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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 19-0021

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

December 17, 2019

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: State Plan Amendment Transmittal Number 19-021

Dear Ms. Corcoran:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #19-021
- Coverage & Limitations and Payment for Services: Behavioral Health
- Effective Date: August 1, 2019
- Approval Date: December 16, 2019

If you have any questions regarding this State Plan Amendment, please have a member of your staff contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP Services
Regional Operations Group

Enclosures

cc: Carolyn Humphrey, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **19-021 REVISED**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **August 1, 2019**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 1905(a)(2), 1905(a)(6), 1905(a)(13)	7. FEDERAL BUDGET IMPACT: a. FFY 2019 $ 6,000 thousands b. FFY 2020 $35,000 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 13-d-1, Pages 1,2,4,5 of 28 Attachment 3.1-A, Item 13-d-2, Page 7 of 9 Attachment 4.19-B, Item 6-d-(5), Page 1 Attachment 4.19-B, Item 6-d-(6), Page 1 of 2 Attachment 4.19-B, Item 13-d-(1), Page 1 of 2 Attachment 4.19-B, Item 13-d-(1), Page 2 of 2 Attachment 4.19-B, Item 13-d-(2), Page 2 of 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: TN for each Attachment 3.1-A, Item 13-d-1, Pages 1,2,4,5 of 28 (TN 17-008) Attachment 3.1-A, Item 13-d-2, Page 7 of 9 (TN 17-013) Attachment 4.19-B, Item 6-d-(5), Page 1 (TN 19-018) Attachment 4.19-B, Item 6-d-(6), Page 1 of 2 (TN 17-016) Attachment 4.19-B, Item 13-d-(1), Page 1 of 2 (TN 19-004) Attachment 4.19-B, Item 13-d-(1), Page 2 of 2 (TN 17-008) Attachment 4.19-B, Item 13-d-(2), Page 2 of 2 (TN 19-004)

10. SUBJECT OF AMENDMENT: Coverage and limitations and payment for services: behavioral health (BH) rate increases, other updates.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **MAUREEN M. CORCORAN**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: September 30, 2019	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 30, 2019	18. DATE APPROVED: December 16, 2019
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: August 1, 2019	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Deputy Director

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

The following explanations apply to the mental health rehabilitative services covered under Item 13-d-1, which are:

- Therapeutic Behavioral Services (TBS)
- Psychosocial Rehabilitation (PSR)

These rehabilitative services are provided to all Medicaid eligible adults and children with an identified mental health and/or substance abuse diagnosis. The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed behavioral health practitioner or physician who is acting within the scope of his/her professional license and applicable state law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. Licensed practitioners of the healing arts operating within their scope of practice under State license include: a medical doctor or doctor of osteopathic medicine; psychologist; clinical nurse specialist; nurse practitioner; licensed independent social worker; licensed social worker; licensed professional clinical counselor; licensed professional counselor; licensed independent marriage and family therapist; licensed marriage and family therapist; or Board-licensed school psychologist. Nursing activities performed as part of Rehabilitative Services by Registered Nurses (RN) and Licensed Practical Nurses (LPN) must be ordered by a physician, physician assistant (PA), clinical nurse specialist (CNS) or certified nurse practitioner (CNP) unless, for RNs, an order is not required in accordance with nursing scope of practice. Direct services provided by the licensed practitioner not listed under TBS or PSR are billable under other sections of the State Plan (e.g., Physician and Other Licensed Practitioner).

Service Utilization:
The components included in the service must be intended to achieve identified treatment plan goals or objectives. All rehabilitative services are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible individual in accordance with section 1902(a)(10)(A) of the Act.

These rehabilitative services are provided according to an individualized treatment plan, which is subject to prior approval. The components included in the service must be intended to achieve identified treatment plan goals or objectives. The frequency and duration of rehabilitation services will be identified in the individual treatment plan and must be supported by an identified need and recovery goal.

The treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. At a minimum, annual reevaluations of the treatment plan must occur. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level.

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

The following Evidence-Based Practices (EBPs) provided as part of Rehabilitative Services require prior approval and fidelity reviews on an ongoing basis as determined necessary by ODM or its designee: Assertive Community Treatment (ACT). ACT includes individualized treatment at the needed intensity using components A – H listed under TBS and all aspects of PSR provided by other qualified providers of TBS and PSR. ACT also includes coordination of behavioral health services and coordination with collaterals including sharing information with healthcare and other providers. Additional EBP techniques included in Rehabilitative Services and not requiring ongoing fidelity reviews, such as trauma-focused CBT, may be integrated into rehabilitation services by providers without prior approval. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the Medicaid behavioral health treatment goals. All coordination regarding Medicaid behavioral health services must be documented in the individual's medical record.

Provider Agency Qualifications:
Any unlicensed or licensed practitioner providing mental health services must operate within an agency licensed, certified or designated by ODM or its designee that is qualified to provide the supervision required of an unlicensed or licensed practitioner for that service. Any entity providing Mental Health treatment services must be certified by Ohio Department of Medicaid or its designee, in addition to any required scope-of-practice license required for the facility or agency to practice in the State of Ohio.

Limitations:
The components included in the service must be intended to achieve identified treatment plan goals or objectives. Rehabilitative services will not substitute or supplant natural supports. Rehabilitative services do not include, and FFP is not available for any of the following, in accordance with section 1905(a)(13) of the Act:

a. educational, vocational and job training services;
b. room and board;
c. habilitation services *(including financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature)*;
d. services to inmates in public institutions as defined in 42 CFR 435.1010;
e. services to individuals residing in institutions for mental diseases as described in 42 CFR 435.1010;
f. recreational and social activities; and
g. services that must be covered elsewhere in the state Medicaid plan.

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

C. Counseling - Developing and providing individual supportive counseling including solution-focused interventions, emotional and behavioral management, and problem behavior analysis drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation. The goal is to assist the individual to re-acquire skills to minimize mental health and behavioral symptoms that interfere with the individual's ability to develop and maintain social, interpersonal, self-care, and independent living skills needed to improve and to restore stability and daily functioning within the individual's natural community settings.

D. Restoration of social skills - Rehabilitation and support with the restoration of social and interpersonal skills, problem solving, conflict resolution, and emotions/behavior management to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop positive coping mechanisms and strategies, and promote effective functioning in the individual's social environment including home, work and school;

E. Restoration of daily functioning - Assisting the individual to restore daily functioning specific to managing their own home, including managing money and medications, using community resources, and other self-care requirements; and

F. Crisis prevention and amelioration - Assisting the individual with effectively responding to or avoiding identified precursors or triggers that would put the individual at risk of not remaining in a natural community location, or that result in functional impairments, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or, as appropriate, seeking other supports to restore stability and functioning.

G. Psychoeducational services including instruction and training of persons served in order to increase their knowledge and understanding of their psychiatric diagnosis(es), prognosis(es), treatment, and rehabilitation in order to enhance their acceptance, increase their cooperation and collaboration with treatment and rehabilitation and favorably affect their outcomes.

H. Nursing Services-Performing Nursing Assessments and assisting the individual with individual and group medication education and developing and providing support for symptom management.

Practitioner qualifications:

Any of the components above may be performed by an unlicensed or licensed TBS provider who is an individual who has at least a Bachelor's Degree in social work, psychology, nursing, or in related human services OR at least a Master's Degree in social work, psychology, nursing or in related human services. Providers with a high school diploma may substitute three years of relevant work experience for a Bachelor's degree.

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

d. Rehabilitative services

1. Mental Health Rehabilitative services

Registered nurses may perform any component to the extent they are operating under the scope of their license and performing nursing services. Nursing assessments and group medication education performed under component G must be performed by a registered nurse. Individuals providing services must have training in the general training requirements required by the State Medicaid agency, including cultural competence and trauma-informed care.

Supervisor qualifications:
Unlicensed TBS providers must receive regularly-scheduled clinical supervision when rendering TBS. Licensed TBS providers whose scope of practice requires supervision must also receive regularly-scheduled clinical supervision when rendering TBS. The following licensed practitioners may provide supervision to both unlicensed and licensed TBS providers as appropriate and when operating within their scope of practice: a medical doctor or doctor of osteopathic medicine, registered nurse, Master of Science in nursing, clinical nurse specialist, certified nurse practitioner, licensed independent social worker, licensed social worker, licensed professional counselor, licensed professional clinical counselor, licensed independent marriage and family therapist, licensed marriage and family therapist, Board-licensed school psychologist, or psychologist. Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Psychosocial Rehabilitation (PSR)

PSR assists individuals with implementing interventions outlined in a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with an individual's behavioral health diagnosis. The combination and intensity of services will be based on an individualized assessment of medical necessity for each beneficiary. PSR is an individual face-to-face intervention with the individual. PSR includes restoration, rehabilitation and support of daily functioning to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily functioning. PSR supports the individual with restoration and implementation of daily functioning and daily routines critical to remaining successfully in home, school, work, and community. PSR includes rehabilitation and support to restore skills to function in a natural community environment.

Practitioner qualifications for PSR specialist:
Any of the activities above may be performed by a PSR specialist must be at least 18 years old and have a high school diploma with applicable experience in mental health. These practitioners also include Licensed Practical Nurses (LPNs) to the extent they are operating within the scope of their license. LPNs certified in the prior-approved Evidence-Based Practice of Assertive Community Treatment may also perform the PSR activities above. Individuals providing services must be trained in the general training requirements

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

Summary of Clinical Provider Qualifications applicable to SUD outpatient and residential services

Provider Agency Qualifications:
Any unlicensed practitioner providing behavioral health services must operate within an agency licensed, certified or designated by ODM or its designee qualified to provide the supervision required of an unlicensed practitioner for that service. Any entity providing SUD treatment services must be certified by Ohio Department of Medicaid or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Ohio.

Provider qualifications:
Services are provided by licensed and other professional staff, who are at least eighteen (18) years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and departmentally approved guidelines and certifications. All providers of SUD services are trained in ASAM criteria and service components. All outpatient and residential SUD agencies are certified under state law.

All providers may provide any component (assessment, skill restoration, counseling and administration of medications for Medication Assisted Treatment (MAT)) of the outpatient or residential SUD services consistent with State law and professional practice statutes and rules with the following exceptions:

- Peer recovery supporters may only provide skill restoration and counseling services in outpatient and residential settings, and
- Agencies that provide MAT must comply with federal and state laws regarding controlled substance prescriber availability. All facilities utilizing buprenorphine based medications must have a physician, physician's assistant; clinical nurse specialist or certified nurse practitioner who is an Ohio authorized prescriber, and who has a Drug Addiction Treatment Act (DATA) waiver to prescribe and dispense or is certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an opioid treatment program (OTP).
- Activities requiring a nurse may only be performed by a registered nurse or a licensed practical nurse within their current scope of practice. Activities performed by a licensed practical nurse must be performed under a physician, physician assistant, clinical nurse specialist, or certified nurse practitioner order.

Unlicensed practitioners who are SUD Peer Recovery Supporters shall:

- Be at least 18 years old;
- Have a high school diploma or equivalent;

6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

d. Other practitioners' services

(5) Physician assistants' services

Payment for physician assistants' services is the lesser of the billed charge or 85% of the Medicaid maximum for the physicians' service specified in the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule published on the agency's website at http://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx. The MSRIAP fee schedule was set as of July 1, 2019 and is effective for services provided on or after that date.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial Medicaid maximum payment amount is set at 80% of the Medicare allowed amount.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

The following payment scenarios apply:

When a physician assistant acts as an assistant-at-surgery for a covered primary surgical procedure, the maximum payment amount for the physician assistant is the lesser of billed charges or 25% of the Medicaid maximum specified for physicians' services in the MSRIAP fee schedule.

Payment rates for evaluation and management services rendered by physician assistants operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after August 1, 2019, the payment for behavioral health evaluation and management services rendered by physician assistants practicing in a community behavioral health agency will be 100% of the rates Ohio pays to physicians practicing in a community behavioral health agency, as described in Item 5-a of this Attachment.

By-report services require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate, or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed. Physician assistants are reimbursed the lesser of billed charges or 85% of the established price established through this manual review pricing process.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

d. Other practitioners' services.

(6) Advanced practice nurses' (APNs') services, other than described elsewhere in this plan.

For dates of service on or after January 1, 2018, payment for anesthesia services furnished by a certified registered nurse anesthetist (CRNA) is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by the following formula:

Maximum payment amount =
(Base unit value + Time unit value) x Conversion factor x Multiplier

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. Effective for dates of service on or after January 1, 2018, the conversion factor and multiplier are listed on the agency's Anesthesia fee schedule at http://medicaid.ohio.gov/ProvidersFee ScheduleandRates.aspx.

Unless otherwise specified, the maximum payment amount for a service furnished by a clinical nurse specialist (CNS) or certified nurse practitioner (CNP) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum for physicians' services as listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNS or CNP will be made to the hospital.

Payment rates for evaluation and management services rendered by nurse practitioners and clinical nurse specialists operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after August 1, 2019, the payment for behavioral health evaluation and management services rendered by nurse practitioners and clinical nurse specialists practicing in a community behavioral health agency will be 100% of the rates Ohio pays to physicians practicing in a community behavioral health agency, as described in Item 5-a of this Attachment.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum for surgical procedures as listed on the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

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

d. Rehabilitative services

1. Mental Health Rehabilitative services.

Payment for mental health rehabilitative services as described in Attachment 3.1-A, Item 13-d-1 shall be the lesser of the billed charge or an amount based on the Medicaid maximum for the service.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

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 agency's mental health rehabilitative services fee schedule rates were set as of August 1, 2019 and are effective for services provided on or after that date.

All rates and unit of service definitions are published on the agency's website at http://medicaid.ohio.gov/providers/feescheduleandrates.aspx.

The fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule. No payments for residents of Institutions for Mental Disease will be made under the Rehabilitation section of the State Plan.

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

d. Rehabilitative services

The fee development methodology is based upon provider cost modeling, which is composed of Ohio provider compensation studies, cost data, and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages of the practitioner delivering the direct care using the Bureau of Labor Statistics wage data for Ohio.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates were developed as the ratio of total annual modeled provider costs to the estimated annual billable units with the following exceptions noted below:

- Therapeutic Behavioral Services (TBS) provided by high school practitioners with three years of experience were set at the same rate as TBS provided by practitioners with a Bachelor's Degree. Rates for TBS provided by unlicensed Bachelor's and Master's degree level practitioners were set using the Bureau of Labor Statistics wage data for Ohio for that level of practitioner. Rates for TBS provided by licensed practitioners were set the same as for a Master's degree level practitioner.
- All TBS and PSR rates for practitioners on Assertive Community Treatment (ACT) teams were set using the respective high school, Bachelor's or Master's Bureau of Labor Statistics wage data for Ohio and indirect cost assumptions for an ACT team of seventy-five individuals (medium team).

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

d. Rehabilitative services

2. Substance use disorder (SUD) services

The fee development methodology is composed of provider cost modeling, although Ohio provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development:

- Staffing assumptions and staff wages;
- Employee-related expenses – benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation);
- Program-related expenses (e.g., supplies);
- Provider overhead expenses; and
- Program billable units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

Except as otherwise noted in the state plan, State-developed fee schedule rates for these services are the same for both governmental and private providers.

The fee schedule rates for substance use disorder services were set as of August 1, 2019 and are effective for services provided on or after that date. All rates and unit-of-service definitions are published on the single state agency's website at http://medicaid.ohio.gov/providers/FeeScheduleandRates.aspx. A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.