5160-56-01 **Hospice services: definitions.**

This rule set forth terms used throughout Chapter 5160-56 of the Administrative Code.

(A) "Advance directive" refers to written instructions recognized under state law that are related to the provisions of health care when the individual is incapacitated. Samples of advance directive documents include a living will, a declaration as defined in Chapter 2133. of the Revised Code, and a durable power of attorney for health care as defined in Chapter 1337. of the Revised Code.

(B) "Advanced practice registered nurse (APRN)" refers to a registered nurse (RN) authorized to practice as a clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife or certified nurse practitioner in accordance with section 4723.43 of the Revised Code.

(C) "Attending physician" refers to a health professional identified by the individual at the time of the election of hospice, as having primary responsibility in the determination and delivery of the individual's medical care while under hospice, and one who is:

(1) A doctor of medicine or osteopathy licensed and legally authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; or

(2) A "nurse practitioner" who meets the training, education, and experience requirements of a certified, advanced practice nurse in accordance with section 4723.43 of the Revised Code. APRNs are prohibited from certifying or recertifying a terminal diagnosis.

(D) "Authorized representative" has the same meaning as a person, in accordance with rule 5160:1-1-01 of the Administrative Code, who is at least eighteen years old, or a legal entity who stands in place of the individual as defined in this rule. If an individual has designated an authorized representative, all references to "individual" in regards to an individual's responsibilities shall include the individual's authorized representative. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. An authorized representative may make health care decisions on behalf of the individual who is mentally or physically incapacitated, or at the request of the terminally ill individual. These decisions may include the termination of medical care, the election of the hospice benefit, or the revocation of election of the hospice benefit on behalf of a terminally ill individual. Documentation of the authorization must be maintained in the individual's hospice record.

(E) "Beginning date of service" means the first billable date on which a designated hospice provider delivers hospice services to an individual.

(F) "Benefit period" or "election benefit period" refers to a span for which the individual is enrolled in the hospice benefit. Benefit periods consist of two ninety day benefit periods, followed by an unlimited number of sixty day benefit periods. The benefit periods may be used consecutively or at intervals. The election benefit period is subject to the conditions set forth in this chapter to include revocation, and must be utilized in sequential order:

(1) An initial ninety-day period (limited to one during the individual's lifetime);

(2) A second subsequent ninety-day period (limited to one during the individual's lifetime);

(3) An unlimited number of subsequent sixty-day periods.

(G) "Bereavement counseling" refers to counseling services furnished to the individual's immediate family or caregiver before and after the individual's death, to assist the family with issues related to grief, loss, and adjustment. Bereavement counseling must be made available by the designated hospice for a period up to one year following the individual's death.

(H) "Certification of the terminal illness" refers to the clinical judgment made by a medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician about the life expectancy of an individual should a terminal illness run its normal course. As a requirement pursuant to 42 C.F.R. 418.22 (October 1, 2017), in order to receive hospice care, the individual must be certified by a hospice medical director or physician member of the IDG and the individual's attending physician as being terminally ill with a medical prognosis that the individual's life expectancy is six months or less.

(I) "Concurrent care for children" refers to a federal provision which allows for curative treatment and hospice care to be covered simultaneously for individuals under age twenty-one.

(J) "Continuous home care" is a level of hospice care covered by medicaid in accordance with 42 C.F.R. 418.302 (October 1, 2017). A continuous home care day is one on which an individual who has elected to receive hospice care is at home and not in an inpatient facility, and when the care provided in the home consists predominantly of nursing care. Continuous home care may involve a home health aide (also known as a hospice aide) or homemaker services, or both. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill individual at home.

(K) "Core hospice services" are nursing care, medical social services, counseling services, and physician services that must routinely be afforded and/or provided directly to the individual by employees of the hospice.

(L) "Corresponding federal fiscal year" refers to the annual period from October first to September thirtieth, as set by the federal government for accounting and budgeting purposes.

(M) "Counseling services" are services provided to the terminally ill individual and the family members or other persons caring for the individual at home, including dietary counseling, training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and the family members and/or caregiver with adjustment to the approaching death.

(N) "Designated hospice provider" refers to the hospice responsible for the professional management of care provided to the individual while enrolled in hospice.

(O) "Dietary counseling" means intervention and education regarding appropriate nutritional intake that is provided to the individual and/or the individual's family by a qualified professional including, but not limited to, a registered nurse, a dietitian and/or a physician.

(P) "Dietitian" means a person licensed to practice dietetics who meets the criteria set forth in Chapter 4759. of the Revised Code.

(Q) "Election statement," "election of hospice statement" and the "hospice election statement" refer to the required, written acknowledgment of the individual's decision to receive hospice care in lieu of curative care or treatment of the terminal illness.

(R) "Ending date of service" means the date on which a designated hospice stops delivering hospice services to the individual because of revocation of the medicaid hospice benefit, discharge from the hospice benefit, change by the individual of the designated hospice, or death of the individual in accordance with Chapter 5160-56 of the Administrative Code.

(S) "Episode of Care" or "Hospice Episode of Care" is a hospice election period or series of election periods separated by no more than a sixty day gap. Each episode is initiated by a start of care and is ended by a discharge to death or a gap in hospice services of more than sixty days. An episode of care may include multiple election benefit periods; however, a benefit period cannot span more than one episode of care.

(T) "General inpatient care" is a level of hospice care covered in accordance with 42 C.F.R. 418.302 (October 1, 2017). A general inpatient care day is a day on which an individual who has elected hospice care receives care in an inpatient facility for

pain control or acute or chronic symptom management which cannot be managed in other settings.

(U) "Home and community based services (HCBS) waivers" refers to medicaid programs operated in accordance with Section 1915 (c) of the Social Security Act (the Act), 42 U.S.C. 1396n(c) (as in effect January 1, 2017) that allow individuals to receive covered services in their own home or community rather than institutions or other isolated settings. The HCBS waiver programs include those waivers administered by the Ohio department of medicaid (ODM), the Ohio department of aging (ODA), and the Ohio department of developmental disabilities (DODD).

(V) "Hospice" refers to a public agency, a private organization, or a subdivision of either, subject to the conditions of participation pursuant to 42 C.F.R. Part 418 (October 1, 2017), that is licensed in the state of Ohio and approved by the ODM to engaged in providing care to terminally ill individuals.

(W) "Hospice aide" refers to one who has successfully completed a training and competency evaluation program for hospice aide services, who meets the conditions of participation prescribed in 42 C.F.R. 418.76 (October 1, 2017), and who provides home care services pursuant to rule 3701-19-16 of the Administrative Code. For purposes of this chapter, hospice aide is interchangeable with the term, "home health aide".

(X) "Hospice care" refers to a comprehensive set of home based, inpatient and/or outpatient services coordinated by an interdisciplinary group of health professionals and volunteers as part of a written plan of care, to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill individual and/or the individual's family members. Hospice stresses palliative care as opposed to curative care.

(Y) "Hospice enrollment" refers to the process of entering hospice data, such as benefit periods pursuant to rule 5160-56-03.3 of the Administrative Code, into the Ohio medicaid information technology system (MITS) for an individual in receipt of hospice care.

(Z) "Hospice quality reporting program" refers to a federal mandate pursuant to the Section 3004 of Affordable Care Act of 2010 (as in effect January 1, 2017). HQRP requires all Medicare-certified hospice providers to comply with data reporting requirements prescribed by the centers for medicare and medicaid services (CMS). Annually, by October 1, CMS publishes the quality measures a hospice must report. The act of submitting data is what determines compliance with HQRP requirements. If the required quality data is not reported by each designated submission deadline, the hospice will be subject to a two percentage point reduction in their annual payment update.

(AA) "Hospice provider span" refers to the date range (begin date to end date) that a valid provider is considered the designated hospice provider. It is an assignment in MITS that refers to the period of time during which an individual receives hospice services from the designated hospice.

(BB) "Individual" refers to the beneficiary eligible for medicaid, who is in need of, or under the care of the designated hospice, and who is considering and/or who has elected the hospice benefit. For decision making purposes, an individual may designate an authorized representative to act on his or her behalf, in place of the individual.

(CC) "Inpatient facility" refers to a facility that is either operated by or under contract with a hospice for the purpose of providing general inpatient and/or respite care to the individual.

(DD) "Inpatient respite care" is a level of hospice care covered in accordance with 42 C.F.R. 418.302 (October 1, 2017). An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for the purpose of providing relief and respite for caregivers.

(EE) "Interdisciplinary group (IDG)" refers to a group of professionals and volunteer staff who provide or supervise the care and the services offered by the hospice in accordance with 42 C.F.R. 418.56 (October 1, 2017).

(FF) "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in rule 5123:2-7-01 of the Administrative Code.

(GG) "Licensed occupational therapist" means a person holding a valid license under Chapter 4755. of the Revised Code as an occupational therapist.

(HH) "Licensed occupational therapy assistant" means a person holding a valid license under Chapter 4755. of the Revised Code as an occupational therapy assistant (OTA).

(II) "Licensed physical therapist" means a person holding a valid license under Chapter 4755. of the Revised Code as a physical therapist.

(JJ) "Licensed physical therapy assistant" means a person holding a valid license under Chapter 4755. of the Revised Code as a physical therapist assistant (PTA).

(KK) "Licensed speech-language pathologist" means a person holding a valid license under Chapter 4753. of the Revised Code as a speech-language pathologist and who is eligible for or meets the educational requirements for a certificate of clinical competence in speech language pathology granted by the "American Speech-Language-Hearing Association."

(LL) "Licensed speech-language pathology aide" means a person holding a valid license under Chapter 4753. of the Revised Code as a speech-language pathology aide.

(MM) "Long Term Care Facility (LTCF)" as defined in section 3721.21 of the Revised Code is a term used interchangeably in the Ohio medicaid information technology system to refer to a nursing home, a facility or part of a facility that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act.

(NN) "Medicaid Information Technology System (MITS)" refers to the information management system utilized by ODM, hospice and other providers, and state agencies for medicaid billing and data management purposes. The "MITS Hospice Portal" refers to the functionality in MITS maintained by ODM that gives authorized entities access to data such as medicaid eligibility, hospice enrollment status, claim and payment status, election and hospice service spans, benefit periods, and payer and provider information.

(OO) "Medicaid Managed Care Plan" or a "Managed Care Plan" has the same meaning as in rule 5160-26-01 of the Administrative Code.

(PP) "Medical director" refers to the doctor of medicine or osteopathy employed by the designated hospice to assume overall responsibility for the medical component of the individual's plan of care, including consulting with other members of the interdisciplinary team and collaborating with the individual's attending physician if any.

(QQ) "Medicare" is the federally financed medical assistance program operated under Title XVIII of the Social Security Act (as in effect January 1, 2017).

(RR) "Non-core hospice services" are hospice services that are the responsibility of the hospice to ensure are provided directly to the individual by hospice employees or under a contractual arrangement made by the hospice.

(SS) "Nursing facility" (NF) has the same meaning as in section 5165.01 of the Revised Code.

(TT) "Nursing services" are services that require the skills of a RN, or a LPN under the supervision of an RN. Services provided by an advanced practice registered nurse (APRN) who is not the individual's attending physician or are not provided by a physician in the absence of an APRN are included under nursing services.

(UU) "Oral Physician Certification Date" refers to the date the verbal certification of the individual's terminally ill is obtained by the hospice medical director (or physician member of the IDG), and the patient's attending physician, if he/she has one.

(VV) "Palliative care" refers to patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the medicaid hospice benefit.

(WW) "Physician" means an individual who is currently licensed and authorized under Chapter 4731. of the Revised Code to practice as a doctor of medicine and surgery or osteopathic medicine and surgery. An unlicensed individual who is authorized to practice under the laws of the state in which the services are performed is not a physician, even if the individual holds a staff or faculty appointment.

(XX) "Physician services" refers to services as defined in Chapter 5160-4 of the Administrative Code. Physician services may be provided by a physician, or an advanced practice registered nurse acting within his or her scope of practice as defined in section 4723.01 of the Revised Code, or a physician assistant acting within his or her scope of practice under the supervision, control, and direction of one or more physicians as defined in section 4730.01 of the Revised Code.

(YY) "Plan of Care" refers to an individualized written plan established at the start of hospice care by the hospice interdisciplinary group in collaboration with the attending physician (if any), the individual and the primary caregiver (when feasible). The plan of care must specify the hospice care and services necessary to meet the individual and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

(ZZ) "Registered nurse" (RN) refers to a person licensed to practice as a RN in accordance with the criteria set forth in Chapter 4723. of the Revised Code.

(AAA) "Routine Home Care" is a level of hospice care covered in accordance with 42 C.F.R. 418.302 (as in effect January 1, 2016). Routine home care shall be afforded to an individual in the individual's residence when the individual is not receiving continuous home care.

(BBB) "Social worker" means a person registered under Chapter 4757. of the Revised Code to practice as a social worker or independent social worker.

(CCC) "Telehealth" has the same meaning as in rule 5160-1-18 of the Administrative Code.

~~(CCC)~~(DDD) "Terminally ill" means that a physician has certified that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

~~(DDD)~~(EEE) "Written Physician Certification Date" refers to the date the completed certification of the individual's terminally ill is signed by the hospice medical director

(or physician member of the IDG, and the patient's attending physician, if he or she has one.

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Certification

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