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State/Territory Name: OH

State Plan Amendment (SPA) #: 16-011

This file contains the following documents in the order listed:

1) Technical Correction Letter
2) Original Approval Letter
3) CMS-179 Form
4) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

July 25, 2017

Barbara R. Sears, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: Technical Correction to Ohio State Plan Amendment (SPA) TN 16-011

Dear Ms. Sears:

This is a technical correction to Ohio SPA 16-011 which was approved on June 9, 2016. Effective January 1, 2016, Ohio SPA 16-011 implemented revisions to coverage, limitations, and payment for hospice services under the Ohio Medicaid State Plan. Per the state's request, we are issuing this technical correction to correct the Ohio Department of Medicaid website address that appears on Attachment 4.19-B, Item 18, page 1 of 3.

If you have any questions, please contact Christine Davidson, of my staff, at (312) 886-3642 or christine.davidson@cms.hhs.gov if you have any questions.

Sincerely,

/s/

Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Sarah Curtin, ODM
Carolyn Humphrey, ODM
Greg Niehoff, ODM
Rebecca Jackson, ODM

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

June 9, 2016

John B. McCarthy, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 16-011

Dear Mr. McCarthy:

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

Transmittal #16-011
- Coverage & limitations, and payment: Hospice Services
- Effective Date: January 1, 2016

If you have any questions about this SPA, please contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/

Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Carolyn Humphrey, ODM
Sarah Curtin, 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: **16 – 011 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 **January 01, 2016**	

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: 42 CFR Part 418	7. FEDERAL BUDGET IMPACT: a. FFY 2016 $ 883.8 thousands b. FFY 2017 $ 1178.4 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A Item 18, page 1 of 3 Attachment 3.1-A Item 18, page 2 of 3 Attachment 4.19-B Item 18, page 1 of 3 Attachment 4.19-B Item 18, page 2 of 3 Attachment 4.19-B Item 18, page 3 of 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A Item 18, page 1 of 3 (TN 11-003) Attachment 3.1-A Item 18, page 2 of 3 (TN 11-003) Attachment 4.19-B Item 18, page 1 of 2 (TN 11-003) Attachment 4.19-B Item 18, page 2 of 2 (TN 13-019) New

10. SUBJECT OF AMENDMENT: Coverage and Limitations and Payment for Services: Hospice care

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: **JOHN B. McCARTHY**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: March 15, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 15, 2016	18. DATE APPROVED: June 9, 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Alan Freund	22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07-92)

18. Hospice care (in accordance with section 1905(o) of the Act).

Hospice care is a benefit for Medicaid beneficiaries who have a terminal illness. Hospice care emphasizes the provision of palliative/supportive services in the beneficiary's home. It is also available to Medicaid beneficiaries who reside in nursing facilities or intermediate care facilities for individuals with intellectual disabilities (ICF-IID). Beneficiaries age twenty-one and over choose Hospice care in lieu of curative care for the terminal illness. Beneficiaries younger than age twenty-one can access Hospice care and concurrent curative treatment without limitation when medically necessary.

A "Hospice" is a public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals. A certified Medicare Hospice provider that meets the Medicare Conditions of Participation for Hospice care can become a provider of Medicaid Hospice care upon execution of the Medicaid provider agreement and approval by the Ohio Department of Medicaid (ODM).

A Medicaid beneficiary may elect the Hospice benefit if the attending physician and Hospice physician certify that the beneficiary has six months or less in which to live if the illness runs its normal course. The beneficiary age twenty-one and over or authorized representativemust sign an election statement, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician. The beneficiary under age twenty-one or authorized representative must sign an election statement, but does not waive any rights to be provided with, or to have payment made for, services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made, in addition to the Hospice care. Election of the Hospice benefit shall be for the same enrollment periods as used for the Medicare Hospice benefit pursuant to Section 1812 (d)(1) of the Act. Beneficiaries dually eligible for Medicare/Medicaid must elect the Medicare and Medicaid Hospice benefits concurrently. Beneficiaries who have third-party coverage of the Hospice benefit must elect the third-party coverage Hospice benefit at the same time that the Medicaid Hospice benefit is elected.

A beneficiary may revoke the election of Hospice care at any time. The election period would end upon revocation, allowing the individual, if eligible, to resume Medicaid coverage of the benefits waived when hospice care was initially elected. An individual may re-elect to receive hospice after a revocation at any time, provided the beneficiary is otherwise entitled to hospice care. Once hospice has been re-elected, a subsequent benefit period will ensue.

Every beneficiary must have a written plan of care developed by the Hospice interdisciplinary team. All covered Hospice care must be consistent with the plan of care. All Hospices providing Hospice care to Medicaid beneficiaries must provide "core" services performed by Hospice employees. These "core" services include: nursing care, medical social services, counseling services including bereavement counseling for the family, and physician services.

18. Hospice care (in accordance with section 1905(o) of the Act), continued.

Other covered Hospice care includes:

- Short-term inpatient hospital and respite.
- Medical appliances, including drugs and biologicals.
- Home health aide and homemaker services.
- Physical therapy, occupational therapy, and speech-language pathology.
- Other medical treatment and diagnostic procedures provided in relation to the terminal condition, when medically indicated.

18. Hospice Care.

Reimbursement for Hospice care will be made at predetermined rates for each day in which a beneficiary is under the care of the Hospice. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day. With the exception of payment for physician services, the following categories or levels of care into which Medicaid hospice is classified are:

- Routine home care, (RHC). (Providers are paid one of two levels of RHC on or after January 1, 2016; see below)
- Continuous home care
- Inpatient respite care
- General inpatient care
- Service Intensity Add-On

The State pays the Medicaid Hospice rates published annually by CMS. Medicaid Hospice rates are based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using the indices published in the Federal Register and the daily Medicaid hospice payment rates announced through the Centers for Medicare and Medicaid's memorandum titled "Annual Change in Medicaid Hospice Payment Rates—ACTION" issued by the Deputy Director of the Center for Medicaid, CHIP Services Financial Management Group (FMG).

The State posts on the agency's website two separate rate tables for Medicaid hospice providers to use. The first table reflects full payment for providers that comply with quality data reporting requirements, while the second table reflects a two-percentage-point payment reduction specific for any Medicaid hospice provider that failed to comply with Section 3004 of the Affordable Care Act [Section 1814(i)(5)(A)(i)] and the Hospice Quality Reporting Program (HQRP).

Upon notice from CMS that a provider has failed to comply with HQRP the previous fiscal year, the State directs the provider to submit all hospice claims to the Ohio Department of Medicaid for the ensuing federal fiscal year using rates posted online at http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/SchedulesandRates.aspx for "Providers that Failed to Comply with Quality Reporting Requirements". The two-percentage-point payment reduction is reflected in categories of hospice care, including routine home care, continuous home care, inpatient respite, and general inpatient care.

Effective January 1, 2016, rates for routine home care are to be paid at a two-tiered per diem, as set by CMS based on a beneficiary's length of stay–with a higher rate for the first 60 days of hospice care and a lower rate starting on day 61. The two-tier rates are applicable irrespective of:

- the beneficiary's level of hospice care;
- whether hospice was elected prior to January 1, 2016;
- whether a beneficiary revokes, transfers, or is discharged from hospice care; and/or
- whether a lapse or break in hospice service occurs after January 1, 2016. A minimum of 60 days' gap in Hospice services is required to reset the counter which determines which payment category a participant is qualified for.

In addition, a service intensity add-on (SIA) payment is payable for services provided by a registered nurse (RN) or social worker in the last seven days of a hospice beneficiary's life. The SIA is available on and after January 1, 2016, under the following conditions:

- The day of care is a routine home care day;
- The day occurs during the last seven days of life;
- The patient's discharge is due to death;
- The direct care provided by an RN or social worker occurred during an in-person visit;
- The total hours paid for the SIA does not exceed four hours in a day for the RN and social worker combined;
- The SIA payment equals the hourly rate for continuous home care, multiplied by the number of hours of RN and social worker direct patient care visit time;
- The SIA payment is paid retrospectively by CMS claims, in addition to the routine home care rate paid by Medicaid; and
- Visits for the pronouncement of death are not be counted for the SIA payment.

Hospices will also be reimbursed a per diem amount to cover room and board services provided by the nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID) to the Medicaid beneficiary who has elected Hospice care and resides in the NF or ICF-IID. 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 to 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 beneficiary'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 multiplied by 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. 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 beneficiaries during the "cap year."