Ohio Administrative Code

Rule 5160-28-01 Federally qualified health centers (FQHCs): eligibility and enrollment as a medicaid provider.

Effective: October 1, 2016

The following definitions apply for purposes ofthis chapter. Policies governing fee-for-service clinics are set forth inChapter 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.