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

(A) The Ohio department of job and family services (ODJFS) reimbursement through the Ohio department of alcohol and drug addiction services (ODADAS) 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) Reimbursement shall be made through a contract between the alcohol and drug addiction services board or the alcohol, drug addiction and mental health services board as defined in section 340.02 of the Revised Code and a community alcohol and drug addiction treatment program that meets the requirements of rule 5101:3-30-01 of the Administrative Code.

(C) For any provider that is a government entity which receives nonfederal funds, including but not limited to county departments of job and family services, county children services boards and local education agencies, eligibility is further contingent upon demonstration by the agency, as requested by ODADAS, that sufficient state and/or local public funds not otherwise encumbered to match other federal funds will be committed to match Title XIX funds for reimbursement of the contracted service(s) and certified as representing expenditures eligible for federal financial participation.

(D) Methods and standards for establishing payment rates:

(1) Rates established for services rendered prior to July 1, 2002 are calculated using the following method:

(a) 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. A program's projected unit rate for each covered service must be set at or below the statewide inflation adjusted seventy-fifth percentile. "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.

(b) 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:

(i) 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.

(ii) 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.

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

(2) Rates established for services rendered July 1, 2002 and after are calculated using the following method:

(a) Payment for covered services by an eligible provider with a medicaid contract are calculated on a fixed fee rate basis. "Fixed fee rate" refers to a predetermined unit rate for a covered service to be paid to a program. The fixed fee rate is considered payment in full with no subsequent cost reconciliation.

(i) A program's fixed fee rate for each covered service is calculated based on the program's state fiscal year 2000 actual unit cost as reported on the uniform financial management system (UFMS) 047 report. UFMS unit costs are calculated by dividing the sum of the program's direct and indirect costs associated with each type of medicaid-eligible service by the total number of units of service provided for the state fiscal year in which the service was rendered for each type of medicaid-eligible service.

(ii) A program's fixed fee rate for each covered service will be set at or below the statewide seventy-fifth percentile and then adjusted for inflation.

(iii) Fixed fee rates that are at or below the statewide fiftieth percentile will receive an incentive adjustment equal to five percent of the difference between the seventy-fifth percentile and the actual unit rate as reported on the state fiscal year 2000 UFMS 047 report.

(iv) Fixed fee rates for subsequent state fiscal years will be adjusted annually at the beginning of each state fiscal year for inflation based on the most recent annual percent change of the United States bureau of labor statistics consumer price index (CPI) for the midwest urban area, all items index with no seasonal adjustment.

(b) Payment for services by a new eligible provider is calculated in accordance with paragraph (D)(1)(a) of this rule. Payment for covered services under this method will remain in place for a maximum of two years from the date of eligibility under this paragraph at which time payment for services will be calculated per paragraph (D)(2)(a) of this rule. For purposes of the reimbursement provisions contained in this paragraph, a "new eligible provider" is defined as any one of the following:

(i) 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.

(ii) 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.

(iii) An eligible provider which is adding an additional service or services to its existing medicaid contract.

(c) The prospective reimbursement rates calculated per paragraph (D)(2)(b) of this rule will remain in place until the end of the fiscal year and will be reconciled upon submission of the annual cost report. 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 by a retroactive rate adjustment of the current fiscal year's prospective unit rates.

(d) Eligible providers may petition ODADAS to utilize a different base year to calculate fixed fee rates and/or to be reimbursed per paragraph (D)(1)(a) of this rule. Final approval of all petitions will be at the discretion of ODADAS.

(E) Costs which are reasonable and allowable to patient care are those costs which are in accordance with paragraph (J) of rule 3793:2-1-03 of the Administrative Code.

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

(F) 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 federal and state auditing standards and guidelines. 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, ODJFS, and the centers for medicare and medicaid services (CMS) for audit purposes. No payment for outstanding unit rates can be made if a request for audit is refused.

(1) 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 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:

WITHDRAWN ELECTRONICALLY

Certification

02/14/2005

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	3793.06, 3793.11, 5111.01 and 5111.02