13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

1. REHABILITATIVE SERVICES PROVIDED BY COMMUNITY MENTAL HEALTH FACILITIES

Each community mental health agency shall maintain a schedule of usual and customary charges for all community mental health services it provides. The agency shall use its usual and customary charge schedule when billing Medicaid for rendered services. Reimbursement for community mental health services shall be the lesser of the charged amount or the Medicaid maximum amount.

Calculation of the Medicaid maximum amount for community mental health services:

A. For all community mental health services except community psychiatric supportive treatment (CPST), the Medicaid maximum amount is equal to the unit rate for the service according to the department's service fee schedule multiplied by the number of units rendered.

B. For CPST services not rendered in a group setting, the Medicaid maximum amount is calculated as follows:
   1. 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.
   2. 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:
      a. The unit rate according to the department's service fee schedule multiplied by six; and
      b. Fifty percent 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.

C. For CPST services rendered in a group setting, the Medicaid maximum amount is calculated as follows:
   1. 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.
   2. 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:
      a. The unit rate according to the department's service fee schedule multiplied by six; and
      b. Fifty percent 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.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

1. REHABILITATIVE SERVICES PROVIDED BY COMMUNITY MENTAL HEALTH FACILITIES, continued

As a condition of participation, all Medicaid providers of community mental health services must have a current "Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations". Providers agree to comply with state statutes, Ohio Administrative Code rules, and Federal statutes and rules. This includes compliance with Ohio Administrative Code rule related to the annual submission of a cost report and related information to the Ohio Department of Mental Health (ODMH). ODMH will provide this information to the Ohio Department of Job and Family Services on an annual basis and in accordance with the requirements of the interagency agreement between the two departments. Future fee schedule updates will be based upon this information.

Except as otherwise noted in the plan, state-developed fee schedule rates for these services are the same for both governmental and private providers. The fee schedule rates are effective for services provided on or after October 4, 2010. Rates and fees can be found by accessing the agency's website at http://jfs.ohio.gov/OHP/provider.stm.

The State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR 441 Suhparts C and D.

The State shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or State definition of a qualified Medicaid provider.

With respect to individuals who are receiving rehabilitation services as residents of facilities the State shall not claim FFP for room and board and for non Medicaid services as a component of the rate for services authorized by this section of the state plan (Attachment 4.19-B, Item 13-d-1 page 2 of 2.) The rates in the department's service fee schedule as authorized by this plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services such as costs associated with the cafeteria. Only those facility (direct or indirect) costs that can be identified as directly supporting the provision of the non-institutional services will be included in the rates.