Ohio Administrative Code

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

Effective: July 1, 2022

(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 where a covered service is rendered on the same date.

(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.