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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 21-0029

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

December 9, 2021

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

Re: Ohio State Plan Amendment (SPA) Transmittal Number 21-0029

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 21-0029. This amendment proposes to increase payment rates for home health and private duty nursing services; allow nurse practitioners, clinical nurse specialists, and physician assistants to order home health services and complete required face-to-face visits; and allow required face-to-face visits to occur through telehealth when clinically appropriate.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR § 435.733. This letter is to inform you that Ohio Medicaid SPA 21-0029 was approved on December 7, 2021, with an effective date of November 1, 2021.

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

Sincerely,

A solid black rectangular box redacting the signature of James G. Scott.

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Carolyn Humphrey, ODM
Rebecca Jackson, ODM
Gregory Niehoff, ODM
Mindy Morrell, CMCS
Deborah Benson, CMCS

7. Home health services.
- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Intermittent or part-time nursing services are available to any Medicaid beneficiary with a medical need for intermittent or part-time nursing services in the beneficiary's place of residence or in any setting in which normal life activities take place. The place of services does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Intermittent or part-time nursing services can only be provided by a Medicare Certified Home Health Agency. Such certification requires meeting all the requirements of Medicare Conditions of Participation. Such agencies must also be enrolled as an Ohio Medicaid provider.

Intermittent or part-time nursing services must be ordered by the qualifying treating physician, nurse practitioner, clinical nurse specialist, or physician assistant (PA) and included in a beneficiary's plan of care that is reviewed by that practitioner at least every 60 days. To be a qualifying treating practitioner, the practitioner must be a doctor of medicine or osteopathy, a nurse practitioner, a clinical nurse specialist, or a PA legally authorized to practice in the state of Ohio.

Intermittent or part-time nursing services are covered only if the qualifying treating practitioner certifying the need for home health services documents that he or she had a face-to-face encounter with the beneficiary within the 90 days prior to the home health care start of care date, or within 30 days following the start of care date inclusive of the start of care date. A certified nurse practitioner, clinical nurse specialist, or certified nurse midwife, in collaboration with a doctor of medicine or osteopathy or a PA, may perform the face-to-face encounter for the purposes of the supervising practitioner certifying the need for home health services.

The face-to-face encounter with the beneficiary must occur independent of any provision of home health services to the beneficiary by the individual performing the face-to-face encounter. Only the qualifying treating practitioner may order these services, document the face-to-face encounter, and certify medical necessity.

Applicable limits are:

- No more than a combined total of eight hours per day of intermittent or part-time nursing services, home health aide services, and physical therapy, occupational therapy, or speech pathology and audiology services;
- No more than a combined total of 14 hours per week of intermittent or part-time nursing services and home health aide services, or as prior authorized by ODM or its designee;
- Visits shall not be more than four hours in length;

TN: 21-029

Supersedes:

TN: 17-018

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Effective Date: 11/01/2021

- An RN assessment cannot be concurrently performed with any other service during a visit in which the RN is furnishing home health services;
- An RN assessment must be performed on an individual prior to the start of home health services for the first time, prior to any change of order to an individual's home health services, and/or any time the RN is informed that the individual receiving the home health services has experienced a significant change in his or her condition that warrants a new RN assessment;
- An RN assessment may be performed no more than once every sixty days, unless a significant change warrants a subsequent RN assessment;
- When an individual is enrolled on an ODM-administered waiver, RN assessment services must be prior-approved by ODM and be specified on the individual's service plan;
- RN consultation services are not covered for consultations between RNs; and
- RN consultations are not covered when performed with nursing delegation services under the Ohio Department of Developmental Disabilities (DODD) waiver.

An individual can also access intermittent or part-time nursing services and/or home health aide services upon discharge from a covered inpatient hospital stay when medically necessary.

Additional intermittent or part-time nursing services provided by a home health agency beyond the established limits may be allowed when medically necessary, and as prior authorized by ODM or its designee.

Beneficiaries younger than age twenty-one can access intermittent or part-time nursing services without limitation when medically necessary.

7. Home health services, continued.

b. Home health aide services provided by a home health agency.

Home health aide services are available to any Medicaid beneficiary with a medical need for home health aide services in the beneficiary's place of residence, licensed child day-care center, or, for a child three years and under, in a setting where the child receives early intervention services as indicated in the individualized family service plan. The place of services does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities.

Home health aide services can only be provided by a Medicare Certified Home Health Agency. Such certification requires meeting all the requirements of Medicare Conditions of Participation. Such agencies must also be enrolled as an Ohio Medicaid provider.

Home health aide services must be ordered by the qualifying treating physician, nurse practitioner, clinical nurse specialist, or physician assistant (PA), and included in a beneficiary's plan of care that is reviewed by that practitioner at least every 60 days. To be a qualifying treating practitioner, the practitioner must be a doctor of medicine or osteopathy, a nurse practitioner, a clinical nurse specialist, or a PA legally authorized to practice in the state of Ohio.

Home health aide services are covered only if the qualifying treating practitioner certifying the need for home health services documents that he or she had a face-to-face encounter with the beneficiary within the 90 days prior to the home health care start of care date, or within 30 days following the start of care date inclusive of the start of care date. A certified nurse practitioner, clinical nurse specialist, or certified nurse midwife, in collaboration with a doctor of medicine or osteopathy or a PA, may perform the face-to-face encounter for the purposes of the supervising practitioner certifying the need for home health services.

The face-to-face encounter with the beneficiary must occur independent of any provision of home health services to the beneficiary by the individual performing the face-to-face encounter. Only the qualifying treating practitioner may order these services, document the face-to-face encounter, and certify medical necessity.

Applicable limits are:

- No more than a combined total of eight hours per day of intermittent or part-time nursing services, home health aide services, and physical therapy, occupational therapy, or speech pathology and audiology services;
- No more than a combined total of 14 hours per week of intermittent or part-time nursing services and home health aide services, or as prior authorized by ODM or its designee; and
- Visits shall not be more than four hours in length.

An individual can also access intermittent or part-time nursing services and/or home health aide services upon discharge from a covered inpatient hospital stay when medically necessary.

7. Home health services, continued.

b. Home health aide services provided by a home health agency.

Additional home health aide services provided by a home health agency beyond the established limits may be allowed when medically necessary, and as prior authorized by ODM or its designee.

Beneficiaries younger than age twenty-one can access home health aide services without limitation when medically necessary.

7. Home health services, continued.

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Physical therapy, occupational therapy, or speech-language pathology and audiology services are available to any Medicaid beneficiary with a medical need for physical therapy, occupational therapy, or speech-language pathology and audiology services in the beneficiary's place of residence, or in any setting in which normal life activities take place. The place of services does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Physical therapy, occupational therapy, or speech-language pathology and audiology services must be ordered by the qualifying treating physician, nurse practitioner, clinical nurse specialist, or physician assistant, and included in a beneficiary's plan of care that is reviewed by that practitioner at least every 60 days.

Providers of these services under the home health benefit must meet the same requirements of providers of such services under the physical therapy and related benefit, described under Attachment 3.1-A, Item 11.

Physical therapy, occupational therapy, or speech-language pathology and audiology services can only be provided by a Medicare Certified Home Health Agency. Such certification requires meeting all the requirements of Medicare Conditions of Participation. Such agencies must also be enrolled as an Ohio Medicaid provider.

Applicable limits are:

- No more than a combined total of eight hours per day of intermittent or part-time nursing services, home health aide services, and physical therapy, occupational therapy, or speech-language pathology and audiology services; and
- Visits shall not be more than four hours in length.

There are no weekly limits for physical therapy, occupational therapy, or speech pathology and audiology services.

Additional physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility beyond the established limits may be allowed when medically necessary, and as prior authorized by ODM or its designee.

Beneficiaries younger than age twenty-one can access physical therapy, occupational therapy, or speech-language pathology and audiology services without limitation when medically necessary.

1. Private duty nursing services.

Private Duty Nursing (PDN) is a service provided in the home and in the community for beneficiaries needing continuous periods of nursing to stay in the home rather than an institutional setting. The service is provided in the beneficiary's covered place of residence or in the community due to the beneficiary's medical condition or functional limitation. The level of care is determined by the treating physician's signed orders and incorporated into the plan of care. The program allows beneficiaries to access PDN through three different avenues.

The first avenue is a post-hospital service and is limited to 60 days duration and 56 hours per week for all Medicaid beneficiaries who have a medical necessity for such services as determined by the treating clinician upon discharge from a three day or more covered inpatient stay when all of the following conditions apply:

- The 60 days begin once the beneficiary is discharged from the hospital to the beneficiary's place of residence, from the last inpatient stay whether or not it was in an inpatient hospital or inpatient rehabilitation unit of a hospital; and
- The 60 days will begin once the beneficiary is discharged from a hospital to a nursing facility although PDN is not available while residing in a nursing facility; and
- The beneficiary has a skilled level of care (SLOC) as evidenced by a medical condition that temporarily reflects SLOC; and
- PDN must not be for the provision of maintenance care.

The second avenue is for beneficiaries up to age 21 who have a PDN authorization by the Medicaid agency or the agency's designee for the PDN services that are medically necessary for the health and welfare of the beneficiary.

The third avenue is for beneficiaries age 21 or older who have a PDN authorization by the Medicaid agency or the agency's designee for the PDN services that are medically necessary for the health and welfare of the adult beneficiary when all of the following conditions apply:

- The beneficiary requires continuous nursing including the provision of on-going maintenance care; and
- The beneficiary has a comparable level of care (LOC) as evidenced by either enrollment in an HCBS waiver, or a comparable institutional level of care evaluated initially and annually by Medicaid agency or its designee; and
- The beneficiary must have a PDN authorization approved by the Medicaid agency or its designee to establish medical necessity and comparable LOC.

A beneficiary who receives private duty nursing pursuant to avenue one after an inpatient stay in a hospital may continue to receive private duty nursing under avenue three if all requirements outlined above are met.

The service is provided to all Medicaid beneficiaries who meet a skilled level of care for post-hospital service and an institutional level of care for adults and children who do not

7. Home Health Services

- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Payment for an intermittent or part-time nursing visit is the lesser of the billed charge or an amount based on the Medicaid maximum for the service listed on the Department's fee schedule. "Base rate" means the amount reimbursed by Ohio Medicaid for the initial 35 to 60 minutes of service delivered. "Unit rate" means the amount paid for each 15-minute unit of service. Reimbursement for a visit is calculated as follows:

The Medicaid maximum rate for intermittent or part-time nursing services visit not rendered in a group setting is equal to the sum of:

- (1) The base rate; and
- (2) The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate, not to exceed four hours. For an initial visit less than 35 minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than 15 minutes in length, and a maximum of two units if the service is 16 through 34 minutes in length.

The Medicaid maximum rate for intermittent or part-time nursing services visit rendered in a group setting is equal to 75% of the sum of:

- (1) The base rate; and
- (2) The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate, not to exceed four hours. For an initial visit less than 35 minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than 15 minutes in length, and a maximum of two units if the service is 16 through 34 minutes in length.

All rates are published on the agency's website at <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's home health intermittent or part-time nursing services fee schedule was set as of November 1, 2021, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

7. Home Health Services

b. Home health aide services provided by a home health agency.

Payment for a home health aide visit is the lesser of the billed charge or an amount based on the Medicaid maximum for the service listed on the Department's fee schedule. "Base rate" means the amount reimbursed by Ohio Medicaid for the initial 35 to 60 minutes of service delivered. "Unit rate" means the amount paid for each 15-minute unit of service delivered when the initial visit is greater than 60 minutes in length or less than 35 minutes in length. Reimbursement for a visit is calculated as follows:

The Medicaid maximum rate for home health aide services visit not rendered in a group setting is equal to the sum of:

- (1) The base rate; and
- (2) The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate, not to exceed four hours. For an initial visit less than 35 minutes, Ohio Medicaid will reimburse a maximum of one unit if the services is equal to or less than 15 minutes in length, and a maximum of two units if the service is 16 through 34 minutes in length.

The Medicaid maximum rate for home health aide services rendered in a group setting is equal to 75% of the sum of:

- (1) The base rate; and
- (2) The unit rate multiplied by the number of covered units following the first four units included in the base rate.

All rates are published on the agency's website at <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's home health aide services fee schedule was set as of November 1, 2021, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

7. Home health services, continued.

- d. Physical therapy, occupational therapy, or speech-language pathology and audiology services provided by a home health agency or rehabilitation facility.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule.

All rates are published on the agency's website at <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency's home health physical therapy, occupational therapy, speech-language pathology, and audiology services fee schedule was set as of November 1, 2021, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

8. Private Duty Nursing Services.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum fee for the service listed on the Department's fee schedule, calculated as follows.

“Base rate” means the amount reimbursed by Ohio Medicaid for the initial 35 to 60 minutes of service delivered. “Unit rate” means the amount paid for each 15-minute unit of service. Reimbursement for a private duty nursing visit is calculated as follows:

The Medicaid maximum rate for a private duty nursing visit not rendered in a group setting is equal to the sum of:

1. The base rate; and
2. The unit rate for a visit in length beyond the initial hour of service, for each unit over the base rate up and including no more than 16 hours per nurse, on the same date or during a 24-hour time period. For an initial visit less than 35 minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than 15 minutes in length, and a maximum of two units if the service is 16 through 34 minutes in length.

The Medicaid maximum rate for a private duty nursing visit rendered in a group setting is equal to 75% of the sum of:

1. The base rate; and
2. The unit rate multiplied by the number of units over four.

All rates are published on the agency's website at <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>.

The agency’s private duty nursing fee schedule was set as of November 1, 2021, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

The Department's fee schedule identifies two rates for private duty nursing services, one for agency providers and another for non-agency/independent nurses.

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Supersedes:

TN: 17-007

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