

- (2) A FINAL COST SETTLEMENT SHALL BE CALCULATED AFTER AN ONSITE AUDIT IS PERFORMED. FINAL SETTLEMENT PAYMENT RATES SHALL NOT EXCEED THE WAGE ADJUSTED CEILINGS ON REIMBURSEMENT RATES FOR CORE AND NONCORE SERVICES CALCULATED FOR INTERIM SETTLEMENT OF THE SAME PERIOD.
- (3) THE PROVIDER MAY APPEAL IMPOSITION OF A FINAL SETTLEMENT PURSUANT TO CHAPTER 119. OF THE REVISED CODE AND CHAPTER 5101:3-50 OF THE ADMINISTRATIVE CODE.
- (4) IF A FINAL SETTLEMENT RESULTS IN AN OVERPAYMENT TO THE PROVIDER, THE OVERPAYMENT AMOUNT SHALL BE REPAID WITHIN TEN DAYS AFTER THE FINAL SETTLEMENT IS ISSUED. ANY OVERPAYMENT NOT REPAID WITHIN TEN DAYS SHALL BE CERTIFIED TO THE STATE AUDITOR AND/OR ATTORNEY GENERAL FOR COLLECTION IN ACCORDANCE WITH THE PROVISIONS OF STATE LAW. IF A FINAL SETTLEMENT RESULTS IN AN UNDERPAYMENT TO THE PROVIDER, UPON ADJUDICATION OF THE FINAL SETTLEMENT, ODHS SHALL PAY TO THE PROVIDER THE UNDERPAID AMOUNT IN A TIMELY MANNER.
- (5) AUDITS WILL BE CONDUCTED BY ODHS OR ITS DESIGNEE FOR SERVICES RENDERED BY FOHCS PARTICIPATING IN TITLE XIX. THESE AUDITS ARE MADE PURSUANT TO FEDERAL REGULATORY LAW AND ARE EMPOWERED TO ODHS THROUGH DIVISION (A) (5) OF SECTION 5111.02 OF THE REVISED CODE. THE EXAMINATION OF FOHC COSTS WILL BE MADE IN ACCORDANCE WITH GENERALLY ACCEPTED AUDITING STANDARDS NECESSARY TO FULFILL THE SCOPE OF THE AUDIT. TO FACILITATE THIS EXAMINATION, PROVIDERS ARE REQUIRED TO MAKE AVAILABLE ALL RECORDS NECESSARY TO FULLY DISCLOSE THE EXTENT OF SERVICES PROVIDED TO PROGRAM RECIPIENTS. THE PRINCIPAL OBJECTIVE OF THE AUDIT IS TO ENABLE ODHS OR ITS DESIGNEE TO DETERMINE THAT PAYMENTS WHICH HAVE BEEN MADE, OR WILL BE MADE, ARE IN ACCORDANCE WITH FEDERAL, STATE, AND ODHS REQUIREMENTS. BASED ON THE AUDIT, ADJUSTMENTS WILL BE MADE AS REQUIRED. RECORDS NECESSARY TO FULLY DISCLOSE THE EXTENT OF SERVICES PROVIDED AND COSTS ASSOCIATED WITH THOSE SERVICES MUST BE MAINTAINED FOR A PERIOD OF SIX YEARS (OR UNTIL THE AUDIT IS COMPLETED AND EVERY EXCEPTION IS RESOLVED).

RECORDS MUST BE MADE AVAILABLE, UPON REQUEST, TO ODHS OR ITS DESIGNEE AND THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR AUDIT PURPOSES. PAYMENT FOR COVERED SERVICES WILL BE SUSPENDED IF AN FOHC DOES NOT COOPERATE IN THE AUDIT PROCESS.

INS# 90-24
SUPERSEDES
INS# NEW

APPROVAL DATE

12/6/91

PREPARED BY

1/1/91

(6) THERE ARE BASICALLY TWO TYPES OF AUDITS.

- (a) THE FIRST IS A DESK AUDIT OF COST REPORTS FILED EACH YEAR TO ENSURE THAT NO MATHEMATICAL ERROR OCCURS AND TO IDENTIFY CATEGORIES OF REPORTED COSTS WHICH, BECAUSE OF THEIR EXCEPTIONAL NATURE, BEAR FURTHER CONTACT WITH THE FOHC FOR CLARIFICATION AND/OR AMPLIFICATION. THE COST REPORT AS SET FORTH IN APPENDIX A OF THIS RULE WILL BE USED TO ESTABLISH INTERIM RATES AND CALCULATE INTERIM SETTLEMENTS.
- (b) THE SECOND IS A FIELD AUDIT. FIELD AUDITS ARE PERFORMED ON-SITE OR WHERE THE NECESSARY DISCLOSURE INFORMATION IS MAINTAINED TO ASSURE THE FOHC HAS COMPLIED WITH THE PRINCIPLES SET FORTH IN PARAGRAPH (D) OF THIS RULE AND PROGRAM REGULATIONS.

SUMMARY REPORTS FOR ALL ON-SITE AUDITS SHALL BE MAINTAINED FOR PUBLIC REVIEW IN THE OHIO DEPARTMENT OF HUMAN SERVICES FOR A PERIOD OF ONE YEAR. THE DEPTH OF EACH ON-SITE AUDIT MAY VARY DEPENDING UPON THE FINDINGS OF COMPUTERIZED RISK ANALYSIS PROFILES DEVELOPED BY THE DEPARTMENT TAKING INTO CONSIDERATION SUCH FACTORS AS COST CATEGORY SCREENS (COST CATEGORIES ABOVE MEDIAN), LOCATION, LEVEL OF SERVICES PROVIDED MEDICAID RECIPIENTS, OCCASIONS OR FREQUENCY OF SERVICES, AND MULTI-SHARED COSTS. THE DEPTH OF EACH ON-SITE AUDIT SHALL BE AT LEAST SUFFICIENTLY COMPREHENSIVE IN SCOPE TO ASCERTAIN, IN ALL MATERIAL RESPECTS, WHETHER THE COSTS AS REPORTED AND SUBMITTED BY THE FOHC ARE TRUE, CORRECT, AND REPRESENTATIVE TO THE BEST OF THE FACILITY'S ABILITY. FAILURE TO RETAIN OR PROVIDE THE REQUIRED FINANCIAL AND STATISTICAL RECORDS RENDERS THE FOHC LIABLE FOR MONETARY DAMAGES EQUAL TO THE DIFFERENCE BETWEEN:

- (i) ESTABLISHED CATEGORICAL UNIT RATES PAID TO THE PROVIDER FOR THE YEAR IN QUESTION; AND
- (ii) THE LOWEST CATEGORICAL UNIT RATES FOR CORE AND NONCORE SERVICES PAID IN THE STATE OF OHIO TO AN FOHC.

TNS # 9024
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91

(J) NEW SITES AND/OR TYPES OF SERVICES.

- (1) EACH NEW SITE OR NEW TYPE OF SERVICE WILL BE EXEMPT FOR ONE YEAR FROM THE EFFICIENCY CRITERIA FOR SERVICES SET FORTH IN PARAGRAPHS (F)(1) TO (F)(8) OF THIS RULE. THE EXEMPTION FROM EFFICIENCY CRITERIA SHALL BE A ONE TIME EXEMPTION. A NEW SITE SHALL BE ENTITLED TO A ONE YEAR EXEMPTION FOR EACH REIMBURSABLE SERVICE. A SITE WHICH PROVIDES A NEW TYPE OF SERVICE SHALL BE ENTITLED TO A ONE YEAR EXEMPTION FOR THE NEW SERVICE.
- (2) REIMBURSEMENT FOR TYPES OF SERVICES WILL NOT EXCEED MEDICARE'S PAYMENT MAXIMUM AS SET FORTH IN PARAGRAPHS (H)(1) AND (H)(2) OF THIS RULE UNLESS THE EXEMPTION SET FORTH IN PARAGRAPHS (E)(1) TO (E)(3) OF THIS RULE CAUSES A REIMBURSEMENT TO EXCEED THE MEDICARE PAYMENT MAXIMUM.
- (3) A "NEW SITE" IS A SITE THAT PREVIOUSLY HAS NOT PROVIDED HEALTH CARE SERVICES. A "NEW TYPE OF SERVICE" IS A TYPE OF SERVICE THAT HAS NOT BEEN PREVIOUSLY PROVIDED AT A SITE.

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91

OUTPATIENT CLINIC

COST REPORT INSTRUCTIONS

The information necessary for the completion of the Outpatient Clinic cost report has been separated into three (3) distinct parts:

- Part I - Introduction
- Part II - Terms and Definitions
- Part III - Instructions For The Completion Of The Outpatient Clinic Cost Report

PART I: INTRODUCTION

This cost report will be used by Outpatient Clinics participating in either the Medicaid-covered Outpatient Health Facility program (OHF) or the Ohio Federally Qualified Health Center program (FQHC).

The current Outpatient Health Facility program was implemented from Am. Sub. H.B. 291, which recognized Outpatient Health facilities as a separate category of medical care providers under the rules governing the administration of the Medicaid program.

The FQHC program was developed in response to Section 6404 of the Omnibus Budget Reconciliation Act (OBRA) 1989. OBRA 89 mandated state Medicaid programs pay 100% of reasonable costs to clinics which receive Public Health Service Grants 329, 330 or 340 monies and "Look Alike" clinics which are those clinics which would be eligible to receive those monies if funding were available.

To assure each provider's total costs are accurately and properly reported, a more detailed cost report was developed. The new cost report includes many new schedules and workpapers to aid the provider in reporting the clinic's total costs. Reimbursement rates will be developed from the cost report for the following clinical care centers:

- 1) Medical Services
- 2) Laboratory
- 3) Radiology
- 4) Dental Services
- 5) Speech Therapy Services

CRINFQHC/10-9

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91

- 6) Mental Health Services
- 7) Transportation
- 8) Vision Care Services
- 9) Podiatry
- 10) Chiropractic

OHF's will receive a rate for each type of service. FQHC's will receive a core services rate for Medical, Lab and Radiology; a core services rate for Clinical Social Worker and Psychology (Mental Health Services); and non-core services rates for each other covered service as described above.

PART II: DEFINITIONS

Accrual Basis of Accounting - Revenue is recorded in the period earned regardless of when it is received, and expenses are recorded in the period they are incurred regardless of when they are paid (Provider Reimbursement Manual, HCFA 15-1, Section 2302.1). All providers except governmental institutions must complete the cost report using the Accrual Basis of Accounting.

Administrative Time - Time spent not providing Direct Patient Care. Administrative time includes but is not limited to any paid time in which a medical professional is attending classes, seminars, or meetings. A portion of the Medical Directors time spent on evaluations, management reports and physician recruitment must also be included. Do not include paid time off, i.e., vacations or paid sick leave.

Cash Basis of Accounting - Revenues are recognized when received, and expenses are recognized when paid (HCFA 15-1, Section 2302.2). The cash basis of accounting can only be used by governmental institutions.

Chiropractic Encounter - a face-to-face contact between a Chiropractor and a patient for the provision of covered "Chiropractic Services".

Contracted Personnel Compensation (services under arrangement) - Compensation paid to personnel under contract with the clinics to provide services. The contract usually shows either an hourly amount or a total dollar amount that is paid by the clinic under the contract. The person receiving the compensation is usually responsible for their own taxes and is not an employee of the clinic. A form 1099 is issued to reflect total yearly compensation paid by the clinic to the contracted personnel.

Dental Encounter - A face-to-face contact between a Dentist or Dental Hygienist, or Oral Therapist under the supervision of a Dentist and a patient for provision of "covered dental services".

Depreciable Assets - According to the Provider Reimbursement Manual, HCFA 15-1, Section 108.1, a depreciable asset is defined as having an estimated useful life of at least two (2) years and a historical cost of at least \$500.

CRINFQHC/10-9

REVISED 90-24
BY: [Signature]
DATE: NEW

APPROVAL DATE 12/1/91
EFFECTIVE DATE 1/1/91

PART II: DEFINITIONS (Continued)

Direct Care Time - The time a medical professional spends in face-to-face encounter with a clinic patient. This also includes any time spent updating medical records. This category of time will be used in the Test of Reasonableness Rate calculations.

Donated Services - To qualify as an allowable, reimbursable cost according to the Provider Reimbursement Manual, HCFA 15-1, Section 700, all of the following conditions must be met: 1) The non-paid worker must work more than twenty (20) hours per week in various types of full-time positions that are normally occupied by paid personnel. 2) The value of the services performed must be recorded as an operating expense and must be identifiable in the records of the clinic as a legal obligation and 3) The services are rendered without direct remuneration (salaries, wages, or gifts) to the non-paid workers by either organization.

Home Office Costs - Costs incurred by the Home Office first must be allowable according to Medicare/Medicaid Regulations (HCFA-Pub. 15-1, Provider Reimbursement Manual). Once the non-allowable costs have been removed the process of allocating the Home Office Costs should begin. There are three (3) steps for the accurate allocation of costs:

- 1) Directly allocable costs - Costs incurred for the benefit of, or costs which are directly attributable to a specific provider or non-provider activity must be allocated directly to where they are incurred. Costs of this type would include mortgage interest paid by the Home Office for a particular entity. These costs should be reported in the appropriate cost center of the applicable clinic.
- 2) Costs allocable on a functional basis - Such costs should be assigned to the appropriate clinic's applicable cost report cost center based upon an independent statistic. Such costs might include, but are not limited to, central purchasing costs allocated by number of requisitions, or central payroll costs distributed by payroll checks issued.
- 3) The remaining costs are considered pooled costs. HCFA recommends these costs be allocated by number of encounters. For providers with both core, non-core, and non-reimbursable direct care areas the total number of encounters should be used. Allocated pooled costs should be reported on Schedule B-1 as an "Other" Administrative cost.

The methodology and the statistics used must be documented and submitted when filing the Outpatient Clinic Cost Report, along with any work papers developed to assign and allocate Home Office Cost. Any desired changes in the methodology and/or statistics used in subsequent cost report periods must be

CRINFQHC/10-9
TNS # 90-24
SUPERSEDED
TNS # NEW
APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91

PART II: DEFINITIONS (Continued)

Home Office Costs - (Continued)

submitted in writing for Department review and approval. For further detail concerning Home Office Cost allocation, please consult Section 2150 - 2153 in Chapter 2100 of HCFA-Pub. 15-1, Provider Reimbursement Manual.

Hours of Operation - The total amount of hours the clinic is open to provide direct care services to patients.

Laboratory Unit-of-Service (OHF Program Only) - Under the OHF program, laboratory services will be reported, billed and paid on a unit of service basis. Each individual laboratory procedure or battery of procedures represents one unit-of-service.

Medical Encounter - A face-to-face encounter between a medical professional and a clinic patient for the provision of covered "medical service".

Under the FQHC program the medical professional can be any one of the following: Physician, Physician's Assistant, Nurse Practitioner, Nurse Midwife or Registered Nurse.

Under the OHF program, the medical professional can be any one of the following: Physician, Physicians Assistant, Nurse Practitioner, Nurse Midwife, Registered Nurse or Licensed Practical Nurse.

Mental Health Encounter - A face-to-face encounter between a licensed Psychologist or clinical Social Worker for the provision of covered "clinical social work or psychology services".

Non-Reimbursable Costs - Expenses for items and services paid for by another governmental entity, e.g., WIC and Sickle Cell, or costs of services not covered under the FQHC or Outpatient Health Facility program, e.g., Pharmacy.

Podiatry Encounter - A face-to-face encounter between a podiatrist, or a physician assistant or nurse practitioner working under the direction of a Podiatrist, for covered "podiatric services".

Physical Therapy Encounter - A face-to-face encounter between a Physician, Physical Therapist, or a Mechanotherapist and a patient for receipt of a covered "physical therapy service".

Radiology Unit-of-Service (OHF Program Only) - Under the OHF program, an individual radiology procedure covered under Medicaid, reported, billed and paid on a unit-of-service basis.

Speech and Hearing Encounter - A face-to-face encounter between an Audiologist or Speech Pathologist and a patient for the provision of "covered speech and hearing services".

CRINFQHC/10-9

TNS # 90-24
SUPERSEDED
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91

PART II: DEFINITIONS Cont'd.

Time Studies - Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria as per the Provider Reimbursement Manual, HCFA 15-1, Section 2313.2 (E).

1. The time records to be maintained must be specified in a written plan, subject to review by ODHS.
2. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.
3. Each week selected must be a full work week (Monday to Friday, Monday to Saturday or Sunday to Saturday).
4. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a twelve (12) month period, three (3) of the twelve (12) weeks in the study must be the first week beginning in the month, three (3) weeks the 2nd week beginning in the month, three (3) weeks the 3rd and three (3) weeks the fourth.
5. No two (2) consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.
6. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.
7. The time study must be provider specific. Thus, chain organizations may not use a time study from one site to allocate the costs of another site or a time study of a sample group of sites to allocate the costs of all sites within the chain.

Transportation Unit-of-Service - An instance of one-way transportation of a patient to or from the clinic. Transportation must be provided on the same date as another billable encounter and shall be limited to one unit of transportation for each instance of one-way transportation of family members, patients or other patient residing at the same address.

Wages - Compensation to clinic employees for services provided, in which applicable federal, state and local taxes are deducted from gross wages. The clinic employee receives a W-2 statement at year end.

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91

EFFECTIVE DATE 1/1/91

PART III: INSTRUCTIONS FOR THE COMPLETION OF THE OUTPATIENT CLINIC COST REPORT

The various schedules and workpapers for the Outpatient Clinic cost report are an integral part of the calculation of reimbursable costs and must be completed by all clinics. When correctly completed, the clinic's total costs should be reflected on the cost report.

To assist with completion of the Outpatient Clinic Cost Report, an outline of the main sections with accompanying subsections are shown below:

SECTION I	Schedule A	(Summary-Statistics & Gen. Info.)
	Schedule A-1	(Workpaper)
	Schedule A-2	(Workpaper)
SECTION II	Schedule B	(Summary & Expenses)
	Schedule B-1	(Workpapers-Expense Trial Balance)
SECTION III	Schedule C	(Depreciation)
SECTION IV	Schedule D	(Summary-Salaried Personnel)
	Worksheet D	(Workpapers)
	Schedule D-1	(Summary-Contract Personnel)
	Worksheet D-1	(Workpapers)
SECTION V	Schedule E	(Workpaper-Other Non-Reimbursable)
	Schedule E-1	(Summary-Other Non-Reimbursable Occurrences)
SECTION VI	Schedule F	(Related Organizations)
SECTION VII	Schedule G	(Revenue Trial Balance)
LAST PAGE	Statement of Certification	

The facility name, Medicaid provider number, and cost reporting period must appear as indicated on the top of each page. This information will specifically identify each page and prevent lost pages should the cost report become separated.

To assure that all areas of the cost report has been completed, follow instructions for each section. Improperly filed cost reports may result in a delay in the issuance of new rates, rates which are higher/lower than they should be resulting in over/under payments, and/or penalties. The cost of non-reimbursable programs must be included where indicated.

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91

The Outpatient Clinic cost report should be completed in the following order:

<u>SCHEDULE</u>	<u>PART III SECTION REFERENCE</u>
1) A-1	Section I
2) A-2	Section I
3) A	Section I
4) C	Section III
5) D-1	Section IV
6) D	Section IV
7) E	Section V
8) E-1	Section V
9) B-1	Section II
10) B	Section II
11) F	Section VI
12) G	Section VII
13) Certification Page	Section VIII

PART III, SECTION I, SCHEDULES A, A-1, AND A-2

The first two (2) segments of Schedule A asks for general provider information. The statistical data area of Schedule A is a summary of Schedule A-1. Schedule A-1 is a workpaper, and therefore must be completed first. Schedule A-2 is the report for square footage and medical record hours.

STEP 1, SCHEDULE A-1, ENCOUNTERS

Start by first completing Schedule A-1, which is the request for the number of Medicaid encounters. Record facility name, provider number, and cost report period. Next, insert the number of Medicaid encounters and Total encounters for each type of Direct Care service performed, on a monthly basis in the applicable columns marked M for Medicaid and T for Total. Total each column and carry forward these totals to Schedule A, Statistical Data.

Encounters are the statistics used to determine the clinic's reimbursement rate and percentage of medicaid utilization. A brief description of each type of Direct Care encounter has been given in Part II of the Cost Report Instructions.

STEP 2, SCHEDULE A

Complete all blanks on Schedule A down to statistical data, with general information requested. With the completion of Schedule A-1, enough data is available to complete the statistical data section.

Begin completing Schedule A's Statistical Data by reporting the hours of operation for each applicable Direct Care Center (Column 1). Next, bring forward encounters totals from Schedule A-1 (Columns 2 and 3). Finish completing Schedule A by dividing total Medicaid encounters (Column 2) by total facility encounters (Column 3) for each applicable Direct Care Cost Center. The result is Medicaid Utilization (Column 4).

CRINFOHC/10-9

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91