PUBLIC HEARING NOTICE
OHIO DEPARTMENT OF MEDICAID

DATE: MAY 16, 2022
TIME: 10:00 A.M.
TELECONFERENCE DIAL-IN PHONE NUMBER: 1-614-721-2972
TELECONFERENCE PIN: 916211497
LINK TO MICROSOFT TEAMS MEETING FOR HEARING: Click here to join the meeting

Pursuant to Chapter 119. and section 5164.02 of the Ohio Revised Code, the Director of the Ohio Department of Medicaid (ODM) gives notice of ODM's intent to consider the adoption, amendment, or rescission of the rules identified below and to hold a public hearing thereon.

The following rules are proposed for rescission:

5160-28-01	Federally qualified health centers (FQHCs): eligibility and enrollment as a medicaid provider.
5160-28-02	Cost-based clinics: medicaid provider requirements and limitations.
5160-28-03.1	Cost-based clinics: FQHC services, co-payments, and limitations.
5160-28-03.2	Cost-based clinics: OHF services, co-payments, and limitations.
5160-28-03.3	Cost-based clinics: RHC services, co-payments, and limitations.
5160-28-04.1	Cost-based clinics: submission of an FQHC cost report.
5160-28-04.2	Cost-based clinics: submission of an OHF cost report
5160-28-04.3	Cost-based clinics: submission of an RHC cost report.
5160-28-05.1	Cost-based clinics: prospective payment system (PPS) method for determining FQHC payment.
5160-28-05.2	Cost-based clinics: prospective payment system (PPS) method for determining OHF payment
5160-28-05.3	Cost-based clinics: prospective payment system (PPS) method for determining RHC payment.
5160-28-06.1	Cost-based clinics: determination of a PVPA for an FQHC service on the basis of a medicaid cost report.
5160-28-06.2	Cost-based clinics: determination of a PVPA for an OHF service on the basis of a medicaid cost report.
5160-28-07.1	Cost-based clinics: alternate payment method (APM) for determining FQHC payment.
5160-28-08.1	Federally qualified health center (FQHC): alternate payment method (APM).
5160-28-08.3	Cost-based clinics: submission and payment of RHC claims.

These rules describe the Medicaid eligibility and enrollment requirements, Medicaid provider requirements and limitations, services, co-payments, cost report requirements, and payment methods for FQHCs, rural health clinics (RHCs), and outpatient health facilities (OHFs). As a result of five-year rule review and for better clarification, these rules are either being replaced with a new rule or consolidated into another rule. Specifically,

- 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 rescinded and consolidated into one new rule 5160-28-03.
- Existing rules 5160-28-04.1 and 5160-28-04.3 are being rescinded and consolidated into

one new rule 5160-28-04.
- Existing rules 5160-28-05.1 and 5160-28-05.3 are being rescinded and consolidated into one new rule 5160-28-05.
- Existing rules 5160-28-08.1 and 5160-28-08.3 are being rescinded and 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 being consolidated into one new rule 5160-28-13.

The following rules are proposed for adoption:

5160-28-01	Federally qualified health center (FQHC) and rural health clinic (RHC) services: definitions and explanations.
5160-28-02	FQHC and RHC services: conditions affecting medicaid provider participation.
5160-28-03	FQHC and RHC services: covered services, limitations, and copayments.
5160-28-04	FQHC and RHC services: submission of a cost report.
5160-28-05	FQHC and RHC services: prospective payment system (PPS) method for determining payment.
5160-28-6.1	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.
5160-28-7.1	FQHC and RHC services: alternate payment method (APM) for determining payment for government-operated FQHCs.
5160-28-13	Outpatient health facility (OHF) services.

These rules describe the Medicaid eligibility and enrollment requirements, Medicaid provider requirements and limitations, services, co-payments, cost report requirements, and payment methods for FQHCs, rural health clinics (RHC), and outpatient health facilities (OHF). They streamline and reorganize existing rules for better clarity.

Global changes to all rules include the following:
- Removal of regulatory restrictions pursuant to Am. Sub. H.B. 166, and recasting the passages in which they appear.
- Replacing the term 'cost-based clinic' with FQHC, RHC, and OHF.

Specific rule changes include the following:
- In new rule 5160-28-01, in the definitions of "federally qualified health center (FQHC)" and “rural health clinic (RHC)” an enumeration of qualifying criteria is being replaced with a single reference to the applicable definition in the United States Code (U.S.C.). The following definitions are being added for clarity: (1) site, (2) PPS payment (3) PPS service, (4) non-PPS service, (5) related off-site location, and (6) services and supplies furnished "incident to". Definitions of "clinical social worker", "homebound", "reasonable and allowable costs", and "urban cost-based clinic" are being removed from the rule because they are no longer used in this Chapter of the Administrative Code. "Managed care plan" is being updated to "managed care entity" which is the new terminology used in Chapter 5160-26 of the Administrative Code. The definition of Medicaid wraparound payment is no longer synonymous with "supplemental payment" and is being updated to further clarify the meaning. The definition of "visit" is being expanded.

- In new rule 5160-28-03, pharmacist services and dietitian services are being added to the list of covered medical services for which PPS payment may be made. RHC transportation services is added to the list of services for which an RHC may be paid under the PPS. A non-exhaustive list of covered non-PPS services, which specifies covered medically necessary services and supplies that may be claimed as non-PPS services, is being added.
- In new rule 5160-28-04 a statement is being added on the principles of reasonable cost reimbursement. The new rule 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. A paragraph was added clarifying that a government-operated FQHC that requests the alternate payment method must submit cost reports in accordance with rule 5160-28-07.1. A list of topics to help a provider write a request for a change in scope of services is also included.
- In new rule 5160-28-06.1, "ceiling" is being redefined because the schedules used to calculate the urban wage adjustment factor (UWAF) set forth in the existing rule no longer exist.
- In new rule 5160-28-07.1, the title of the rule is being changed to better describe the content of the rule.
- All OHF provisions are being moved into one new rule, 5160-28-13.

Pursuant to Section three of Sub. H.B. 51 (134th General Assembly), ODM will hold the public hearing for this rule package via teleconference. The phone number, PIN (access code), link for teleconference attendance, and the date and time for this hearing are listed at the top of this notice. All interested parties are invited to participate in the public hearing. Both oral and written testimony will be accepted for this hearing and will be given the same consideration. Persons who want to give oral testimony are asked to send a message by e-mail to Rules@medicaid.ohio.gov no later than one hour before the hearing to be added to the witness list. There will be a final call at the end of the hearing for persons who wish to offer oral testimony but do not yet appear on the witness list.

Written comments submitted by e-mail, postal mail, or fax that are received or postmarked no later than the day of the hearing will be accepted as testimony and will become part of the hearing record. All testimony will become public record; therefore, ODM asks that protected health information (PHI) be excluded unless the information belongs to the person submitting the testimony or to a person for which the submitter is a legal guardian. Written testimony sent by e-mail is highly recommended. All persons who submit testimony by e-mail will be sent a confirmation of receipt.

A copy of the proposed rules is available to any person, without charge, at the following locations:

Ohio Department of Medicaid, Office of Legal Counsel, 50 W. Town Street, Suite 400, Columbus, Ohio 43215-3414; or

On the internet at http://www.registerofohio.state.oh.us/.

Requests for a copy of the proposed rules or comments on the rules should be submitted in any of the following ways:

By mail to the Ohio Department of Medicaid, Office of Legal Counsel, 50 W. Town Street, Suite 400, Columbus, Ohio 43215-3414,

By fax at (614) 995-1301, or

By e-mail at Rules@Medicaid.Ohio.gov.

ODM is committed to providing access and inclusion and reasonable accommodation in its services, activities, programs, and employment opportunities in accordance with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act, and other applicable laws. To request an interpreter, written information in a language other than English or in other formats (large print, audio, accessible electronic formats, other formats), or a reasonable accommodation due to a disability, please contact ODM's Civil Rights/ADA Coordinator at 614-995-9981/TTY 711, Fax 1-614-644-1434, or Email: ODM_EEO_EmployeeRelations@medicaid.ohio.gov. Requests should be made no later than three (3) business days prior to the scheduled hearing. If you believe ODM has failed to provide these services or discriminated in another way, you can file a grievance with ODM's Civil Rights Coordinator and/or file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Further information on these processes and ODM's compliance with civil rights and other applicable laws can be found here: Notice of Nondiscrimination.