.

(D) Copayments established in accordance with rule 5160-1-09 of the Administrative Code may apply to services rendered by an FQHC or RHC. Copayments for services

rendered to MCE members are applied in accordance with applicable medicaid rules in the Administrative Code concerning MCEs.

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*** DRAFT - NOT YET FILED ***

5160-28-05 **FQHC and RHC services: prospective payment system (PPS) method for determining payment.**

(A) A discrete, all-inclusive per-visit payment amount (PVPA) is established for each FQHC PPS service provided at an FQHC or related off-site location and for an RHC PPS service provided at an RHC or related off-site location.

(1) For all FQHC or RHC sites that are already enrolled as medicaid providers, ODM establishes new PVPAs equal to the current PVPAs revised to reflect the latest available medicare economic index (MEI) percentage. The new PVPAs are established by October first of each year and are in effect from October first through the following September thirtieth.

(2) When an enrolled FQHC or RHC site requests adjustment of a PVPA, ODM may establish a new PVPA based on a cost report in accordance with rule 5160-28-04 of the Administrative Code.

(3) For an FQHC or RHC site that is enrolling as a new medicaid provider or an FQHC site that is adding a new FQHC PPS service, ODM establishes an initial PVPA in accordance with the following procedure:

(a) First, the initial PVPA is set equal to the corresponding PVPA of other FQHC or RHC sites in the immediate area that are similar in size, caseload, and scope of services. If no such FQHC or RHC site exists, then the initial PVPA is set equal to the current PVPA at the applicable statewide sixtieth percentile for the appropriate FQHC or RHC classification (FQHC or RHC).

(b) This initial PVPA remains in effect until a new PVPA is established.

(c) After the initial PVPA is set, the FQHC or RHC site submits a cost report in accordance with rule 5160-28-04 of the Administrative Code. A new PVPA is established on the basis of the cost report and is revised to reflect any changes in the MEI that have occurred since the cost report was submitted.

(d) Thereafter, the PVPA is revised in accordance with paragraph (A)(1) of this rule.

(4) For an FQHC PPS service only, if no current PVPA at the applicable statewide sixtieth percentile is available, then the initial PVPA, P, is obtained by the formula $P = M \times (S / E)$, rounded up to the next whole dollar.

(a) M is the greater of two figures:

(i) The current PVPA for medical services at the applicable statewide sixtieth percentile for FQHC sites; or

(ii) The current PVPA for medical services at the particular FQHC site.

(b) S is the medicaid maximum payment amount (or the median 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.

(c) E is the medicaid maximum non-facility payment amount for a mid-level evaluation and management service (office visit) for an established patient.

(B) 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 thirtieth. A PVPA that is established or adjusted before September thirtieth and becomes effective on or after October first is then further revised to reflect the applicable MEI. No retroactive establishment or adjustment will be made for a PVPA.

(C) A PVPA is specific to an FQHC or RHC site. No FQHC or RHC site may submit claims based on the PVPAs of another FQHC or RHC site.

(D) Decisions of ODM with respect to the establishment or adjustment of a PVPA are not subject to Chapter 119. of the Revised Code.

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5160-28-06.1 **FQHC and RHC services: limits on a per-visit payment amount (PVPA) determined on the basis of a cost report for an FQHC PPS service.**

(A) Allowable costs are calculated in accordance with the instructions for the federally qualified health center (FQHC) cost report. Certain restrictions apply:

(1) Costs related to direct inpatient care are not allowable.

(2) Procedures or items that are not PPS services are not allowable.

(3) The straight-line method of computing depreciation is used for all depreciable assets.

(4) The cost claimed for services, facilities, and supplies furnished by a related organization cannot exceed the lesser of two figures:

(a) The cost to the related organization; or

(b) The price of comparable services, facilities, or supplies that are generally available in the competitive marketplace.

(5) Total allowable administrative and general overhead costs cannot exceed thirty-five per cent of the costs of the services to which they are applied. Of these costs, not more than thirty thousand dollars are allowable annually as recruitment cost incurred by a provider of FQHC medical service.

(B) Limits are established by applying tests of reasonableness to the allowable costs.

(1) For each PPS service except transportation, a limit is established by dividing the allowable cost by the greater of two figures:

(a) The total number of visits; or

(b) The product of the actual number of direct hours worked by the professional and the applicable number of visits per hour from the following list:

(i) Physician services, per physician – 2.4;

(ii) Physician assistant or advanced practice registered nurse services, per practitioner – 1.2;

(iii) Dental services – 1.8;

(iv) Physical therapy services – 2.0;

(v) Behavioral health services or substance use disorder services – 0.7;

(vi) Speech pathology and audiology services – 1.8;

(vii) Podiatry services – 2.4;

(viii) Vision services – 1.9;

(ix) Chiropractor services – 2.4. and

(x) Occupational therapy services – 2.0;

(2) For transportation, a limit is established of twenty-five dollars per unit of service.

(C) A ceiling is established for each PPS service at one hundred twenty per cent of the statewide sixtieth percentile PVPA.

(D) The final PVPA for an FQHC PPS service is the least of the allowable cost, the limit, or the ceiling.

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