Ohio | Common Sense Initiative

Mike DeWine, Governor
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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

Permanent Filing of Hospice Public Health Emergency Rules

Rule Number(s): 5160-56-04 (amend); 5160-56-05 (amend); and 5160-56-06 (amend).

5160-56-01 (amend) – for informational purposes only.

Date of Submission for CSI Review: August 24, 2020

Public Comment Period End Date: August 31, 2020

Rule Type/Number of Rules:

New/___ rules **No Change/____ rules (FYR? ___)**

Amended/_3_ rules (FYR? N_) **Rescinded/____ rules (FYR? ___)**

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**

   5160-56-04 (amend) Hospice services: provider requirements

   This rule sets forth the provisions for the responsibilities of a hospice to be eligible to provide and to request reimbursement for hospice services.

   - In paragraph (E), language is being added to allow the utilization of pseudo-patients in competency testing for hospice aides and to allow individuals who are competency tested only in tasks in which they will be assigned to function as hospice aides.

   5160-56-05 (amend) Hospice services: covered services.

   This rule sets forth the provisions for the Medicaid covered services that hospice providers may or must furnish to the extend specified by the individual's plan of care. The additions to the rule include:

- In paragraph (D)(1), language is being added to allow core services to be provided through a combination of contracting services and telehealth services as necessary.

- In paragraph (D)(2), language is being added to allow non-core services to be provided through a combination of contracting services and telehealth services as necessary and appropriate.

5160-56-06 (amend) Hospice services: reimbursement.

This rule sets forth the provisions for the Ohio Department of Medicaid payment for hospice services and care. The additions to the rule include:

- In paragraph (C), language is being added to clarify that telehealth services can be provided when in-person visits are required.

- In paragraph (C)(5), language is being added to explain the way routine home care services and continuous home care services will be billed when there is a component of the services delivered through telehealth.

- In paragraph (C)(6), language is being added to clarify that services billed with T2044 for inpatient respite care and T2045 for general inpatient care are not eligible to be provided via telehealth.

- In paragraph (D)(5), language is being added to explain the way room and board services will be billed when there is a component of the services delivered through telehealth.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

5160-56-04

Statutory Authority: 5164.02

Amplifies: 5162.02

5160-56-05

Statutory Authority: 5162.02

Amplifies: 5162.03

5160-56-06

Statutory Authority: 5164.02

Amplifies: 5162.03

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
If yes, please briefly explain the source and substance of the federal requirement.

5160-56-04

This rule requires all individuals and hospice providers to meet federal eligibility requirements as prescribed in Section 1861(dd) of the Social Security Act and 42 C.F.R. Part 418. The Act specifies services covered under hospice care and the conditions which a hospice program must meet in order to participate in the state's administered and/or supervised hospice program. 42 C.F.R. Part 418 amplifies section 1861(dd) of the Social Security Act and serves as the basis for OAC rules 5160-56-04, 5160-56-05, and 5160-56-06 which detail hospice provider eligibility requirements.

5160-56-05

This rule requires hospice provider to comply with federal requirements found in 42 C.F.R. 418.114 (October 1, 2017) which details personnel qualifications within the conditions of participation for hospice providers.

5160-56-06

This rule requires hospice provider to comply with federal requirements found in 42 C.F.R. 418.312 (as in effect January 1, 2016) which details the data submission requirements under the hospice quality reporting program for hospice providers.

5. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

5160-56-04

The regulations amplify hospice provisions in the C.F.R. and do not extend beyond these federally imposed requirements.

5160-56-05

The Department of Medicaid believes the provisions in this rule that exceed federal requirements are necessary to ensure compliance with numerous regulations in the Administrative Code related to the delivery of hospice covered services to individuals in a NF or ICF-IID and individuals enrolled in a home and community based services waiver program.

5160-56-06

The Department of Medicaid believes the provisions in this rule that exceed federal requirements are necessary to ensure compliance with numerous regulations in the Administrative Code related to the reimbursement of hospice covered services, including individuals residing in a NF or ICF-IID.

What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

5160-56-04

The public purpose of this rule is to implement provisions contained in the Code of Federal Regulations, the Social Security Act, the Revised Code and the Administrative Code regarding hospice provider requirements.

5160-56-05

The public purpose of this rule is to implement provisions contained in the Code of Federal Regulations and Administrative Code regarding hospice covered services.

5160-56-06

The public purpose of this rule is to implement provisions contained in the Code of Federal Regulations, the Social Security Act and the Administrative Code regarding reimbursement for hospice providers.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

5160-56-04

The success of this rule will be measured by the extent to which hospice providers follow the provider requirements according to the specifications of this rule.

5160-56-05

The success of this rule will be measured by the extent to which hospice providers execute the services according to the specifications of this rule.

5160-56-06

The success of this rule will be measured by the extent to which hospice providers bill for appropriate hospice procedure codes according to the specifications of this rule.

7. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**

If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

None of the proposed rules are being submitted pursuant to these specified sections of the Revised Code.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.
If applicable, please include the date and medium by which the stakeholders were initially contacted.

The hospice provider associations in Ohio are:

- Leading Age Ohio
- Ohio Council for Home Care & Hospice
- Ohio's Hospice
- Ohio Department of Developmental Disabilities
- Ohio Department on Aging
- Ohio Health Care Association

The hospice provider associations, represented by Leading Age Ohio, Ohio Council for Home Care & Hospice, Ohio's Hospice and Ohio Health Care Association were involved in a meeting conducted through skype on July 23, 2020 to go over the provisions being added to these hospice rules.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

On July 23, 2020, representatives of Leading Age Ohio, Ohio Council for Home Care & Hospice, Ohio's Hospice and Ohio Health Care provided minimal comments as they recognized the amendments to be of "no significant change," "technical," and "minimal" in nature.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Scientific data was not applicable to the development of these rules.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

No alternative regulations were considered. The tenets proposed in OAC 5160-56-04 through 5160-56-06 are based on provisions prescribed by the Centers for Medicaid and Medicare Services (CMS). No alternative regulations were considered by the Agency as the requirements of these rules were dictated by federal law.

13. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    Performance-based regulations are not considered appropriate for these regulations.

14. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    The Department of Medicaid's staff reviewed the applicable ORC and OAC to ensure these rules do not duplicate any of the Department of Medicaid's rules or any other regulations in the ORC or OAC.

15. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    The final rules as adopted by the Department of Medicaid will be made available to stakeholders and the general public on the Department's website.

Adverse Impact to Business

16. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**
    a. **Identify the scope of the impacted business community; and**
    These rules impact approximately 130 hospice providers in Ohio that choose to participate in the Medicaid program. Provider participation in the Medicaid program is optional and at the provider's discretion.

    b. **Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and**
    Compliance with Medicaid program requirements is mandatory for providers who choose to participate in the program and may result in administrative costs as detailed below.

    c. **Quantify the expected adverse impact from the regulation.**
    The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

5160-56-04

b.) and c.)

In accordance with paragraph (A) of this rule, hospice providers must execute the Medicaid provider agreement in the format provided by the Department of Medicaid. The Department estimates it will take a hospice provider's attorney approximately 1.5 hours at the rate of approximately $400.00 per hour (total estimated cost: $600.00) to review one provider agreement. The Department further estimates it will take a hospice director of operations approximately 1 hour at the rate of approximately $55.00 per hour (total estimated cost: $55.00) to prepare one provider agreement in the format provided by the Department. The Department therefore estimates it will cost a total of approximately $655.00 for a hospice provider to execute one Medicaid provider agreement in the format provided by the Department.

In accordance with paragraph (B) of this rule, hospice providers are required to meet the Medicare guidelines in accordance with 42 C.F.R. part 418. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet the various Medicare guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (C) of this rule, hospice providers are required to be licensed by the Ohio Department of Health according to ORC Chapter 3712. There should be no cost of compliance for providers to be licensed by the Ohio Department of Health in order to be Medicaid hospice providers, as licensure is a requirement for all hospice providers in Ohio regardless of whether they serve Medicaid or non-Medicaid individuals. The hospice providers have already been licensed and therefore there are no additional costs.

In accordance with paragraph (D) of this rule, hospice providers must comply with all the requirements for Medicaid providers in Chapter 5160-1 of the Administrative Code. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet the various Medicaid guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (E) of this rule, hospice providers are required to ensure that all employees, volunteers, and contracted staff who provide direct services to hospice individuals are trained, licensed, certified, and/or registered in accordance with applicable federal and state law. The department estimates it will take a hospice director of operations approximately 4 hours at the rate of approximately $55.00 per hour (total estimated cost

$220) to ensure that hospice employees, volunteers and contracted staff are trained, licensed, certified and/or registered in accordance with applicable law.

In accordance with paragraph (G) of this rule, hospice providers must arrange for another individual or entity to furnish hospice services when the designated hospice cannot provide services to the individual. This arrangement must include a signed agreement that is to remain on file with the hospice agency. The department estimates that it will take a hospice RN case manager approximately 2 hours at the rate of approximately $32.00 per hour (total estimated cost: $64.00) to arrange for services that cannot be provided by the designated hospice. The department estimates that it will take a hospice RN case manager approximately 1 hour at the rate of approximately $32.00 per hour (total estimated cost: $32.00) to complete a signed agreement to document the arrangement between the designated hospice and other individual or entity furnishing hospice services to the individual when the designated hospice cannot.

In accordance with paragraph (H) of this rule, hospice providers must assume professional management of the individual's hospice care, including providing for and ensuring the ongoing sharing of information between all disciplines providing care across all settings. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (I) of this rule, hospice providers must facilitate concurrent care with other Medicaid providers for individuals under the age of twenty-one. Hospice providers must ensure hospice services are maintained and coordinated with concurrent care service; document the delineation in which services and the assessment process are coordinated between Medicaid hospice and non-hospice providers to avoid duplication of similar services; maintain up-to-date contact information for providers of concurrent care and services. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (J) of this rule, hospice providers must have a signed agreement with a nursing facility, ICF-IID, or inpatient facility and must contain the information specified in this paragraph. The department estimates that it will take a hospice director of operations approximately .5 hour at the rate of approximately $55.00 per hour (total estimated cost: $27.50) to complete one signed agreement.

In accordance with paragraph (K) of this rule, hospice providers must ensure all necessary hospice care and services are furnished to the individual and that such care and services are specified in the individual's plan of care for the items as specified in the

paragraph. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours it would take for a hospice RN case manager to meet these guidelines and multiplying by $32.00 per hour, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (L) of this rule, hospice providers must designate a registered nurse, who is a member of the interdisciplinary group to provide care coordination and assist with the implementation of the plan of care. The department estimates that it will take a hospice director of operations approximately .25 hours at the rate of approximately $55.00 per hour (total estimated cost: $13.75) to designate a registered nurse to meet the requirements of this rule.

In accordance with paragraph (M)(3)(a) of this rule, hospice providers must ensure care coordination for individuals enrolled in a home and community-based waiver program, by reviewing and approving a comprehensive plan for concurrent provision of services. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours it would take for a hospice RN case manager to meet these guidelines and multiplying by $32.00 per hour, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (M)(3)(b) of this rule, hospice providers must ensure care coordination for individuals enrolled in a home and community-based waiver program, by resolving any issues resulting from the comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours it would take for a hospice RN case manager to meet these guidelines and multiplying by $32.00 per hour, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (M)(3)(c) of this rule, hospice providers must ensure care coordination for individuals enrolled in a home and community-based waiver program, by resolving any issues of interpretation when implementing the requirements in this chapter. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours it would take for a hospice RN case manager to meet these guidelines and multiplying by $32.00 per hour, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (M)(3)(d) of this rule, hospice providers must ensure care coordination for individuals enrolled in a home and community-based waiver program, by applying any exceptions to the requirements of this chapter on a case-by-case basis. The department cannot quantify the adverse impact for this requirement because it is not

feasible to do so. However, the impact might be quantified by determining the number of hours it would take for a hospice RN case manager to meet these guidelines and multiplying by $32.00 per hour, then adding any additional costs that would be incurred to comply with this requirement.

5160-56-05

b.) and c.)

In accordance with paragraph (A)(1) of this rule, the designated hospice shall ensure the hospice services furnished to an individual in accordance with this rule are reasonable and necessary for the palliation and management of the terminal illness and related conditions. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (C) of this rule, the designated hospice shall ensure covered services provided to the individual are furnished by qualified personnel pursuant to 42 C.F.R. 418.114 (October 1, 2017), who are employed by the hospice, under an individual contract, or under arrangement with another provider. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (D)(1) of this rule, core hospice services that are outlined in this paragraph must be furnished or arranged by the designated hospice based on the individual's needs, appropriate level of care and plan of care. These core services may be provided through a combination of contracting services and telehealth services as necessary. The Department cannot quantify the adverse impact because the department cannot predict which core services will be provided because the services are based on the individual's needs, appropriate level of care and plan of care. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (D)(2) of this rule, non-core hospice services that are outlined in this paragraph must be furnished or arranged by the designated hospice based on the individual's needs, appropriate level of care and plan of care. These non-core services may be provided through a combination of contracting services and telehealth

services as necessary. The Department cannot quantify the adverse impact because the department cannot predict which non-core services will be provided because the services are based on the individual's needs, appropriate level of care and plan of care. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (D)(3) of this rule, the hospice provider is responsible for providing ambulance transports for an individual under the guidelines provided in this paragraph. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, as well as the cost of the ambulance transport, then adding any additional costs that would be incurred to comply with this requirement.

In accordance with paragraph (E) of this rule, when an individual is eligible to receive room and board coverage in a NF or ICF-IID, the designated hospice shall pay the facility per diem reimbursed to the designated hospice by the Ohio department of Medicaid in accordance with rule 5160-56-06 of the Administrative Code which includes the room and board services listed in the paragraph and that are covered pursuant to section 20.3 of the "Medicare benefit policy manual, chapter nine: coverage of hospice services under hospital insurance" under hospital insurance, www.cms.gov (revised May 08, 2015). The department estimates that it will take a hospice biller approximately .25 hour at the rate of approximately $20.00 per hour (total estimated cost: $5.00) pay the facility for room and board charges for a hospice patient residing in a NF or ICF-IID.

In accordance with paragraph (F) of this rule, when an individual is enrolled in a home and community-based services waiver program, the designated hospice has the responsibility to cover hospice services pursuant to paragraph (M) of rule 5160-56-04 of the Administrative Code. The department cannot quantify the adverse impact for this requirement because it is not feasible to do so. However, the impact might be quantified by determining the number of hours for various hospice staff to meet these guidelines and multiplying by the applicable rate of pay for each staff person, then adding any additional costs that would be incurred to comply with this requirement.

b.) and c.)

In accordance with paragraph (B)(3) of this rule, hospice providers that fail to comply with the federally mandated hospice quality reporting program will reimbursed by ODM, the payment amount minus a two percentage point reduction for hospice services, as prescribed by CMS for the corresponding federal fiscal year.

In accordance with paragraph (C) of this rule, the designated hospice shall bill ODM the appropriate code and unit(s), listed in this rule, for the appropriate level of care. The department estimates that it will take a hospice biller approximately .50 hour at the rate of approximately $20.00 per hour (total estimated cost: $10.00) to bill for each hospice individual each month.

In accordance with paragraph (C)(5) of this rule, hospice providers must add the GT modifier code to the appropriate procedure code for routine home care and continuous home care when any component of hospice services are delivered via telehealth. The department estimates that it will take a hospice biller approximately .50 hour at the rate of approximately $20.00 per hour (total estimated cost: $10.00) to bill for each hospice individual each month.

In accordance with paragraph (D) of this rule, hospice providers must follow the guidelines in this rule to bill Medicaid for room and board for hospice individuals residing in a NF or ICF-IID. The department estimates that it will take a hospice biller approximately .50 hour at the rate of approximately $20.00 per hour (total estimated cost: $10.00) to bill for each hospice individual each month.

In accordance with paragraph (D)(5) of this rule, hospice providers must add the GT modifier code to the appropriate procedure code for room and board when any component of hospice services are delivered via telehealth. The department estimates that it will take a hospice biller approximately .50 hour at the rate of approximately $20.00 per hour (total estimated cost: $10.00) to bill for each hospice individual each month.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Hospice regulations are required by federal statute and as such, are required for Medicaid to reimburse for hospice services.

Regulatory Flexibility

18. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

    No. The provisions in these rules are the same for all hospice providers and are based on federal law.

19. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    ORC section 119.14 is not applicable to these rules as these rules do not impose any fines or penalties for paperwork violations as defined in ORC section 119.14.

20. **What resources are available to assist small businesses with compliance of the regulation?**

    Providers in need of assistance may contact the Bureau of Long-Term Care Services and Supports, through the Provider Relations Hotline at (800) 686-1516.

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

This rule sets forth the responsibilities, including the conditions of participation for a hospice engaged in the provision of medicaid hospice services. To be eligible to provide and to request reimbursement for hospice services, a designated hospice must:

(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, 2017).

(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) Ensure that all hospice employees, volunteers, and contracted staff who provide direct services to hospice individuals are trained, licensed, certified, and/or registered in accordance with applicable federal and state law. ODM will allow hospices to utilize pseudo-patients, such as a person trained to participate in a role-play situation or a computer-based mannequin device instead of real patients, in competency testing of hospice aides and allow individuals who are competency tested only in the tasks for which they will be assigned to function as hospice aides.

(F) Not discontinue or diminish the hospice care provided to the individual because of the inability of the individual to pay or receipt of medicaid reimbursement for such care pursuant to the medicare requirements outlined in Section 1861 (dd)(2)(D) of the Social Security Act, 42 U.S.C. 1395x(dd)(2)(D) (as in effect January 1, 2017).

(G) Arrange for another individual or entity to furnish services to the individual in accordance with 42 C.F.R. 418.56 (October 1, 2017) when the designated hospice cannot provide services to the individual. This arrangement must include a signed agreement which shall remain on file at the hospice agency.

(H) Assume responsibility for the professional management of the individual's hospice care. Professional management involves the assessment, planning, monitoring, directing and evaluation of the individual's hospice care across all settings. The designated hospice must provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.

(I) Facilitate concurrent care and services with other medicaid providers for which the

individual under age twenty-one is eligible. As a responsibility for the professional management of the individual's hospice care, the designated hospice shall:

(1) Ensure hospice services are maintained and coordinated with concurrent care services;

(2) Document the delineation in which services and the assessment process are coordinated between medicaid hospice and non-hospice providers to avoid the duplication of equivalent or similar scope of services; and

(3) Maintain up-to-date contact information for providers of concurrent care and services.

(J) 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 designated 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 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.

(K) Ensure all necessary care and services set forth in this chapter are furnished to the individual and that such care and services are specified in the individual's plan of care in accordance with the standards set forth in 42 C.F.R. 418.56 (October 1, 2017) for:

(1) Approaching service delivery;

(2) Care planning;

(3) Contents of the plan of care;

(4) Reviewing and revising the plan; and

(5) Coordinating hospice and non-hospice services.

(L) Designate a registered nurse who is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each individual's and family's needs and implementation of the plan of care.

(M) Ensure hospice care is coordinated for an individual enrolled in a home and community based waiver program. A collaborative effort must occur between the designated hospice 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 designated hospice 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.

5160-56-05 **Hospice services: covered services.**

This rule sets forth medicaid covered services that hospice providers may or must furnish to individuals to the extent specified by the individual's plan of care.

(A) The designated hospice shall ensure the hospice services furnished to an individual in accordance with this rule are reasonable and necessary for the palliation and management of the terminal illness and related conditions.

(B) Unless otherwise specified, covered services shall be furnished to the individual in his or her residence, including the individual's home, a relative's home or any other type of living arrangement, a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility for individuals with intellectual disabilities (ICF-IID), or a hospice inpatient unit.

(C) The designated hospice shall ensure covered services provided to the individual are furnished by qualified personnel pursuant to 42 C.F.R. 418.114 (October 1, 2017), who are employed by the hospice, under an individual contract, or under arrangement with another provider.

(D) The following services are covered by medicaid when furnished or arranged by the designated hospice based on the individual's needs, appropriate level of care, and plan of care:

(1) Core hospice services may be provided through a combination of contracting services and telehealth services as necessary:

(a) Nursing care;

(b) Medical social services, provided by a social worker under the direction of a physician or attending provider;

(c) Physicians' services, including attending physician services, and services rendered by advance nurse practitioners acting as attending physicians; and

(d) Counseling services, including but not limited to dietary counseling, bereavement counseling and spiritual counseling.

(2) Non-core hospice services may be provided through a combination of contracting services and telehealth services as necessary and appropriate:

(a) Physical therapy, occupational therapy, and speech-language pathology

provided for symptom control or to enable the individual to maintain activities of daily living and basic functional skills;

(b) Hospice aide, home health aide and homemaker services that enable the individual to carry out the plan of care;

(c) Volunteers;

(d) Medical appliances and supplies, including drugs and biologicals;

(e) Short-term inpatient care provided in hospital, hospice inpatient unit, or a participating SNF or NF on an intermittent, non routine basis for relief of the individual's caregivers, and/or general inpatient care for the purpose of respite, pain control and acute or chronic symptom management that cannot feasibly be provided in other settings; and

(f) Any other item or service provided in relation to the terminal condition, when medically indicated, included in the plan of care and for which payment may otherwise be made under medicaid.

(3) Ambulance transports or an individual that are related to the terminal illness and that occur after the effective date of election, are covered to the extent specified by the individual's plan of care, when deemed the responsibility of the hospice as specified in section 40.1.9 of the "medicare benefit policy manual, chapter nine: coverage of hospice services under hospital insurance" under hospital insurance, www.cms.gov (revised May 08, 2015).

(a) Transports to an individual's home which occur on the effective date of the hospice election, the date of admission, prior to the initial assessment or prior to establishing the plan of care are not covered under the hospice benefit.

(b) If the hospice determines that the individual's need for transportation is for any reason other than receiving care related to the terminal illness, the hospice may make arrangements pursuant to paragraph (G) of this rule for the appropriate level or type of transportation and the service to be covered under the ambulance benefit for medicaid in accordance with Chapter 5160-15 of the Administrative Code.

(E) Coverage for individuals who reside in a NF or ICF-IID:

(1) Pursuant to rule 5160-56-06 of the Administrative Code, the room and board shall be covered for the individual when all of the following applies:

(a) The individual has elected hospice and is receiving hospice care;

(b) The individual resides in a NF, SNF or ICF-IID; and

(c) All other payments for room and board have been exhausted, making medicaid the payer of last resort.

(2) The designated hospice shall pay the facility per diem reimbursed to the designated hospice by the Ohio department of medicaid in accordance with rule 5160-56-06 of the Administrative Code. The following room and board services are covered pursuant to section 20.3 of the "medicare benefit policy manual, chapter nine: coverage of hospice services under hospital insurance" under hospital insurance, www.cms.gov (revised May 08, 2015):

(a) Performing personal care services;

(b) Assisting with ADLs;

(c) Administering medication;

(d) Socializing activities;

(e) Maintaining the cleanliness of the individual's room; and

(f) Supervising and assisting in the use of durable medical equipment and prescribed therapies.

(F) Hospice care for individuals enrolled in a home and community based services (HCBS) waiver program:

(1) Waiver services are provided by approved waiver providers in the amount and scope approved on the individual's plan of care.

(2) The designated hospice has the responsibility to cover hospice services pursuant to paragraph (M) of rule 5160-56-04 of the Administrative Code.

(G) For any medicaid services that are unrelated to the treatment of the terminal condition for which hospice care was elected, non-designated hospices and/or non-hospice providers must:

(1) Follow all applicable medicaid authorization policies and procedures; and

(2) Contact the designated hospice to coordinate the individual's care and to clarify provider payment responsibility.

5160-56-06 **Hospice services: reimbursement.**

This rule sets forth the Ohio department of medicaid (ODM) payment for hospice services and care.

(A) ODM will directly pay the designated hospice to care for an individual enrolled in medicaid hospice. Payment to the designated hospice shall cover the array of services listed in rule 5160-56-05 of the Administrative Code, except for:

(1) Services pursuant to paragraph (E) of this rule which are paid directly to the physician; and

(2) Services furnished by a non-hospice provider pursuant to paragraph (I) of this rule for the concurrent care of an individual under the age of twenty-one.

(B) Reimbursement rates paid by ODM to the designated hospice shall be based on the level of care that is appropriate for the individual for each day while receiving hospice care. Based on the methodology set forth in 42 C.F.R. 418.302 (as in effect January 1, 2016), the medicaid payment for hospice care is made at predetermined rates in accordance with paragraph (C) of this rule for levels of care as defined in rule 5160-56-01 of the Administrative Code.

(1) The medicaid payment for hospice covers the cost of services rendered by the hospice either directly or under contractual arrangement.

(2) For designated hospices that are compliant with the hospice quality reporting program in accordance with 42 C.F.R. 418.312 (as in effect January 1, 2016), ODM will reimburse the full medicaid payment rate for hospice services, up to the maximum payment rate prescribed for the county where services were provided.

(3) For designated hospices that fail to comply with the hospice quality reporting program as federally mandated, ODM will reimburse the payment amount minus a two percentage point reduction, as prescribed by CMS for the corresponding federal fiscal year.

(C) The designated hospice shall bill ODM the appropriate code and unit(s) for the appropriate level of care. ODM will allow telehealth services to be provided where in-person visits are mandated:

(1) Hospice providers must use code T2042 for one unit per day to bill for routine home care afforded to an individual in his or her home, who is not receiving continuous home care.

(a) Routine home care days shall be paid using a two-tiered system in accordance with 42 C.F.R 418.302 (as in effect January 1, 2016), where the per diem for the first sixty days of hospice care is paid at a higher rate and days sixty-one and thereafter are paid at a lower rate for the duration of the individual's hospice episode of care. A minimum of a sixty day gap in hospice services is required to reset the counter that determines which per diem to apply.

(b) In accordance with 42 C.F.R 418.302 (as in effect January 1, 2016), routine home care may be eligible for an add-on payment for services provided by a registered nurse (RN) authorized to practice under Chapter 4723. of the Revised Code, and/or a social worker licensed to practice under Chapter 4757. of the Revised Code during the last seven days of an individual's life, when the discharge from hospice care is due to death.

The service intensity add-on (SIA) payment shall be billed using code G0299 for the direct care provided in an in-person visit completed by an RN. The SIA payment shall be billed using code G0155 for the direct care provided during an in-person visit completed by a social worker.

The reimbursement rate for the SIA payment shall be equal to the continuous home care hourly rate converted into fifteen minute increments, up to a maximum of four hours (sixteen units) combined total per day for RN and social worker visits. Visits solely for the pronouncement of death shall not be counted for the service intensity add-on payment.

(2) Hospice providers must use code T2043 for one unit per hour, with a minimum of eight hours per day, to bill for continuous home care.

(3) Hospice providers must use code T2044 for one unit per day to bill for inpatient respite care.

(4) Hospice providers must use code T2045 for one unit per day to bill for general inpatient care.

(5) Hospice providers that deliver any component of services via telehealth will add the GT modifier on those claims, in addition to the appropriate procedure code above.

(6) Services billed with T2044 and T2045 are not eligible to be provided via

telehealth.

(D) When the individual is a resident of a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), the hospice may be reimbursed for room and board. This additional per diem amount is reimbursable at ninety-five per cent of the rate established for the long-term care facility, as reported to ODM for the individual pursuant to rule 5160-56-06 of the Administrative Code, and only on days where the individual receives routine home care or continuous home care. To receive reimbursement, the hospice:

(1) Must bill for room and bill using code T2046.

(2) Must bill patient liability until consumed to zero dollars.

(3) Must bill only for days that the individual is in the NF or ICF-IID overnight and is medicaid eligible.

(4) Must bill for individuals who are medicare and medicaid eligible, medicare for services provided under the medicare hospice benefit and medicaid for the individual's room and board.

(5) Hospice providers that deliver any component of services via telehealth will add the GT modifier on those claims, in addition to the procedure code above.

(E) Separate payment may be made to a physician for services involving direct patient care. The physician may be an employee of the hospice, a practitioner under contractual arrangement with the hospice, or an attending practitioner who is not an employee of the hospice but is an eligible medicaid provider. Separate payment cannot be made, however, for the following services:

(1) A physician service furnished on a volunteer basis or on an administrative basis;

(2) A procedure classified as a technical service; or

(3) Laboratory or radiography services performed in connection with the physician service.

(F) After receipt of all third-party resources, including private insurance, and taking into account patient liability for room and board, ODM may be billed for the balance owed to the designated hospice, except for services covered by individuals receiving hospice through managed care. For each day the medicaid eligible individual is enrolled in hospice, the total reimbursement for hospice services

cannot exceed the medicaid per diem reimbursement rate.

(G) Medicaid eligible residents of NFs or ICF-IIDs who are enrolled in a medicare or medicaid hospice program are not entitled to medicaid-covered bed-hold days. It is the hospice's responsibility to contract with and pay the NF in accordance with rule 5160-3-16.4 of the Administrative Code. It is the hospice's responsibility to contract with and pay the ICF-IID in accordance with rule 5123:2-7-08 of the Administrative Code.

(H) Pursuant to Section 1861(dd)(2)(A)(iii) of the Social Security Act, 42 U.S.C. 1395x(dd)(2)(A)(iii) (as in effect January 1, 2017) there shall be a limitation on reimbursement for inpatient care during the hospice cap period.

(I) For any services related to the terminal illness, non-hospice providers must bill the designated hospice provider directly unless the services were for concurrent care of the terminal illness for individuals under age twenty-one. Providers billing for concurrent care must comply with, and will only be reimbursed according to, all the requirements for medicaid providers in Chapter 5160-1 of the Administrative Code.

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.