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

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

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

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

A beneficiary may revoke the election of Hospice care at any time once an election period. Upon revocation, the beneficiary forfeits Hospice coverage for any remaining days in that election period. The beneficiary may elect to receive Hospice benefit for any additional period of eligibility.

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

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

Other covered Hospice care ("non-core" services) includes:

- Short-term inpatient hospital and respite.
- Medical appliances, including drugs and biologicals.
- Home health aide and homemaker services.
- Physical therapy, occupational therapy, and speech-language pathology.

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

- Transportation services, if needed in order for the beneficiary to receive medical care for the terminal condition.

Hospices may arrange for another individual or entity to furnish services to Medicaid beneficiaries receiving Hospice care. If services are provided under such an arrangement, the Hospice must assume fiscal and professional management responsibility for those services.

18. Hospice Care.

Reimbursement for Hospice care will be made at one of four predetermined rates for each day in which a beneficiary is under the care of the Hospice. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day. There are four levels of care into which each day of care is classified:

- Routine home care.
- Continuous home care.
- Inpatient respite care.
- General inpatient care.

The Medicaid Hospice rates are set prospectively by CMS based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register and daily Medicaid hospice payment rates announced through the Centers for Medicare and Medicaid's memorandum titled "Annual Change in Medicaid Hospice Payment Rates--ACTION" issued by the Director of the Center for Medicaid, CHIP and Survey & Certification Disabled and Elderly Health Programs Group (DEHPG).

Hospices will also be reimbursed a per diem amount to cover room and board services provided by the nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) to the Medicaid beneficiary who has elected Hospice care and resides in the NF or ICF-MR. This reimbursement rate is equal to 95 percent of the base rate paid to that particular facility of residence.

Physicians who provide direct patient care are reimbursed according to Medicaid's fee-for-service system. This reimbursement is in addition to the daily rate paid to the Hospice. If the physician is a Hospice employee, the Hospice will bill for services on behalf of the physician. If the physician is the beneficiary's attending physician and is not a Hospice employee, the physician will bill the department directly.

A Hospice's annual Medicaid reimbursement cannot exceed its annual Medicaid caseload multiplied by the statutory cap amount. Total Medicaid payments made to the Hospice for services provided by physicians who are Hospice employees, along with total payments made at the various Hospice daily rates, will be counted in determining whether the cap amount has been exceeded. Payments made for the services of physicians who are not Hospice employees and for payments made for room and board will not be included in the cap calculation. A hospice will not be reimbursed for inpatient days (general and respite) beyond 20 percent of the total days of care it provides to Medicaid beneficiaries during the "cap year."

The department will perform a desk audit on each Hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm and clicking the Fee Schedules/Rates link. The rates available at this website include all annual or periodic adjustments to the fee schedule. The agency's fee schedule was set as of October 1, 2010, 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.