

13-d. Diagnostic, Screening, Preventive, and Rehabilitative Services Other Than Those Described Elsewhere In This Plan (Continued)

A. Community Mental Health Services Provided By Community Mental Health Facilities (Continued)

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

New Facilities: The unit charges for new facilities will be computed as follows. Upon entry into the Title XIX 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 Title XIX program. New facilities 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 facility" is defined as any one of the following:

- a. A new facility never certified or accredited or participating in Medicaid prior to community mental health facility application;
- b. A facility not participating in the Medicaid program for one year prior to community mental health facility application.

Conversion To Community Mental Health AGENCY Program Participation Upon The Effective Date For Implementation: For community mental health AGENCIES which were providers under the Medicaid Ambulatory Health Care Facility program prior to the effective implementation date of this new program, the unit charges will be based upon the current billing rates the facilities are using in billing other third party sources which reimburse on a cost-related basis. These rates will remain in place until the end of the fiscal year and will be reconciled upon submission of the annual cost report.

Audits: The prospective rates for community mental health AGENCY services upon being established are not subject to subsequent adjustments except in instances of rate adjustments specified under the section entitled "General Provisions" and except as specified in this section. The difference between the budget-based prospective unit rates and the unit rates reported by a facility 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.

TNS# 91-16
SUPERSEDES
TNS# 90-38

APPROVAL DATE 11-5-91
EFFECTIVE DATE 7/1/91

13-d. Diagnostic, Screening, Preventive, and Rehabilitative Services Other Than Those Described Elsewhere In This Plan (Continued)

A. Community Mental Health Services Provided By Community Mental Health Facilities (Continued)

a. Audits will be conducted for services rendered by the community mental health facilities participating in Title XIX (Medicaid). 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 the Ohio Department of Mental Health 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 cost associated with these services must be maintained for a period of six years or until audit is completed and every exception is resolved. The records must be available to the Ohio Department of Mental Health, the Ohio Department of Human Services, and the Health Care Finance Administration for audit purposes. No payment for outstanding unit rates can be made if a request for audit is refused.

b. All audits performed and cost reports shall be retained for at least SIX years. 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 a community mental health facility similar in structure.

Contracted Services: It is recognized that community mental health facilities may wish to augment staff delivered services through contractual arrangements. Such arrangements are recognized to the extent that the conditions set forth in this paragraph are met. Under the community mental health facility program, services provided by contract may either be included as a cost item in determining the prospective rates or may be billed independently by the contract provider. If the contract provider bills independently, any such services will not be subject to prospective cost-related reimbursement, but will instead be reimbursed in accordance with methods established for that particular service program involved (e.g., physician (psychiatric) services will be reimbursed under provisions set forth in Chapter 5101:3-4 of the Administrative Code).

TNS # 91-16
SUPERSEDES
TNS # 90-38

APPROVAL DATE 11-5-91
EFFECTIVE DATE 7/1/91

13-d. Diagnostic, Screening, Preventive, and Rehabilitative Services Other Than Those Described Elsewhere In This Plan (Continued)

A. Community Mental Health Services Provided By Community Mental Health Facilities (Continued)

In order for contractual arrangements to be recognized, community mental health facilities must provide the following information to the Ohio Department of Mental Health at the point of entry into the program and any subsequent point when new contracts are negotiated or when existing contracts are revised:

- a. Identification by name and, where applicable, Medicaid provider number of each individual practitioner providing services under contractual arrangements. Where the contract is let with a legal entity other than the individual practitioner, both the name of the legal entity and the name(s) of any individual practitioner(s) involved must be furnished.
- b. A written statement indicating, for each legal entity or individual practitioner, whether the contracted services are:
 - (i) To be included as a cost item and reimbursed under the applicable prospective rate for the type of service provided; or
 - (ii) To be billed independently by the legal entity or individual practitioner under contract.

TNS # 91-16
SUPERSEDES
TNS # 90-38

APPROVAL DATE 11-5-91
EFFECTIVE DATE 7/1/91

13-d. Diagnostic, Screening, Preventive, and Rehabilitative Services Other Than Those Described Elsewhere In This Plan

B. REHABILITATION SERVICES FURNISHED BY ALCOHOL AND DRUG TREATMENT PROGRAMS

Payment for covered services is on a prospective reasonable cost basis. Unit rates are calculated for each service based on a program's projected cost and may vary from program to program. Prospective rates are predetermined rates calculated from each programs approved budget plan. The established rates are subject to subsequent reconciliation and cost settlement for any overpayment made during that reporting period, based upon the program's reported actual costs at the end of each state fiscal year. There will be no adjustments made to compensate for underpayments that occurred during the reporting period.

Costs which are reasonable and allowable to patient care are those costs which are in accordance with Title 42 Part 413 of the CFR. Costs need to be related to client treatment and services that are Medicaid covered alcohol and drug addiction treatment services. Unallowable costs contained in OMB Circular A-87 are excluded. The straight line method of computing depreciation is required. Audits must be performed in accordance with OMB Budget Circular A-133.

TNS# 91-17
SUPERSEDES
TNS# NEW

APPROVAL DATE 10-30-91
EFFECTIVE DATE 7/1/91

14. Services For Individuals Age 65 or Older In Institutions For Mental Diseases

b. Skilled nursing facility services

None designated to date.

c. Intermediate care facility services

None designated to date.

TNS # 90-38
SUPERSEDES
TNS # 89-27

APPROVAL DATE 10-12-90
EFFECTIVE DATE 7/1/90

STATE OF OHIO

ATTACHMENT 4.19-8
REFERENCE PRE-PRINT PAGE 7
AND SUPPLEMENT 2
OF ATTACHMENT 3.1-A
ITEM 15, PAGE 1 OF 1

15. Intermediate Care Facility Services

- a. Public Institutions for Mentally Retarded or
Developmentally Disabled

REFERENCE ATTACHMENT 3.1-A SUPPLEMENT 2, RULE
5101:3-3-06.

- b. General (Other Than Institutions For Tuberculosis and
Mental Diseases)

See Attachment 4.19(D), RULES 5101:3-3-07 AND
5101:3-3-17.

SUBSTITUTE PAGE

TN No. 93-39
SUPERSEDES
TN No. 90-38

APPROVAL DATE 2-16-94
EFFECTIVE DATE 10-1-93

17. Nurse-Midwife Services

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

TNS # 90-38
SUPERSEDES
TNS # 89-27

APPROVAL DATE 10-12-90
EFFECTIVE DATE 7/1/90

18. Hospice Care.

Reimbursement for Hospice care will be made at one of four predetermined rates for each day in which a recipient is under the care of the Hospice. The daily rate is applicable to the type and intensity of services furnished to the recipient for that day. There are four levels of care into which each day of care is classified:

- . Routine home care.
- . Continuous home care.
- . Inpatient respite care.
- . General inpatient care.

The Medicaid Hospice rates are set prospectively by HCFA based on the methodology used in setting Medicare Hospice rates, adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the State Medicaid Manual.

Hospices will also be reimbursed a per diem amount to cover room and board services provided by the skilled nursing facility or intermediate care facility to the Medicaid recipient who has elected Hospice care and resides in the nursing facility. This reimbursement rate is equal to 95 percent of the base rate paid to that particular facility of residence.

Physicians who provide direct patient care are reimbursed according to Medicaid's fee-for-service system. This reimbursement is in addition to the daily rate paid the Hospice. If the physician is a Hospice employee, the Hospice will bill for services on behalf of the physician. If the physician is the recipient's attending physician and is not a Hospice employee, the physician will bill the department directly.

A Hospice's annual Medicaid reimbursement cannot exceed its annual Medicaid caseload times the statutory cap amount. Total Medicaid payments made to the Hospice for services provided by physicians who are Hospice employees, along with total payments made at the various Hospice daily rates, will be counted in determining whether the cap amount has been exceeded. Payments made for the services of physicians who are not Hospice employees and for payments made for room and board will not be included in the cap calculation. Also, a Hospice will not be reimbursed for inpatient days (general and respite) beyond 20 percent of the total days of care it provides to Medicaid recipients during the "cap year."

ODHS will perform a desk audit on each Hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.

TNS # 90-38
SUPERSEDES
TNS # 90-22

APPROVAL DATE 10-12-90
EFFECTIVE DATE 7/1/90

19. CASE MANAGEMENT SERVICES

Rate setting, payment and reconciliation shall be in accord with the methodologies described in Attachment A of Attachment 4.16-0 that are applicable to the community-based component of the Medicaid-covered habilitation center program.

TNS # 90-53
SUPERSEDES
TNS # 90-38
90-38

APPROVAL DATE _____
EFFECTIVE DATE 10/1/40
fms

20. Extended services to pregnant women.

Reimbursement for extended services to pregnant women is made to the service provider in accordance with the reimbursement descriptions found in corresponding medical service items in 4.19.

TNS # 90-38
SUPERSEDES
TNS # NEW

APPROVAL DATE 10-12-90
EFFECTIVE DATE 7/1/90

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service according to the department's payment schedule.

c. Care and Services in Christian Science Sanitoria

Payment is the same as it is in any ICF admitting the general geriatric or disabled patient. Both Christian Science facilities are certified as ICF's.

d. Skilled Nursing Services for Patient Under 21

Payment is the same for patients under 21 years of age as it is for an individual over 21 requiring skilled nursing care.

e. Emergency Hospital Services

Payment is made on the same basis as for out-of-state hospital services as outlined in Attachment 4.19-A.

TNS # 90-45
SUPERSEDES
TNS # 90-38
90-35

APPROVAL DATE 11-2-90
EFFECTIVE DATE 10/1/90