Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

Medicaid Transmittal Letter (MTL) No. 3354-16-01

DATE: September 30, 2016

TO: Federally Qualified Health Centers
Outpatient Health Facilities
Rural Health Clinics
Chief Executive Officers, Managed Care Plans
Other Interested Parties

FROM: John B. McCarthy, Medicaid Director

SUBJECT: Consolidation of Rules for Cost-Based Clinics, Located in Chapters 5160-16, 5160-28, and 5160-29 of the Ohio Administrative Code

Rules concerning the delivery of services in federally qualified health centers (FQHCs), outpatient health facilities (OHFs), and rural health clinics (RHCs) were previously set forth respectively in Chapters 5160-28, 5160-29, and 5160-16 of the Ohio Administrative Code. These rules have been rescinded and their provisions consolidated into a new chapter, numbered 5160-28, that addresses all three types of cost-based clinics.

The new rules take effect for dates of service beginning October 1, 2016.

The text of the rules has been reorganized, streamlined, and clarified. On the whole, the intent remains the same, but a few differences should be noted:

- In the definition of "outpatient health facility (OHF)," a lengthy enumeration of qualifying criteria has been replaced with a single reference to the Ohio Revised Code.
- In the definition of "rural health clinic (RHC)," explicit reference to the Ohio Department of Health (ODH) has been removed to allow enrollment not only of RHCs certified in Ohio but also of RHCs certified in other jurisdictions.
- An outdated provision concerning Medicare crossover claims has been removed.
- The previous requirement for FQHCs to submit documentation of receiving an assigned Medicare number from the Centers for Medicare and Medicaid Services—a process that could take up to nine months—has been dropped. In place of this requirement, FQHCs are now only required to submit a Notice of Grant Award from the Health Resources and Services Administration.

- Occupational therapy has been added to the list of FQHC services for which payment may be made.
- One new provision permits (but does not require) the imposition of a penalty for cost reports submitted after the deadline.
- An FQHC includes data in cost reports to document its productivity level. Tests of reasonableness, in the form of numerical standards, are applied to some of this information. For vision services, the benchmark figure was changed from 2.3 to 1.9 encounters per hour.
- Provisions have been added requiring FQHCs and RHCs to report coordination-of-benefits information, such as adjustment reason codes, on supplemental payment claims for services provided to managed care plan (MCP) enrollees.
- An extension of prescriptive and supervisory authority has been added for advanced practice registered nurses.
- The initial per-visit payment amount (PVPA) for an FQHC service is normally established in relation to a reference figure. A new provision includes a formula by which a PVPA can be established if no reference figure is available. A specification of a formula for developing the initial PVPA has been added for a service when no current PVPA at the applicable statewide sixtieth percentile is available.

Additional Information

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, http://www.medicaid.ohio.gov.

Questions pertaining to this letter should be directed to the Ohio Department of Medicaid:

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