TO BE RESCINDED

5160-56-04 **Hospice services: provider requirements.**

The hospice assumes full responsibility for professional management of the individual's hospice care in accordance with the hospice conditions of participation. To be eligible to provide medicaid hospice services, a hospice must meet the criteria in paragraphs (A) to (R) of this rule.

(A) Be eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code.

(B) Meet the medicare guidelines in accordance with 42 C.F.R. part 418 (October 1, 2014).

(C) Be licensed under Ohio law in accordance with Chapter 3712. of the Revised Code by the Ohio department of health.

(D) Comply with all requirements for medicaid providers in Chapter 5160-1 of the Administrative Code.

(E) Assure that all hospice employees who provide services are licensed, certified, or registered in accordance with federal and state law.

(F) Not discontinue nor diminish the hospice care it provides to the individual because of the inability of the individual to pay or receive medicaid reimbursement for such care pursuant to the medicare requirements at Section 1861 (dd)(2)(D) of the Social Security Act, 42 U.S.C. 1395x(dd)(2)(D) (as in effect January 1, 2015).

(G) Inform the county department of job and family services (CDJFS) in writing of any change in the individual's address.

(H) Arrange for another individual or entity to furnish services to the hospice's individuals in accordance with 42 C.F.R. 418.56 (October 1, 2014) when the hospice cannot provide services to the individuals. This arrangement must include a signed agreement and this agreement must remain on file at the hospice agency.

(I) Facilitate concurrent curative treatment for children under age twenty-one with other medicaid providers to assure that continuity of care is maintained and coordinated to avoid duplication of equivalent services. The provider must document the delineation of the manner in which services and the assessment process are coordinated between medicaid providers.

(J) Provide a copy of the hospice election form that specifies the type of hospice care and services in accordance with rule 5160-56-02 of the Administrative Code to other medicaid providers, including providers of concurrent curative treatment.

(K) Provide a copy of the individual's advance directive to other medicaid providers, including providers of concurrent curative treatment.

(L) Have a signed agreement with the nursing facility, the intermediate care facility for individuals with intellectual disabilities (ICF-IID), the general inpatient facility, and/or the inpatient respite care facility in which the individual resides and/or receives services. The terms of the agreement must not violate the medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code and must not violate the individual's freedom of choice of providers. This agreement must remain on file at the hospice agency and contain, at a minimum, the following:

(1) A stipulation that the hospice maintains responsibility for the professional management of the individual's hospice care;

(2) A delineation of the manner in which contracted services are coordinated and supervised by the hospice;

(3) A delineation of the role of the hospice and the facility in the admissions process, patient/family assessments, and the interdisciplinary group (IDG) conferences; and

(4) A stipulation that the facility must have a valid medicaid provider agreement in accordance with rule 5160-1-17.2 of the Administrative Code and accept the payment from the hospice as payment in full as negotiated.

(M) The hospice must obtain written certification of terminal illness for each election period:

(1) For the first ninety-day election period, the hospice must obtain, no later than two calendar days after hospice care is initiated, a written physician certification statement signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group (IDG) and the individual's attending provider;

(2) For subsequent benefit periods, the hospice must obtain a written physician certification statement no later than two calendar days after hospice care is initiated in each of the subsequent benefit periods. The written physician certification statement shall be signed and dated by the hospice medical director or a physician member of the IDG;

(3) If the hospice cannot obtain the written physician certification statement within two calendar days after a benefit period begins, it must obtain an oral physician certification statement within two calendar days and obtain the signed and dated written physician certification statement prior to submission of a claim;

(4) The hospice must document the oral physician certification statement in the individual's hospice record and retain the written physician certification statements in the individual's hospice records;

(5) The physician certification must include a statement that the individual has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs it normal course and specific clinical findings and other documentation supporting a life expectancy of six months or less in accordance with 42 C.F.R. 418.22 (October 1, 2014); and

(6) The hospice must also follow these requirements for those individuals who had been previously discharged and subsequently re-elected hospice care.

(N) At the time of election of the hospice care, the hospice must:

(1) Assist the individual or representative with the election process;

(2) Retain a copy of the election form in the individual's hospice record; and

(3) On the date of election, provide the individual or the representative with the following materials and written information:

(a) Conditions of election of the hospice benefit; including

(i) Duration and scope of coverage; and

(ii) Notice of the individual's responsibility for reporting other insurance and for obtaining health care; and

(iii) Notice of the individual's responsibility for reporting other providers of concurrent curative treatment for children under age twenty-one; and

(b) Grievance procedures;

(c) Procedures for revocation of the hospice benefit; and

(d) Information regarding advance directives in accordance with Chapter 2133. of the Revised Code and any policies the hospice has regarding the implementation of advance directives.

(i) Each individual has the right to formulate an advance directive, including a do not resuscitate order; and

(ii) The hospice must maintain the indvidual's advance directive in an accessible part of the indivdual's current hospice record and include a notation in the individual's plan of care.

(O) Establish a written plan of care for each individual prior to providing care, and the care provided to the individual must be in accordance with the plan. The plan of care must:

(1) Be established and maintained in accordance with 42 C.F.R. 418.56 (October 1, 2014);

(2) Be established by the attending provider, the medical director or physician designee and the IDG;

(3) Be reviewed and updated, at intervals specified in the plan, by the attending provider, the medical director or physician designee and IDG. These reviews must be documented; and

(4) Include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the individual's and family's needs.

(P) Designate a registered nurse to coordinate the implementation of the plan of care for each individual.

(Q) Assure that care is coordinated for individuals enrolled in a home and community based (HCBS) waiver program. A collaborative effort must occur between the hospice case manager and the waiver case manager or the service and support administrator (SSA) as applicable to maintain a continuum of the overall care provided to the individual.

(1) Case management of hospice services shall be provided by the hospice case manager in accordance with this chapter;

(2) Case management of waiver services shall be provided by the waiver case manager; and

(3) The hospice must provide services to a waiver individual in accordance with a comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers. The administrating agency of the waiver or its designee shall assist in the coordination of care by:

(a) Reviewing and approving the comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers;

(b) Resolving any issues resulting from the comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers;

(c) Resolving any issues of interpretation when implementing the requirements in this chapter; and

(d) Applying any exceptions to the requirements of this chapter on a case-by-case basis.

(R) Each month, the hospice must identify the individual as a hospice individual by labeling the medicaid card with the name of the hospice next to the individual's name. This is to indicate that hospice care has been elected and a restriction exists on medicaid coverage. Since the medicaid card lists the names of all medicaid-eligible individuals under a particular case number, the hospice must label the card in such a way as to clearly identify which individual has elected medicaid hospice care.

(1) The hospice must label the card no later than the eighth of each month to indicate that the individual is enrolled in the hospice program; or

(2) The hospice must label the card no later than eight days after the individual has enrolled in the hospice program.

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Certification

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