

9. Clinic Services (Continued)

- d. Tests of reasonableness include those identified in paragraphs (4) to (8).
  - e. The department reserves the right to establish other tests of reasonableness which may be necessary to assure effective and efficient program administration.
5. The ceiling for costs reported on the cost report will be the median plus one standard deviation of the percentage relationship of administrative and general costs to total costs as reported by outpatient hospital departments participating in the Medicaid program in areas of the state where participating OHFs are located.
  6. For each of the services identified in paragraph (1)(a) otherwise allowable costs allocated for items, will be adjusted in instances when hours of operation of the service component are less than 30 per week on an annualized basis. Any adjustment would be computed based on application of the ratio of actual hours of operation of the service component to a base of 30 hours per week on an annualized basis, not to exceed 100 percent.
  7. Costs recognized for rate setting purposes will be adjusted based on minimum required efficiency standards calculated as encounters per hour. Prospective rates established for any of the following service components will not exceed the lower of either the reported allowable cost divided by the product of hours worked by a professional and the encounters per hour as shown below:
    - a. medical services--2.97 encounters per hour
    - b. dental services--1.85 encounters per hour
    - c. mental health services--.8 encounters per hour
    - d. vision care services--2.3 encounters per hour
    - e. speech and hearing services--1.8 encounters per hour
    - f. physical medicine services--2.0 encounters per hour
  8. When the number of participating OHFs is 25 or greater, the test of reasonableness prescribed in this paragraph will replace the tests of reasonableness provided in paragraphs (5) and (6). For each of the services identified in paragraph (1)(a), the median plus one standard deviation weighted by a reasonable utilization factor will be determined from all cost reports filed by participating OHFs. The rate assigned to each OHF for each service component will be the lesser of the OHF's otherwise allowable costs or the weighted median plus one standard deviation for similar services.

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- 9. An OHF's unit rates are calculated from historical cost information as reported in cost reports filed by each participating clinic for a prior cost-reporting period. Allowable and reasonable costs determined will be updated by an inflation factor as described in this paragraph. For allowable costs recognized in the cost report year, an inflationary factor will be added for various categories of cost equal to the total of the actual inflationary factor between the midpoint of the cost report year and the midpoint of the following year as established by the Department of Labor Statistics and an estimated inflationary factor from the midpoint of the preceding year to the midpoint of the year for which the prospective rate is calculated based upon the preceding 12-month average. For each calendar year for each of the following categories of costs, an inflationary factor will be computed from the U.S. Department of Labor's "Monthly Labor Review" (unless otherwise specified):
  - a. Personal (e.g., nurses, administration, legal, accounting, management, data services, employee fringe benefits, medical records, operation and maintenance services, housekeeping, and laundry).
  - b. Medical supplies subject to cost-related reimbursement and expenses.
  - c. Nondurable goods (e.g., office supplies and printing).
  - d. Fuel and utilities.
  - e. Transportation services.
  - f. Medical and rehabilitation professional personnel.
  - g. Insurance.
  - h. Real estate taxes.
  
- 10. As a condition for participation in the Title XIX program, all OHFs must submit cost reports.
  - a. Annual cost reports must be filed, except for the initial program year as provided in paragraph (2), by April 1st of each year for the period beginning January 1st and ending December 31 of the preceding calendar year.

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9. Clinic Services (Continued)

- b. Failure to file an annual cost report by April 1st of each year will result in termination of the OHF's provider agreement, with such termination to be effective within 30 days unless a complete and adequate cost report is submitted by the OHF within that 30-day period.
- c. If an incomplete or inadequate cost report is received prior to April 1st, the department will notify the OHF that information is lacking. A corrected cost report is to be submitted within 45 days of notification of inadequacy. Any resubmission of an inadequate cost report within the 45-day period or any failure to resubmit within 45 days indicates a lack of good-faith effort and will result in immediate termination.
- d. The accrual method of accounting shall be used for all cost reports filed except that government institutions operating on a cash method may file on the cash method of accounting. The "accrual method of accounting" means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. The "cash method" of accounting means that revenues are recognized only when cash is received, and expenditures for expenses and asset items are not recorded until cash is disbursed for them.
- e. OHFs are required to identify all related organizations; i.e., related to the OHF by common ownership or control. The cost claimed on the cost reports 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.

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9. Clinic Services (Continued)

- 11. The prospective rates for services established for an OHF are not subject to subsequent adjustments except in instances of rate adjustments specified in paragraphs (1) and (3). The difference between the cost reported by a clinic in a cost report used for calculating the various prospective rates and those costs established by a field or on-site audit are subject to recovery in full by means of a retroactive rate adjustment of the prospective rates. Audit exceptions will apply to the various rates established for the prospective year upon which the cost report is based. If the errors in the cost report increase the various unit rates which otherwise would have been paid. All overpayments found in on-site audits not repaid within 30 days after the audit is finalized shall be certified to the state auditor and/or attorney general for collection in accordance with the provisions of state law.

Audits will be conducted by ODPW for services rendered by OHFs participating in Title XIX (Medicaid). These audits are made pursuant to federal regulatory law and are empowered to ODPW through section 5101.37 of the Revised Code. The examination of OHF 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 ODPW or its designee to determine that payments which have been made, or will be made, are in accordance with federal, state, and agency requirements. Based on the audit, adjustments will be made as required. Records necessary to fully disclose the extent services provided and costs associated with those services must be maintained for a period of three years (or until the audit is completed and every exception is resolved). These records must be made available, upon request, to ODPW and the U.S. Department of Health and Human Services for audit purposes. No payment for outstanding unit rates can be made if a request for audit is refused.

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9. Clinic Services (Continued)

There are basically two types of audits.

- a. The first is a desk audit of cost reports filed each year and subsequent calendar quarterly reports to ensure that no mathematical error occurs, that the cost calculations are consistent with the rate-setting formula as established by the department, and to identify categories of reported costs which, because of their exceptional nature, bear further contact with the OHF for clarification/amplification.
- b. The second is a field audit. These are performed on-site or where the necessary disclosure information is maintained to assure the OHF has complied with both cost principles and program regulations.

Cost reports shall be retained for at least three years. Summary reports for all on-site audits shall be maintained for public review in the Ohio Department of Public Welfare 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 OHF 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 OHF liable for monetary damages equal to the difference between:

- (i) established categorical unit rates paid to the provider for the prospective year in question and;
- (ii) the lowest categorical unit rates for like services paid in the state of Ohio to an OHF similar in structure.

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9. Clinic Services (Continued)

12. Based on the filing of calendar quarterly utilization evaluation reports, adjustments will be made in the rates. Quarterly reports for utilization evaluation must be filed within 30 days of calendar quarter end. This filing will result in a utilization adjustment of rates, if variances in utilization would result in a five percent or greater increase or decrease in the prospective rate, with 60 days of due date. The approved rates will be adjusted to reflect the four most current calendar quarters of reported utilization. During the initial four quarters of participation of an OHF, the utilization factors will be adjusted by substituting the reporting quarterly utilization for the average quarterly utilization factors report. Failure to file the quarterly utilization evaluation report (see paragraph (6)) will result in suspension of payment for eligible services rendered until such time as the quarterly report is received, evaluated, and adjusted by the Division of Fiscal Affairs. The OHF will then be notified of any adjustment and any new rates applicable. If the quarterly utilization evaluation report is not received within 60 days after suspension, termination will be recommended.

c. Ambulatory Surgery Centers

Payment for the facility services furnished by ambulatory surgery centers will be in accordance with Medicare regulations and instructions issued pursuant thereto, except that no regional wage adjustments will be made.

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10. Dental Services

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

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11. Physical Therapy and Related Services

a. Physical Therapy

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

b. Occupational Therapy

Covered only as a home health agency or hospital service. See items (1), (2), and (7) for reimbursement provisions.

OCCUPATIONAL THERAPY FOR RESIDENTS OF INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED IS INCLUDED IN THE PER DIEM. FOR RESIDENTS OF NURSING FACILITIES, OCCUPATIONAL THERAPY IS BILLED ON A FEE-FOR-SERVICE BASIS AND REIMBURSED THE LESSER OF BILLED CHARGES OR THE MEDICAID MAXIMUM FEE.

c. Speech, Hearing, and Language Disorders

Covered only as a hospital, home health agency, or clinic service. See items (1), (2), (7), and (9) for reimbursement provisions.

OCCUPATIONAL THERAPY FOR RESIDENTS OF INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED IS INCLUDED IN THE PER DIEM. FOR RESIDENTS OF NURSING FACILITIES, OCCUPATIONAL THERAPY IS BILLED ON A FEE-FOR-SERVICE BASIS AND REIMBURSED THE LESSER OF BILLED CHARGES OR THE MEDICAID MAXIMUM FEE.

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12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

a. Prescribed Drugs

Reimbursement for drugs will be made based on the various categories as specified below.

No supplemental allowance will be authorized for broken-lot charges, prescription delivery charges or state and local sales tax..

Billings must be submitted on the basis of the pharmacist's reasonable and customary charge, that is, a charge which does not exceed the average prescription price paid by the general public for similar services, including billing charges, family prescription profiles, delivery charges, and other pharmaceutical services.

Reimbursement for drugs is based on the lowest of the submitted charge or the Estimated Acquisition Cost (EAC) plus the dispensing fee.

Estimated Acquisition Cost is determined in the following manner:

- . For federally designated multiple source drugs, the department will pay no more, in the aggregate, than the federally established ceilings.
- . For other drugs reimbursement will be:

The 65th percentile cost of generics and trade name drugs for those generics listed to the exclusion of the trade name drug equivalents; or

The 65th percentile cost of the generics only for those generics listed in addition to the supplement of the trade name drug equivalents; or

Average wholesale price (AWP) less seven percent for those drugs which, in the department's opinion, are typically purchased from wholesalers; or

Direct price for those drugs which, in the department's opinion, can be readily obtained directly from the manufacturer; or

AWP for those schedule two drugs which, in the department's opinion, are typically purchased at prices which approximate AWP.

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12. Continued

b. Dentures

The payment is based on the lesser of the billed charge or the Medicaid maximum for a particular service performed according to the department's payment schedule.

c. Prosthetic Services

The payment is based on the lesser of the billed charge or the Medicaid maximum for a particular service performed according to the department's medical supply formulary.

d. Eyeglasses

The payment is based on the lesser of the billed charge or the Medicaid maximum for a particular service performed according to the department's payment schedule.

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13-d. Diagnostic, Screening, Preventive, and Rehabilitative Services Other Than Those Described Elsewhere In This Plan

A. Community Mental Health Services Provided By Community Mental Health Facilities

General Provisions: Payment for covered services in a community mental health AGENCY is calculated on a prospective reasonable cost related basis for each state fiscal year. Prospective costs recognized for covered services provided during a particular state fiscal year are the costs which are reported in the community mental health AGENCY'S approved annual budget plan submitted to the Ohio Department of Mental Health and in accordance with the Ohio Department of Mental Health's prescribed methodology. The unit rate for each covered service is calculated on the community mental health facility's projected cost of allowable items, and thus may vary from clinic to clinic. Prospective rates refer to predetermined cost-related rates calculated for each community mental health AGENCY from that AGENCY'S approved budget plan. The rates thus established are subject to subsequent reconciliation and cost settlement based upon the facility's reported actual costs at the end of each state fiscal year for any overpayment made for that reporting period. There will be no adjustments made to compensate for underpayments during that reporting period.

Cost Reports: As a condition of participation in the Title XIX program, all community mental health AGENCIES must submit cost reports at least annually for the period beginning July 1st and ending June 30th of each state fiscal year. Any community mental health AGENCY failing to file a cost report within 180 days after the close of a state fiscal year shall have their provider status terminated. When an incomplete or inadequate cost report is submitted within the prescribed time period, the provider will be notified that information is lacking. Lacking information is due within 45 days after notification of inadequacy.

Allowable and Reasonable Costs: Costs which are reasonable and allowable to patient care are those COSTS WHICH ARE IN ACCORDANCE WITH TITLE 42 PART 413 OF THE CFR except:

1. Cost related to client treatment and services that are not covered in community mental health program as described in Attachment 3.1-A, item 13(d) are not allowable.
2. THE UNALLOWABLE COSTS CONTAINED IN THE OFFICE OF MANAGEMENT AND BUDGET CIRCULAR A-87 MUST BE EXCLUDED FROM THE REIMBURSEMENT RATES.

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