TO BE RESCINDED

5101:3-30-04 **Reimbursement.**

(A) The Ohio department of human services (ODHS) reimbursement through the Ohio department of alcohol and drug addiction services to eligible providers of medicaid covered treatment services will be the applicable rate of federal financial participation (FFP) under medicaid. ODADAS shall certify the availability of sufficient community state subsidy and local public funds to match Title XIX reimbursement funds. The provider may not request the recipient to contribute to the funds which match Title XIX reimbursement. The eligible provider must accept the total of state/local funds and Title XIX federal financial participation as payment in full. All federal fiscal disallowances or federal audit exceptions that are attributed to the eligible provider are the responsibility of the eligible provider.

(B) Methods and standards for establishing payment rates.

Payment for covered services by an eligible provider are calculated on a prospective reasonable cost related basis for each state fiscal year. The unit rate for each covered service is calculated on the program's projected cost of allowable items, and thus may vary from program to program. "Prospective rates" refer to predetermined cost-related rates calculated for each program from that approved budget plan. The rates thus established are subject to subsequent reconciliation and cost settlement based upon the program'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.

(C) Cost finding (cost report).

As a condition of participation in the medicaid program, all eligible providers must submit cost reports at least annually for the period beginning July first and ending June thirtieth of each state fiscal year. The cost report must be prepared in accordance with generally accepted accounting principles. Any eligible provider failing to file a cost report within one hundred eighty days after the close of a state fiscal year shall have its 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 forty-five days after notification of inadequacy.

(D) 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 Code of Federal Regulations.

(1) Cost related to client treatment and services that are not covered in the alcohol and drug addiction treatment services program described in Chapter 5101:3-30 of the Administrative Code 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.

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

(E) The unit charges for new eligible providers will be computed as follows. Upon entry into the medicaid program, new providers will use unit rates developed from their approved annual budget plans for the fiscal year of entry. These rates will become the prospective rates for the remainder of the fiscal year of entry into the medicaid program. New eligible providers will be required to submit cost reports at the end of the fiscal year of entry. For purposes of reimbursement provisions contained in this paragraph, a "new eligible provider" is defined as any one of the following:

(1) An eligible provider which has never participated in the alcohol and drug addiction treatment services program set forth in Chapter 5101:3-30 of the Administrative Code.

(2) An eligible provider which has not participated in the alcohol and drug addiction treatment services program set forth in Chapter 5101:3-30 of the Administrative Code for one year prior to application.

(F) The prospective reimbursement rates will remain in place until the end of the fiscal year and will be reconciled upon submission of the annual cost report.

(1) The prospective rates for alcohol and drug addiction treatment services upon being established are not subject to subsequent adjustments except in instances of rate adjustments specified in paragraphs (B) and (F) of this rule. The differences between the budget-based prospective unit rates and the unit rates reported by an agency in a cost report established by a desk audit or on-site audit are subject to recovery in full means of a retroactive rate adjustment of the current fiscal year's prospective unit rates.

(2) Annual audits will be conducted for services rendered by the eligible provider. The examination of costs will be made in accordance with generally acceptable audit standards necessary to fulfill the scope of the audit. The audit must also be consistent with auditing standards contained in the "Federal Office of Management and Budget Circular A-133." 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 principle objective of the audit is to enable ODADAS or its designee to determine that payments which have been made are in accordance with federal, state, and agency requirements. Based upon the audit, adjustments will be made as required. Records necessary to fully disclose the extent of services provided and costs associated with these services must be maintained for the longer of a period of six years or six years after the fiscal audit has been adjudicated. The records must be available to ODADAS, ODHS, and the U.S. department of health care financing administration for audit purposes. No payment for outstanding unit rates can be made if a request for audit is refused.

(3) Failure to retain or provide the required financial and statistical records renders the provider liable for monetary damages equal to the difference between:

(a) Established unit rates paid to the provider for the prospective year in question; and

(b) The lowest unit rates for like services paid in the state to an eligible provider similar in structure.

(G) Should medicare cover the provided service and the client has medicare coverage, medicare shall be billed first in accordance with the provisions set forth in rule 5101:3-1-05 of the Administrative Code.

(H) Should workers' compensation, an insurance policy, or other third-party resource cover the provided service, that third-party resource shall be billed first in accordance with the provisions set forth in rule 5101:3-1-08 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 03/15/2005

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Certification

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Date

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