Medicaid Cost Reporting Guidelines for Opioid Treatment Services

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Connecticut Department of Social Services

2015

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I. CONTACT INFORMATION

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II. COST REPORT SUBMISSION AND REVIEW TIMELINES

Item	**Due**
Cost Report	July 31, 2015 Subsequent submissions will be required annually and are due Six (6) months from provider's fiscal year end
Additional Documentation	Thirty (30) days from date of request

Cost reports are submitted to:

Department of Social Services
Attn: Office of Reimbursement and CON
55 Farmington Avenue
Hartford, CT 06105

Additional required information may be submitted by email: con-ratesetting.dss@ct.gov

Upon receipt of the cost report, a preliminary review will be performed to determine if all required documentation has been submitted. If the cost report is incomplete, or if required documentation has not been submitted, the cost report will be returned to the provider. A delinquent letter will be issued for cost reports not received within the specified time requirements.

Providers may have multiple locations. Costs may vary from location to location, please treat each clinic as unique and complete a separate cost report for each clinic service location.

III. COST REPORT & ACCOMPANYING INFORMATION

Cost reports and accompanying information submitted to the Connecticut Department of Social Services (DSS) should be complete and accurately represent the provider's expenses for the cost reporting period. Providers receiving payment on the basis of reimbursable cost must provide adequate data based on financial and statistical records which can be verified. Item 22 of Connecticut Department of Social Services Health Care Financing Provider Enrollment Agreement addresses making records and information available to DSS.

The following items should be submitted to DSS at the address provided in Section II of this manual:

- Two (2) hard copies of the cost report (Connecticut DSS version) signed by the facility administrator or appropriate personnel.

- If the provider completes the Connecticut Department of Mental Health & Addiction Services (DHMAS) Annual Financial Report (AFR), please include 'Schedule A' with this submission package.

IV. DESK REVIEW

A desk review will be performed on each cost report. Based on the initial review of the cost report and the supporting schedules, a determination will be made regarding whether additional information is required. An information request letter will be submitted to the provider indicating the additional information required to complete the desk review. The provider will have thirty (30) days to respond to the request.

This request list will include any information deemed necessary to accomplish full financial disclosure of the provider's operation.

V. COST REPORT INSTRUCTIONS

Please Note: On any schedule, if there are not enough lines to enter all required information, a blank line or Other -Specify line may be given a description of 'See attached' and a summary total entered. A schedule containing the details of the summary total must be attached to the cost report and clearly labeled.

COST REPORT PAGE 1 – FACILITY INFO AND CERTIFICATION

Line 1: **NAME AND ADDRESS**: Enter here the full legal name, address, and telephone number of the primary service location. In addition, please provide the name and title of the contact person at the primary service location.

Line 2: **MEDICAID PROVIDER NUMBER**: Enter the Medicaid identification number for each provider specialty, i.e., medical, dental, mental health, etc. If you are providing multiple types of services, it is necessary that an application is submitted to provide those services in order to receive the number that corresponds to those services.

Line 3: **REPORTING PERIOD**: Enter the dates covered by this report. A reporting period is a period of 12 consecutive months used for other reporting purposes (tax year, grant reporting, etc.). The first and last reporting period may be less than 12 months.

Line 4: **TYPE OF CONTROL**: Indicate the type of entity.

Line 5: **OWNED BY**: Enter the name of the organization(s) or individual(s) who are the legal owner(s) of the site, or state if the clinic is controlled by a non-profit organization.

Line 6: **CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC**: This certification must be prepared and signed after the cost report has been completed in its entirety. The individual signing must be an officer or other authorized responsible person. The cost report will be considered incomplete and returned to the facility if left unsigned.

COST REPORT PAGE 2 – SERVICE SITES AND RELATED PARTIES

Line 7: **SERVICE SITES:** List individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility. Additionally, list all service sites, including all opioid clinic sites and any non-opioid treatment service sites. Indicate whether the service site is opioid treatment certified. If a site or sites are not certified for opioid treatment, the associated costs should be reported on Form A-4 as non-allowable costs.

Line 8: **RELATED PARTIES:** Select the appropriate option from the drop-down menu to denote one of the following:

A. A separate statement of costs of services from related organizations accompanies this cost report submission.
B. Schedule A from the Department of Mental Health & Addiction Services (DMHAS) Annual Financial Report (AFR).
C. All related parties and service sites are listed on this schedule page.
D. Not applicable. The provider does not have any related party individuals or organizations.

Note: The following definition of a related party can be found in the CMS Publication 15-1, Provider Reimbursement Manual, Chapter 10:

- Related to the provider means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

- Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

- Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

- In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of

common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other.

- The existence of an immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests indicated above are met. The following persons are considered immediate family for Medicare program purposes: (1) husband and wife, (2) natural parent, child and sibling, (3) adopted child and adoptive parent, (4) step-parent, step-child, step-sister, and step-brother, (5) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law, (7) grandparent and grandchild.

- A determination as to whether an individual (or individuals) or organization possesses significant ownership or equity in the provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be made on the basis of the facts and circumstances in each case. This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).

FORMS A-1 THROUGH A-5 – TOTAL COSTS, RECLASSIFICATIONS, ADJUSTMENTS, NET COSTS

Forms A-1 through A-5 are worksheets for recording the trial balance of expense accounts from the clinic's accounting books and records. The worksheets also include provisions for any necessary reclassifications and adjustments to these accounts. Forms A-1 through A-4 are for reporting direct costs only, and indirect costs are reported on Form A-5. All costs, both direct and indirect, must comply with allowable cost principles described in Section III of these guidelines.

The costs associated with health care personnel providing professional health care services to patients under the scope of their practice should be reported on Form A-1 through Form A-4. Health care personnel means health professionals and allied health professionals as defined in the Regulations for Connecticut State Agencies, Sec. 17b-262-995. Costs for all other personnel should be reported on Form A-5, including those who interact with patients but are not health care professionals (e.g., front desk staff). Forms A-1 through A-4 are for reporting direct costs. Form A-5 is for reporting indirect overhead costs. The following definitions should be used to apportion costs between direct and indirect:

1. Direct Health Care Costs: Activities directly related to the medical, behavioral health, or dental care of the patient. These activities comprise medical, behavioral health, or dental services that contribute to the diagnosis of the patient's condition or treatment.

2. Indirect Administrative/Overhead Costs: Activities representing services not directly related to the medical care of the patient, and which do not contribute to the diagnosis of the patient's condition or treatment. Services include clinic administration and management, personnel matters, receptionist/front desk activities, medical records (including EHR) and other documentation administration and maintenance, data analysis, billing, eligibility verification, outreach, and any other activities that are not health-care activities that contribute to the diagnosis of the patient's condition or treatment.

For a list of staff categories reportable as direct vs. indirect, please see Appendix A. Appendix A is intended to be a guide and is not an all-inclusive list of staff categories. Not all of the listed cost centers will apply to each facility. For example, a clinic may not employ dental staff. In that case, lines B1a through B1c of Form A-2 (Dental Care Cost) would be left blank. The worksheets also provide blank lines where specific descriptions may be included for services in addition to those specified on the forms (Other – Specify____).

The expenses listed in **Columns I through III** must be in accordance with the clinic's accounting books and records. In order to be considered an allowable expense, the amount must be included on the provider's audited financial statements and must comply with

allowable cost principles as described in Section III of these guidelines. Enter on the appropriate lines in Columns I and II the total expenses incurred during the reporting period. Expenses must be detailed between salaries (Column I) and other costs (Column II). The sum of Columns I and II must equal Column III. Any needed reclassifications and adjustments must be recorded in Columns IV and VI. A reconciliation schedule is required if Line J, Column III does not agree to the Audited Financial Statements.

Column IV, Reclassifications

This column is used to reclassify expenses among cost centers for proper grouping of expenses. Reclassifications are used in instances in which the expenses applicable in more than one of the cost centers listed on the worksheet, are maintained in the clinic's accounting books and records in one cost center. For example, a physician performs some administrative duties, the appropriate portion of his compensation and applicable payroll taxes and fringe benefits would need to be reclassified from "Physician" to "Administration". Reduction of expenses should be shown in brackets (). The net total of the entries in Page 7, Column IV, Line J, must equal zero.

Column V, Reclassified Trial Balance

This column is the sum of Columns III and IV. The net balance for each line is entered in Column V. The total of Page 7, Column V, Line J must equal the sum of Columns III and IV, Line J.

Column VI, Adjustments

This column is used to indicate the amount of any adjustments to the clinic's reclassified expenses. Adjustments may be required to increase or decrease expenses in accordance with the Medicare rules on allowable costs. Examples of situations in which adjustments to expenses would be required are:

1. The clinic has transactions with a related organization.
2. The clinic depreciates assets on other than an acceptable basis recognized by Medicare.
3. The clinic includes non-allowable bad debt expense as allowable on its submitted cost report.
4. The clinic has non-allowable gifts-in-kind.
5. The clinic has other income offsets.

Column VII, Net Expenses

This column is the sum of Columns V and VI. The net balance of each is entered into Column VII.

FORM A - 1 (DIRECT HEALTH CARE COST)

A. Direct Health Care Cost, Reclassifications and Adjustments

Line 1. Staff Cost (excluding Dental, Mental Health, and Other)

a. Physician
b. Physician Assistant
c. Nurse (Advanced Practice Registered Nurse, Nurse Midwife, Registered Nurse)
d. Other (Specify). List any other health care practitioners not specifically identified above. Examples include medical assistants, case managers, and any other direct care practitioners.
e. Subtotal Direct Health Care Cost

Line 2. Other Direct Health Care Cost

a. Medical Supplies
b. Transportation
c. Depreciation – Medical Equipment
d. Professional Liability Insurance
e. Laboratory (point of care testing performed by clinic staff and not separately billable; does not include services of an independent/outside laboratory, which are non-allowable)
f. Radiology (performed by clinic staff and not separately billable; does not include services of an independent/outside radiologist, which are non-allowable)
g. Physician-Administered Drugs
h. Other (Specify)
i. Subtotal Other Direct Health Care Cost

Line 3. Total Direct Health Care Cost

FORM A-2 (DIRECT DENTAL CARE COST)

B. Direct Dental Care Cost, Reclassifications and Adjustments

Line 1. Staff Cost

a. Dentist

b. Dental Hygienist
c. Other (Specify). List any other dental practitioners not specifically identified above.
d. Subtotal Direct Dental Care Cost

Line 2. Other Direct Dental Care Cost

a. Dental Supplies
b. Transportation
c. Depreciation – Dental Equipment
d. Professional Liability Insurance
e. Other (Specify)
f. Subtotal Other Direct Dental Care Cost

Line 3. Total Direct Dental Health Care Cost

FORM A-3 (DIRECT MENTAL HEALTH CARE COST)

C. Direct Mental Health Care Cost, Reclassifications and Adjustments

Line 1. Staff Cost

a. Psychologist
b. Social Worker
c. Other (Specify). List any other mental health practitioners not specifically identified above.
d. Subtotal Direct Mental Health Care Cost

Line 2. Other Direct Mental Health Care Cost

a. Medical Supplies
b. Transportation
c. Depreciation-Mental Health Equipment
d. Professional Liability Insurance
e. Other (Specify)
f. Subtotal Other Direct Mental Health Care Cost

Line 3. Total Direct Mental Health Care Cost

D. Total Direct Cost Before Non-Allowable Services

FORM A-4 (NON-ALLOWABLE DIRECT OTHER SERIVCE COST)

E. Non-Allowable Direct Other Service Cost, Reclassifications and Adjustments

Line 1. Service

a. Clinical Diagnostic Lab (independent/outside lab)
b. Radiology (independent/outside radiologist)
c. Prescription drugs/pharmacy (including 340B)
d. Battered Women
e. Homeless
f. WIC
g. Non-Clinic Sites
h. Other – Specify
i. Total Non-Allowable Direct Other Service Cost

F. Total Direct Cost

(Sum Total Direct Cost Before Non-Allowable Services (D) and Total Non-Allowable Direct Other Service Cost) (E)

FORM A-5 (OVERHEAD COST)

G. Overhead – Facility Cost, Reclassifications and Adjustments

(*The overhead cost related to the facility: cost to own, lease, or rent, maintain and improve the clinic building and equipment.*)

a. Rent
b. Insurance
c. Interest on Mortgage or Loans
d. Utilities
e. Depreciation – Building (not previously reported)
f. Depreciation – Equipment (not previously reported)
g. Housekeeping and Maintenance
h. Other (Specify)
i. Subtotal Overhead – Facility Cost

H. Overhead – Administrative Cost, Reclassifications and Adjustments

(*The overhead cost related to the administration and management of the clinic*.)

a. Office Salaries
b. Depreciation – Office Equipment
c. Office Supplies
d. Legal
e. Accounting
f. Insurance
g. Telephone
h. Fringe Benefits and Taxes
i. Interest – Capital Loans (not previously reported)
j. Other (Specify). Include the costs of electronic health/medical records systems in this line, or in line H.b., in accordance with the clinic's capitalization policy.
k. Subtotal Overhead – Administrative Cost

I. Total Overhead Cost

J. Grand Total Costs (Sum Total Direct Cost (F) and Total Overhead Cost (I))

FORMS B-1 THROUGH B-3 – COMPENSATION, ENCOUNTERS, HOURS, FTES

Forms B-1 through B-3 are used to record the compensation, encounters, hours and full time equivalent (FTE) information of health care personnel. Exclude personnel reported in overhead cost centers (such as administrative staff) or non-reimbursable cost centers. "Health care personnel" means health professionals and allied health professionals as defined in the Regulations for Connecticut State Agencies, Sec. 17b-262-995.

Column I Specialty

This column is used to report the specialty of all physicians, both employed and contracted. Report the physician's clinical specialty, e.g., Family Medicine, Obstetrics/Gynecology, etc. This column is applicable to Form B-1 only.

Column II Compensation

This column is used to report the compensation of health care personnel. Compensation costs reported in this column must be in accordance with the clinic's accounting books and records as specified in the instructions for Forms A-1 through A-5 and must be included in the costs reported on Forms A-1 through A-5. Compensation means regular salaries, wages, bonuses, and any other form of remuneration paid by the clinic to the practitioner. Do not include fringe benefits paid by the clinic. If a practitioner is contracted through an agency, any agency fees should be reported as administrative/overhead cost.

Column III Encounters

This column is used to record all encounters furnished by health professionals of the clinic, both employees and professionals under agreement/contract. An encounter means a face-to-face visit between a client and health professional or an allied health professional for medically necessary services and includes the client's visit to the clinic and all services and supplies incidental to the health professional's services. Visits with more than one health professional or allied health professional or multiple visits with the same health professional or allied health professional that take place on the same day shall be considered one encounter, except under either of the following circumstances:

1. A client, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.
2. A client has different types of encounters (medical, behavioral health and dental) for different diagnoses on the same day. Medicaid pays for one encounter per day for each of these services.

Column IV Hours

This column is used to report the number of hours during the cost reporting period for which the employee was compensated (e.g., worked hours, paid leave time, etc.) and is used in the calculation of FTEs in Column V.

Column V Employee FTEs

This column is used to report the number of FTEs for staff who are employees of the clinic. The full time equivalent (FTE) for each type of practitioner (i.e., physician, physician assistant, nurse practitioner, etc.) is determined using the usual definition of an FTE, i.e., 2,080 hours per year, or 40 hours per week for 52 weeks.

Fractional amounts are rounded to two decimal places. If you use a definition of FTE other than the above, you must attach to your cost report your work-paper detailing how FTE's were calculated.

FORM B-1 (COMPENSATION, ENCOUNTERS, HOURS, FTES – HEALTH CARE)

Health Care Compensation, Encounters, Hours, & FTEs (itemized by practitioner)

A. Physician
B. Physician Assistant
C. Nurse (Advance Practice Registered Nurse, Nurse Midwife, Registered Nurse)
D. Physician Services Under Contract
E. Other Health Care Practitioner. List any other health care practitioners not specifically identified above. Examples include medical assistants, case managers, and any other direct care practitioners. For services reported on this schedule that do not constitute face-to-face encounters, the "Encounters" column should remain blank.

FORM B-2 (COMPENSATION, ENCOUNTERS, HOURS, FTES – DENTAL CARE)

Dental Care Compensation, Encounters, Hours, & FTEs (itemized by practitioner)

A. Dentist
B. Dental Hygienist
C. Other Dental Practitioner. List any other dental practitioners not specifically identified above. For services reported on this schedule that do not constitute face-to-face encounters, the "Encounters" column should remain blank.

FORM B-3 (COMPENSTION, ENCOUNTERS, HOURS, FTES – MENTAL HEALTH CARE)

Mental Health Services Compensation, Encounters, Hours, & FTEs (itemized by practitioner)

A. Psychologist
B. Social Worker
C. Other Mental Health Practitioner. List any other mental health practitioners not specifically identified above. For services reported on this schedule that do not constitute face-to-face encounters, the “Encounters” column should remain blank.

FORM B-4 – SUMMARY COMPENSATION, ENCOUNTERS, HOURS, FTES (IN LIEU OF B-1 THROUGH B-3)

Form B-4 is used to record summary compensation, encounters, hours and full time equivalent (FTE) information of health care personnel. This form can be completed in lieu of Forms B-1 through B-3 in the initial filing year(s). DSS will evaluate at a later date whether detailed compensation, encounter, hours, and FTE information by practitioners on Forms B-1 through B-3 is needed. Exclude personnel reported in overhead cost centers (such as administrative staff) or non-reimbursable cost centers. "Health care personnel" means health professionals and allied health professionals as defined in the Regulations for Connecticut State Agencies, Sec. 17b-262-995.

Information should be aggregated by practitioner type as listed on the cost report. In Section A. Health Care Practitioners, the category "Other Health Professionals" should include chiropractors, ophthalmologists, optometrists, and podiatrists, and the category "Other Allied Health Professionals" should include certified dietitians and certified nutritionists.

In Section C. Mental Health Practitioners, the category "Other Mental Health Practitioners" should include allied health professionals such as alcohol and drug counselors, marital and family therapists, and professional counselors.

Column I Number of Practitioners

This column is used to report the number of practitioners that were employed (or contracted, in the case of contracted practitioners) during the cost reporting period.

Column II Total Compensation

This column is used to report the total compensation by practitioner category. Compensation costs reported in this column must be in accordance with the clinic's accounting books and records as specified in the instructions for Forms A-1 through A-5 and must be included in the costs reported on Forms A-1 through A-5. Compensation means regular salaries, wages, bonuses, and any other form of remuneration paid by the clinic to the practitioner. Do not include fringe benefits paid by the clinic. If a practitioner is contracted through an agency, any agency fees should be reported as administrative/overhead cost.

Columns III-IV Compensation Range

These columns are used to report a compensation range by practitioner category. For each category,

report the highest salary paid and the lowest salary paid. Report the salary amounts on an annualized basis regardless of whether the highest-paid and lowest-paid practitioners were employed for a full year.

Columns V-VI Turnover

These columns are used to report turnover by practitioner category. For each category, report the number of practitioners hired and the number of practitioners that departed (voluntarily or involuntarily).

Column VII Encounters

This column is used to report by practitioner category all encounters furnished by health professionals of the clinic, both employees and professionals under agreement/contract. An encounter means a face-to-face visit between a client and health professional or an allied health professional for medically necessary services and includes the client's visit to the clinic and all services and supplies incidental to the health professional's services. Visits with more than one health professional or allied health professional or multiple visits with the same health professional or allied health professional that take place on the same day shall be considered one encounter, except under either of the following circumstances:

1. A client, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.
2. A client has different types of encounters (medical, behavioral health and dental) for different diagnoses on the same day. Medicaid pays for one encounter per day for each of these services.

Column VIII Hours

This column is used to report the number of hours during the cost reporting period for which the practitioners in each category were compensated (e.g., worked hours, paid leave time, etc.) and is used in the calculation of FTEs in Column IX.

Column IX Employee FTEs

This column is used to report the number of FTEs for the practitioners in each category who are employees of the clinic. The full time equivalent (FTE) for each type of practitioner (i.e., physician, physician assistant, nurse practitioner, etc.) is determined using the usual definition of an FTE, i.e., 2,080 hours per year, or 40 hours per week for 52 weeks. Fractional amounts are rounded to two decimal places. If you use a definition of FTE other than the above, you must attach to your cost report your work-paper detailing how FTEs were calculated.

FORM C (COST ADJUSTMENT AND ALLOCATION)

The required information on Form C has been linked to the related cost report schedules and should pre-populate. The cost report lines from which the information is being populated are indicated on Form C. Please verify that the amounts that are populated on Form C accurately reconcile to the amounts indicated on the referenced form, line and column, and the calculations are correct. Discrepancies should be resolved before the cost report is submitted.

Cost Adjustment and Allocation

A. Direct Cost Title XIX Services (Form A-3, Line D, Col. VII) (pre-populated)
B. Direct Cost Non-Allowable Other Services (Form A-4, Line E1i, Col. VII) (pre-populated)
C. Total Direct Costs (A+B) (calculation)
D. Portion of Title XIX Services (A/C) (calculation)
E. Total Overhead Cost (Form A-5, Line I, Col. VII) (pre-populated)
F. Overhead Cost Applicable to Title XIX Services (DxE) (calculation)
G. Total Title XIX Services Cost (A+F) (calculation)
H. Thirty Percent (30%) of Total Title XIX Svc Cost (Gx.30) (calculation)
I. Cost Adjustment (H-F) (calculation) (If the difference is positive, zero will appear.)
J. Allowable Title XIX Overhead Cost (F+I) (calculation)
K. Direct Costs
    1. Health Care Services (Form A-1, Line A3, Col. VII) (pre-populated)
    2. Dental Services (Form A-2, Line B3, Col. VII) (pre-populated)
    3. Mental Health Services (Form A-3, Line C3, Col. VII) (pre-populated)
    4. Total Direct Costs (K1 thru K3) (calculation)
L. Direct Costs as a % of Total (carried to four decimal places)
    1. Health Care Services (K1/K4) (calculation)
    2. Dental Services (K2/K4) (calculation)
    3. Mental Health Services (K3/K4) (calculation)
M. Allocated Allowable Overhead Cost
    1. Health Care Services (JxL1) (calculation)
    2. Dental Services (JxL2) (calculation)
    3. Mental Health Services (JxL3) (calculation)
    4. Total Allowable Title XIX Overhead Cost (M1 thru M3) (calculation)

FORM D (ALLOWABLE COST PER ENCOUNTER)

The required information on Form D has been linked to the related cost report schedules and should pre-populate. The cost report lines from which the information is being populated are indicated on Form D. Please verify that the amounts that are populated on Form D accurately reconcile to the amounts indicated on the referenced form, line and column, and verify that the calculations are correct. Discrepancies should be resolved before the cost report is submitted.

I. Health Care Cost (Excluding Dental and Mental Health)
   A. Direct Health Care Cost (Form A-1, Line A3, Col. VII) (pre-populated)
   B. Allowable Overhead Cost (Form C, Line M1) (pre-populated)
   C. Total Allowable Health Care Cost (A+B) (calculation)
   D. Encounters (Form B-4, Health Care Total) (pre-populated)
   E. Allowable Health Care Cost Per Encounter (C/D) (calculation)

II. Dental
   A. Direct Dental Care Cost (Form A-2, Line B3, Col. VII) (pre-populated)
   B. Allowable Overhead Cost (Form C, Line M2) (pre-populated)
   C. Total Allowable Dental Cost (A+B) (calculation)
   D. Encounters (Form B-4, Dental Total) (pre-populated)
   E. Allowable Dental Cost Per Encounter (C/D)(calculation)

III. Mental Health
   A. Direct Mental Health Care Cost (Form A-3, Line C3, Col. VII) (pre-populated)
   B. Allowable Overhead Cost (Form C, Line M3) (pre-populated)
   C. Total Allowable Mental Health Cost (A+B) (calculation)
   D. Encounters (Form B-4, Mental Health Total) (pre-populated)
   E. Allowable Mental Health Cost Per Encounter (C/D) (calculation)

FORM E (REVENUES BY SOURCE AND SERVICE TYPE)

A. Operating Revenue
   1. Medicaid
   2. Private
   3. Medicare
   4. Patient Cash/Self Pay
   5. Other – Specify
   6. Total Operating Revenue

B. Other Revenue
   1. Contributions
   2. Grants
   3. Interest
   4. Donations
   5. State Agency
   6. State Agency
   7. Other – Specify (items 7-10)
   11. Total Other Revenue

C. Other Revenue Generated by Non-approved Opioid Treatment Sites
   1. Other – Specify (items 1-6)
   7. Total Other Revenue from Non-approved Opioid Treatment Sites

D. Total Revenue

FORM F (GRANTS AND CONTRIBUTIONS, ACTUAL)

A. Contributions
   1. Services (excluding Dental, Mental Health, and Other)
   2. Dental
   3. Mental Health
   4. Other – Specify
   5. Total Contributions

B. Grants
   1. Services (excluding Dental, Mental Health, and Other)
   2. Dental
   3. Mental Health
   4. Other – Specify
   5. Total Grants

FORM G (COST DISALLOWANCE AND OFFSET)

As described in Section III of these guidelines, clinic costs should be reported in accordance with 42 CFR Parts 405, 491, and 493, and allowable cost principles of the CMS Provider Reimbursement Manual (CMS Pub. 15-1). Below are examples of cost disallowances and offsets that may be applied.

A. Cost Disallowance
   1. Entertainment
   2. Fines and penalties
   3. Bad debt
   4. Cost of actions to collect receivables
   5. Advertising, except for recruitment of personnel
   6. Contingent reserves
   7. Legal, accounting, and professional services incurred in connection with rehearing, arbitration, or judicial proceedings pertaining to the reimbursement approved by the Commissioner
   8. Fundraising
   9. Amortization of goodwill
   10. Directors fees
   11. Contributions
   12. Membership dues for public relations
   13. Cost not related to patient care
   14. Interest
   15. Pass through expense
   16. Total Cost Disallowance

B. Cost Offset (expense recovery)
   1. Refunds – Medicaid Outreach
   2. Rent Income
   3. In-Kind medical supplies
   4. In-Kind dental supplies
   5. In-Kind computer supplies
   6. In-Kind advertising
   7. Total Cost Offset

C. Total Cost Disallowance and Offset

FORM H (SERVICE SUMMARY)

This worksheet is for data collection purposes only. The worksheet is designed to gain an understanding of the frequency, duration, and type of services provided.

The worksheet features examples of procedure codes for services that may be offered at the clinic. Complete the worksheet by matching the most similar procedure code to the service provided. Procedures should be reported as one unit of service. Example: One 50 minute counseling session will equal one unit of service.

Please Note

This worksheet is for data collection only. Providers may submit their own worksheets featuring a description of service, frequency, and duration. Providers may also submit their own CPT procedure codes used in the clinic setting, if available.

To submit additional information, please use the “Other-Specify” line and supply a brief description of the service, total units, and duration. If there are not enough lines to enter additional information, the "Other-Specify" line may be given a description of 'See attached'. A schedule containing the details must be attached to the cost report and clearly labeled.

VI. PROVIDER RECORDS

Medical Records

The Medical records that are maintained in the offices of clinics should sufficiently document the services that are provided to Connecticut Medicaid recipients. The documentation requirements for these medical records can be found in 42 CFR Parts 405, 491, and 493.

Also, in accordance with the Provider Enrollment Agreement, providers should maintain all records for a minimum of five years or for the minimum amount of time required by federal or state law, which ever period is greater.

Financial Records

As stated in the Provider Enrollment Agreement, providers whose reimbursement is determined by the Connecticut Department of Social Services should maintain financial records for at least five years or for the minimum amount of time required by federal or state law, which ever period is greater.

VII. INCOME / REVENUE OFFSETS

Income generated from sources other than medical/healthcare services are generally categorized as “Other” or “Miscellaneous” revenue. Unlike income derived from medical/healthcare services, these “Other” income items are taken into consideration when determining allowable cost. This income may represent a reduction of cost or can serve as an indicator that an expense in a related cost center should be offset. “Other” or “Miscellaneous” income/revenue will be reviewed in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1).

The clinic should be prepared to provide appropriate documentation for income that is categorized as “Miscellaneous” or “Other” revenue. If the provider is unable to submit the supporting documentation, the income amount will be used to offset administrative and general expenses on Form A-5.

VIII. APPENDIX A

Direct vs. Indirect Staff/Position List

Definitions:

- Direct Health Care Costs: Activities that are directly related to the medical, behavioral health, or dental care of the patient. These activities comprise medical, behavioral health, or dental services that contribute to the diagnosis of the patient's condition or treatment.

- Indirect Administrative/Overhead Costs: Activities representing services which are not directly related to the medical care of the patient and which do not contribute to the diagnosis of the patient's condition or treatment. These services include clinic administration and management, personnel matters, receptionist/front desk activities, medical records (including EHR) and other documentation administration and maintenance, data analysis, billing, eligibility verification, outreach, and any other activities that are not health-care activities that contribute to the diagnosis of the patient's condition or treatment.

Staff Position/Title	DSS Cost Report Reporting Category
Adult Medicine Office Manager	Administrative
APRN	Direct-Medical
APRN (Psych)	Direct-Behavioral Health
BH Clinician MSW	Direct-Behavioral Health
BH Clinician: Other Licensed	Direct-Behavioral Health
Billing Staff	Administrative
Call Center Staff	Administrative
Care Facilitator/Home Visitor	Direct-Medical
Case Management	Direct-Medical
Chief Medical Officer (Physician)	Costs split based on activity; direct (patient time), administrative (admin time)
Chief Quality	Administrative
Community Outreach Coordinator	Administrative

Credentialing Specialist	Administrative
Data Analyst	Administrative
Dental Assistant	Direct-Dental
Dental Financial Coordinator/Patient Advocate	Administrative
Dental Hygienists	Direct-Dental
Dental Office Manager	Administrative
Dental Receptionist	Administrative
Dentists	Direct-Dental
Director of Adolescent Medicine & Pediatrics (Physician)	Costs split based on activity; direct (patient time), administrative (admin time)
Director of Adult Medicine (APRN)	Costs split based on activity; direct (patient time), administrative (admin time)
Director of Behavioral Health (LCSW)	Costs split based on activity; direct (patient time), administrative (admin time)
Director of Women's Health (Physician)	Costs split based on activity; direct (patient time), administrative (admin time)
EHR IT Support	Administrative
Eligibility Staff	Administrative
Front Desk Staff	Administrative
Health Educator	Direct-Medical
Healthy Start Coordinator	Not-allowable; HRSA grant-funded program
HIV Data Coordinator	Administrative
HIV Medication Adherence Nurse/ Floor Nurse	Direct-Medical
HIV-EIS Program Manager	Not-allowable; HRSA grant-funded program
LCSW	Direct-Behavioral Health
Lead Eligibility Specialist	Administrative
Lead Medical Receptionist	Administrative
Licensed Practical Nurse	Direct-Medical

Medical Assistant	Direct-Medical
Medical Assistant Supervisor	Costs split based on activity; direct (patient time), administrative (admin time)
Medical Case Manager	Direct-Medical
Medical Receptionist	Administrative
MSW	Direct-Behavioral Health
Network IT Support	Administrative
Nurse Practitioners	Direct-Medical
Nurse Practitioners Under Agreement	Direct-Medical
Nursing Manager	Costs split based on activity; direct (patient time), administrative (admin time)
OB/GYN	Direct-Medical
Office Manager (LPN)	Costs split based on activity; direct (patient time), administrative (admin time)
Outreach Educators	Administrative
Outreach Staff	Administrative
Patient Access Reps	Administrative
Patient Advocate	Administrative
Patient Navigators	Administrative
Patient Registration	Administrative
Pediatrics/Adolescent Office Mgr	Administrative
Physician Assistant	Direct-Medical
Physician Under Agreement	Direct-Medical
Physicians	Direct-Medical
Psychiatric APRN	Direct-Behavioral Health
Psychiatrist	Direct-Behavioral Health
Psychologist	Direct-Behavioral Health
Pt Acct Reps(sites)/Health Records/Medical Records	Administrative

Referral Coordinators	Administrative
Referral Specialist/MA	Administrative
Registered Dental Hygienist	Direct-Dental
Registered Dietician	Direct-Medical
Registered Nurse	Direct-Medical
Service Coordinator-ETI	Administrative
Staff Dentist	Direct-Dental
Staff Pediatrician	Direct-Medical
Staff Physician	Direct-Medical
Staff Podiatrist	Direct-Medical
Staff Psychiatrist	Direct-Behavioral Health
Women's Health Office Manager	Administrative
CEO	Administrative
CFO	Administrative
COO	Administrative
Director of Nursing	Costs split based on activity; direct (patient time), administrative (admin time)
Executive Assistant	Administrative
HR	Administrative
Accounting	Administrative
CMO (Admin %)	Costs split based on activity; direct (patient time), administrative (admin time)
Facility Manager	Administrative
IT Support (Non EMR)	Administrative
Practice Manager	Administrative