5160-27-05 **Reimbursement for community mental health medicaid services.**

(A) This rule sets forth the reimbursement and rate setting for the following medicaid covered community mental health services:

(1) "Behavioral health counseling and therapy" as described in rule 5122-29-03 of the Administrative Code.

(2) "Community psychiatric supportive treatment" as described in rule 5122-29-17 of the Administrative Code.

(3) "Crisis intervention mental health" as described in rule 5122-29-10 of the Administrative Code.

(4) "Mental health assessment" as described in rule 5122-29-04 of the Administrative Code.

(5) "Partial hospitalization" as described in rule 5122-29-06 of the Administrative Code.

(6) "Pharmacologic management" as described in rule 5122-29-05 of the Administrative Code.

(7) "Health home services for persons with serious and persistent mental illness" as described in rule 5122-29-33 of the Administrative Code.

(B) Each agency shall maintain a fee schedule of usual and customary charges for all community mental health medicaid services it provides. The agency shall bill the community medicaid program its usual and customary charge for a medicaid-covered service. The reimbursement rate to each agency shall be the lesser of the agency's usual and customary charge or the amount established in appendix A to this rule with the exception for community psychiatric supportive treatment (CPST) as described in paragraph (C) of this rule and health home services for persons with serious and persistent mental illness as described in ~~paragraph~~ paragraphs (H) to (J) of this rule. Reimbursement for community mental health medicaid services is considered payment in full .

(C) The reimbursement rate for CPST shall be as follows:

(1) For CPST services not rendered in a group setting, the medicaid maximum amount is calculated as follows:

(a) If the total number of service units rendered by a provider per date of service is less than or equal to six, the medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.

(b) If the total number of services units rendered by a provider per date of service is greater than six, the medicaid maximum amount is equal to the sum of:

(i) The unit rate according to the department's service fee schedule multiplied by six; and

(ii) Fifty per cent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

(2) For CPST services rendered in a group setting, the medicaid maximum amount is calculated as follows:

(a) If the total number of service units rendered by a provider per date of service is less than or equal to six, the medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.

(b) If the total number of services units rendered by a provider per date of service is greater than six, the medicaid maximum amount is equal to the sum of:

(i) The unit rate according to the department's service fee schedule multiplied by six; and

(ii) Fifty per cent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

(D) The community medicaid program will not pay for community mental health medicaid services for medicaid clients when those same services are routinely provided to non-medicaid clients at no charge, except when medicaid reimbursement for such services are prescribed by federal law or in rule ~~5101:3-1-03~~5160-1-03 of the Administrative Code. If a reduced charge or no charge is made, the lowest charge made becomes the medicaid rate for that service.

The community mental health medicaid services are not considered to be provided to non-medicaid clients at no charge or at a reduced charge if all of the following requirements are met:

(1) The agency establishes a fee schedule of usual and customary charges (UCC) for each service available and the agency utilizes a sliding fee schedule whereby individuals without third party insurance are charged; and

(2) The agency collects third-party insurance information from all medicaid and non-medicaid clients; and

(3) The agency bills other responsible third party insurers or payers, including medicare, in accordance with ~~rule 5101:3-1-08~~rules 5160-1-05 and 5160-1-08 of the Administrative Code where such insurers or payers are known.

(E) The agency may enter into arrangements with insurers and other responsible payers for reimbursement at levels that may differ from the published usual and customary fee schedule.

(F) Services reimbursed under this rule are subject to review in accordance with 42 C.F.R. 456.3, ~~dated October 1, 2007~~as in effect on October 1, 2013, and rule ~~5101:3-1-27~~5160-1-27 of the Administrative Code.

(G) Notwithstanding the provisions set forth in paragraph (G) of rule ~~5101:3-27-02~~5160-27-02 of the Administrative Code the agency shall be deemed to be in compliance with paragraph (G) of rule ~~5101:3-27-02~~ 5160-27-02 of the Administrative Code if it satisfies all the requirements in rule 5122-27-06 of the Administrative Code.

(H) Health home services for persons with serious and persistent mental illness, as defined in rule 5122-29-33 of the Administrative Code, are reimbursed using a monthly case rate specific to the health home service ~~provider~~ providers located in Ohio counties Adams, Butler, Lawrence, Lucas, and Scioto, and shall be calculated as follows:

(1) Annual costs must be compiled in accordance with the uniform cost report principles and cost categories described in rule 5122-26-19 of the Administrative Code.

(2) Calculation of the monthly case rate is as follows:

(a) Divide the annual cost as developed in accordance with paragraph (H)(1)

of this rule by the caseload, then

(b) Divide the result of the calculation in paragraph (H)(2)(a) of this rule by twelve.

(3) A provider's cost will be reviewed annually to determine whether it is necessary to rebase the case rate, based on the information from the provider's actual costs for the prior year.

(4) Health home service payments are not subject to cost reconciliation.

(5) Reimbursement for health home services is considered payment in full for all components of the service as defined in rule 5122-29-33 of the Administrative Code, including service components that may otherwise be reimbursable as CPST.

(I) Beginning July 1, 2014, reimbursement for health home service providers located in Ohio counties Cuyahoga, Franklin, Hamilton, Portage, Erie, and Summit will be made using the base rate stated in appendix A of this rule and the methodology described in this rule. Each health home's rate will be adjusted from the base rate based on health home enrollee risk scores using a methodology determined by the Ohio department of medicaid. Rates will remain in effect until changed by the Ohio department of medicaid in consultation with the Ohio department of mental health and addiction services and certified health home providers.

~~(I)~~(J) The reimbursement amount for an injectable or provider-administered medication listed in appendix A to rule ~~5101:3-27-02~~5160-27-02 of the Administrative Code is the lesser of the provider's submitted charge or the maximum fee listed, described, or referenced in rule ~~5101:3-1-60~~ 5160-1-60 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 10/01/2015

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02, 5164.03, 5164.15, 5164.88
Prior Effective Dates:	8/1/82, 12/22/86(Emer.), 7/1/91, 9/1/05, 2/15/10, 10/4/10, 7/1/11(Emer.), 9/29/11