TO BE RESCINDED

5160-28-09 **Federally qualified health centers (FQHCs): prospective payment system (PPS) rate review for change in scope of service.**

This rule describes the two methods for determining PPS rates for a change in scope of service.

(A) Definitions.

(1) "Change in scope of service" means:

(a) The addition or deletion of a new category of service as described in paragraph (B) of this rule; or

(b) The department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (C) of this rule.

(2) "Category of service" means the following different types of services:

(a) Medical, as defined in Chapter 5101:3-4 of the Administrative Code;

(b) Dental, as defined in Chapter 5101:3-5 of the Administrative Code;

(c) Mental health, as defined in rules 5101:3-8-05 and 5101:3-4-29 of the Administrative Code;

(d) Physical therapy, as defined in rule 5101:3-8-02 of the Administrative Code;

(e) Podiatry, as defined in Chapter 5101:3-7 of the Administrative Code;

(f) Optometry, as defined in Chapter 5101:3-6 of the Administrative Code;

(g) Chiropractic, as defined in Chapter 5101:3-11 of the Administrative Code;

(h) Speech pathology and audiology, as defined in Chapter 5101:3-13 of the Administrative Code; and

(i) Transportation, as defined in Chapter 5101:3-15 of the Administrative Code.

(3) "Increase or decrease in the scope of services" means the addition or deletion of a category of service or the department has granted a request filed by an FQHC that a service has changed in scope as specified in paragraph (C) of this rule.

(B) Method one:

A routine change in scope of service is the addition or deletion of a new category of service as defined in paragraph (A) of this rule. The following methodology will be used to establish the rate for a service type that meets the provisions in paragraph (A)(1)(a) of this rule.

(1) As an interim step, FQHCs that establish a new category of service will be given a start-up rate for the new category of service. The start-up rate for urban FQHCs will be the sixtieth percentile for urban FQHCs offering that category of service in accordance with paragraph (C) of rule 5101:3-28-08 of the Administrative Code. For rural FQHCs, the start-up rate will be the sixtieth percentile for rural FQHCs offering that category of service in accordance with paragraph (C) of rule 5101:3-28-08 of the Administrative Code. This interim rate will be in effect until a rate for that FQHC for that category of service is established by the department based on the methodology described in paragraphs (B)(3) to (B)(7) of this rule.

(2) FQHCs adding a new category of service must file a cost report in accordance with the instructions in JFS 03421 (07/2001) and rule 5101:3-28-10 of the Administrative Code:

(3) Upon receipt of a complete and accurate cost report, the department will review the FQHC's costs for the service that has changed in scope of service and will adjust the PPS rate based on the reasonable cost parameters described in paragraphs (B)(4) to (B)(7) of this rule.

(4) General provisions for allowable and reasonable costs.

"Costs that are reasonable and related to patient care" are those contained in the following reference material in the following priority: 42 C.F.R. part 413 "principles of reasonable cost reimbursement" effective October 1, 2005; "centers for medicare and medicaid services (CMS) publication 15-1, provider reimbursement manual," available at www.cms.hhs.gov/manuals/ (rev. 1/2005); and "the American institute of certified public accountants (AICPA) Federal generally accepted accounting principles (GAAP) hierarchy statement on auditing standards (SAS) No. 91 (1999)," except that:

(a) Costs related to patient care and services that are not covered under the FQHC program as described in Chapter 5101:3-28 of the Administrative Code are not allowable.

(b) The straight line method of computing depreciation is required for cost filing purposes, and it must be used for all depreciable assets.

(c) For purposes of determining allowable and reasonable cost in the purchase of goods and services from a related party, the following definition of related shall be used: "related" is one who enjoys, or has enjoyed within the previous five years, any degree of another business relationship with the owner or operator of the facility, directly or indirectly, or one who is related by marriage or birth to the owner or operator of the facility.

(d) Upper limits for costs associated with related party transactions are defined as the following:

(i) FQHCs are required to identify all related organizations; i.e., related to the FQHC by common ownership or control.

(ii) The cost claimed on the cost report for services, facilities, and supplies furnished by the related organization shall not exceed the lower of:

(a) The cost to the related organization; or

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

(e) Tests of reasonableness, ceilings and upper limits as identified in paragraphs (B)(5) to (B)(7) of this rule shall be applied in determining allowable and reasonable cost.

(5) Ceilings on administrative and general costs.

(a) A thirty-five per cent ceiling for total allowable administrative and general and overhead costs shall be applied to all services. Total allowable administrative and general and overhead costs are defined as costs reported on the JFS 03421, schedule C-1, part II and schedule C-2 parts III and IV, plus any allowable costs to these costs areas from schedule C-1, part I of the JFS 03421.

(b) An annual exemption of thirty thousand dollars per year per provider from the ceiling on administrative and general costs is allowable for the recruitment costs of core providers.

(6) Tests of reasonableness for professional services and transportation.

Allowable costs reported to the department in accordance with the instructions for the JFS 03421 will be adjusted based on minimum required efficiency standards calculated as encounters per hour. The rate established for the following service components will not exceed the lower of the rates as determined by dividing allowable costs by allowable encounters or allowable costs divided by the product of direct hours worked by the professional and the encounters per hour as shown:

(a) Physician services - 2.4 encounters per hour per physician;

(b) Physician assistant or advanced practice nurses services - 1.2 encounters per hours per practitioner;

(c) Mental health services in accordance with paragraph (B)(8) of rule 5101:3-28-02 of the Administrative Code - .7 encounters per hour;

(d) Physical therapy services - 2.0 encounters per hour;

(e) Speech pathology and audiology services - 1.8 encounters per hour;

(f) Dental services - 1.8 encounters per hour;

(g) Podiatry services - 2.4 encounters per hour;

(h) Optometric and/or optician services - 2.3 encounters per hour; and

(i) Chiropractor services - 2.4 encounters per hour; and

(j) Transportation reimbursement shall not exceed twenty-five dollars per one way unit of service to and/or from a medicaid covered FQHC service.

(7) Reimbursement rates shall not exceed the higher of the appropriate medicare ceiling or the wage adjusted ceilings on reimbursement rates as follows:

(a) Using as filed the JFS 03421 for each eligible FQHC site, an allowable cost per encounter for any new category of service shall be calculated. Tests of reasonableness, ceilings, and upper limits identified in paragraphs (B)(5) to (B)(7) of this rule shall be applied to the as filed cost of each eligible FQHC site prior to calculation of the percentile cost per encounter.

(b) The statewide urban sixtieth percentile cost per encounter is the sixtieth percentile of the values of all urban facilities receiving a grant under section 330 of the Public Health Service Act in accordance with paragraph (C) of rule 5101:3-28-08 of the Administrative Code. The statewide rural percentile cost per encounter is the sixtieth percentile of the values of all rural facilities receiving a grant under section 330 of the Public Health Service Act in accordance with paragraph (C) of rule 5101:3-28-08 of the Administrative Code.

(c) The urban wage adjustment factor is the adjustment factor for the FQHC's location obtained from the most recent Ohio wage index published in the Federal Register for the year in which the FQHC's rate is being established divided by the most recent Ohio rural wage index.

(d) The final ceilings on core and noncore service reimbursement for each rural facility is the statewide rural sixtieth percentile as set forth in paragraph (B)(7)(b) of this rule. The final ceilings on core and noncore service reimbursement for each urban facility is calculated by multiplying the statewide urban sixtieth percentile as set forth in paragraph (B)(7)(b) of this rule by the adjustment factor for the FQHC's wage adjustment factor described in paragraph (B)(7)(c) of this rule.

(e) The payment rate shall not exceed the higher of the medicare ceiling or wage adjusted ceilings for reimbursement rates as set forth in paragraph (B)(7)(d) of this rule.

(f) The final rate for the service that has changed in scope of service will be effective within sixty days of receipt of a complete and accurate cost report.

(C) Method two:

An FQHC also may request a review for a change in scope of service if none of the provisions in paragraph (A) of this rule apply.

(1) A change in scope of service may include but is not limited to the following:

(a) The addition of a service that has been mandated by a governmental entity such as the the centers for medicare and medicaid services (CMS) in federal statute, rules, or policies enacted or amended after January 1, 2002;

(b) The addition of an obstetrical-gynecological physician or nurse mid-wife or other advanced practice nurse with a certification in obstetrical-gynecological services to an FQHC site that did not previously offer obstetrical services;

(c) The addition of a dentist to a site that only offered dental hygienist's services previously. The site did not previously employ a licensed dentist and did not offer the full scope of dental services; or

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

(2) The following situations are not considered a change in scope of services:

(a) Wage increases;

(b) Negotiated union contracts;

(c) Renovations or other capital expenditures;

(d) The addition of a disease management program;

(e) An increase in the number of staff working in the clinic such as the addition of:

(i) A lower level staff member such a family nurse practitioner when a site employs a family physician;

(ii) A hygienist when a dentist is employed at the site;

(iii) A physical therapy assistant when the site employs a physical therapist; and

(iv) Social service staff;

(f) An increase in office space that is not directly associated with an approved change in scope of service, e.g., the addition of an obstetrical-gynecological physician;

(g) An increase in equipment or supplies that is not directly associated with an approved change in scope of service, e.g., the addition of an obstetrical-gynecological physician;

(h) An increase in patient volume; and

(i) An increase in office hours.

(3) An FQHC's request for a rate increase due to a change in scope of service will be granted at the sole discretion of the department. The calculated PPS rate for the service that changed in scope must increase by at least twice the MEI for that year before the department will grant the request for a change in scope of service.

(4) A rate review for a change in scope of service shall not increase a rate in excess of any rate limitations, ceilings, or tests of reasonableness set forth in division-level 5101:3 of the Administrative Code.

(5) A request for review of a change in scope of service must be filed no later than ninety days after the close of one year of operation of the service that has changed in scope.

(6) A rate adjustment due to a change in scope shall be granted only once for a particular circumstance for a particular FQHC.

(7) A request for rate review due to a change in scope of service must be filed in accordance with the following procedures:

(a) The request for review of a change in scope of service must be in writing.

(b) The request for a rate review must indicate that it is due to a change in scope of service.

(c) The request for a rate review must provide a detailed explanation and

evidence to prove why a rate adjustment is warranted. The FQHC should demonstrate that by providing either:

(i) A community needs assessment shows that population demographic changes warrant the change in scope of service; or

(ii) A business plan or other similar documentation indicates that the new service is warranted; and

(iii) Efforts were made to address the problem outside of the rate review process.

(d) If the request is due to a change in the intensity of services provided, the FQHC must provide evidence that the intensity of services has changed and that the increased costs are directly related to the change in intensity of service. This evidence might include a report showing that patients' diagnoses have changed the acuity of care or a report proving that the relative values of the services provided has changed.

(e) The FQHC must file two complete cost reports as specified in rule 5101:3-28-10 of the Administrative Code that include all schedules and attachments specified for the JFS 03421 cost report and documentation supporting the cost increase. The FQHC must specify in its written request exactly what cost centers in the cost report have been impacted by the increased costs for the service that has changed in scope and why they were impacted. Failure to file the cost reports within the time period described in paragraph (A)(3) of rule 5101:3-28-10 of the Administrative Code will mean that the department will not evaluate the request for consideration of a change in scope.

(8) The department shall respond in writing within sixty days of receiving each written request for a change in scope of service. If the department requests additional information to determine if the rate request is warranted, the department shall respond in writing within sixty days of receiving the additional information.

(9) If a request for a rate adjustment due to a change in scope of service is granted, the following provisions will apply:

(a) The department will review the FQHC's costs for the service that has changed in scope and will set a rate based on the reasonable cost parameters described in paragraphs (B)(4) to (B)(7) of this rule.

(b) The rate increase shall be the difference between the new rate calculated for the service that has changed in scope minus the rate previously calculated for the prior year for that category of service. The rate increase amount shall be added to the current year's PPS rate for that specific category of service for the FQHC.

(c) The rate described in paragraph (C)(9)(b) of this rule shall be inflated by the MEI in accordance with paragraph (C) of rule 5101:3-28-08 of the Administrative Code.

(d) The rate adjustment shall be effective on the first day of the first full month after the department has granted the request. Retroactive adjustments will not be made.

(D) The department's decision at the conclusion of the rate review process shall not be subject to any administrative proceedings under Chapter 119. of the Revised Code.

(E) An FQHC must notify the department in writing within ninety days of any permanent decrease in a scope of service.

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