Table of Contents

State/Territory Name: OH

State Plan Amendment (SPA) #: 15-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES

June 22, 2015

John B. McCarthy, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 15-007

Dear Mr. McCarthy:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA):

Transmittal #15-007
- Coverage, limitations, and payment for services: Home Health and Private Duty Nursing
- Effective Date: July 1, 2015

If you have any questions, please have a member of your staff contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Carolyn Brewer, ODM
Sarah Curtin, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: **15-007 (Revised)**	2. STATE **OHIO**
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2015**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 440.70 42 CFR 440.80 42 CFR 441 42 CFR 447 42 CFR 484	a. FFY 2015 $0 b. FFY 2016 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	**9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:**
Attachment 3.1-A, Item 7, Pages 1, 2 and 3 of 6 Attachment 3.1-A, Item 8, Pages 1 and 2 of 3 Attachment 3.1-A, Item 8, Page 3 of 3 Attachment 4.19-B, Item 7-a, Page 1 of 1 Attachment 4.19-B, Item 7-b, Page 1 of 1 Attachment 4.19-B, Item 8, Page 1 of 1	Attachment 3.1-A, Item 7, Pages 1, 2 and 3 of 6 (TN 11-002) Attachment 3.1-A, Item 8, Pages 1 and 2 (TN 09-035) (New) Attachment 4.19-B, Item 7-a, Page 1 of 1 (TN 13-019) Attachment 4.19-B, Item 7-b, Page 1 of 1 (TN 13-019) Attachment 4.19-B, Item 8, Page 1 of 1 (TN 13-019)

10. SUBJECT OF AMENDMENT: Coverage and Limitations and Payment for Services: ~~Nurse Consultation and Assessment~~ Home Health and Private Duty Nursing (PDN)

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE: [redacted]	16. RETURN TO:
13. TYPED NAME: **JOHN B. McCARTHY**	**Carolyn Brewer** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: 4/24/15	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
4/24/15	6/22/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
7/1/15	/s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Associate Regional Administrator

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

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. The place of services does not include a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities.

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, and included in a beneficiary's plan of care that is reviewed by that physician at least every 60 days. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in the state of Ohio.

Intermittent or part-time nursing services are covered only if the qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the beneficiary within the ninety days prior to the home health care start of care date, or within thirty 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 the qualifying treating physician, or a physician assistant under the supervision of the qualifying treating physician, may perform the face-to-face encounter for the purposes of the supervising physician 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 physician 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;
- Visits shall not be more than four hours in length;

- 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.

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, and included in a beneficiary's plan of care that is reviewed by that physician at least every 60 days. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in the state of Ohio.

Home health aide services are covered only if the qualifying treating physician certifying the need for home health services document s that he or she had a face-to-face encounter with the beneficiary within the ninety days prior to the home health care start of care date, or within thirty 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 the qualifying treating physician, or a physician assistant under the supervision of the qualifying treating physician, may perform the face-to-face encounter for the purposes of the supervising physician 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 physician 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; 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.

Additional home health aide services provided by a home health agency beyond the established limits may be allowed when medically necessary.

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

8. 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 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 physician 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.

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

have a hospital stay and need to receive continuous nursing care from non-agency registered nurse; non-agency licensed practical nurse; Medicare Certified Home Health Agency; or a home health agency accredited by a national accreditation organization approved by the Centers for Medicare and Medicaid Services (CMS), which may include, but is not limited to, one of the following: the Accreditation Commission for Health Care (ACHC), the Community Health Accreditation Program (CHAP), and the Joint Commission (TJC).

PDN visits are required to be continuous nursing visits that are medically necessary and:

- More than 4 hours but less than or equal to 12 hours in length a visit, and
- Require a lapse of two or more hours between the provision of home health nursing and PDN.

The exceptions to the visit requirements, above, are as follows:

- An unforeseen event which causes a medically necessary visit to end in less than four hours or extend beyond twelve hours, up to and including but no more than16 hours; or
- Less than a two hour lapse between visits has occurred and the length of the PDN service requires an agency to provide a change in staff; or
- Less than a two hour lapse between visits has occurred and the PDN service is provided by more than one non-agency provider; or
- The Medicaid agency or its designee has authorized PDN visits that are four hours or less in length.

Applicable limits to PDN are:

- The PDN post-hospital service is limited to 60 days, as described, above, in the first avenue.
- PDN services provided through the second and third avenues have no limits on the number of PDN visits.
- An RN assessment must be performed on an individual prior to the start of PDN services for the first time, prior to any change of order to an individual's PDN services, and/or any time the RN is informed that the individual receiving the PDN services has experienced a significant change in his or her condition that warrants a new RN assessment.
- An RN assessment cannot be concurrently performed with any other service during a visit in which the RN is furnishing PDN services.
- An RN assessment cannot be performed 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 consultations are not covered for consultations between RNs.

- RN consultations are not covered when performed with nursing delegation services under the Ohio Department of Developmental Disabilities (DODD) waiver.

Additional private duty nursing services provided beyond the established limits may be allowed when medically necessary.

Individuals up to age 21 can access PDN services without limitation when medically necessary.

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 thirty-five to sixty minutes of service delivered. "Unit rate" means the amount paid for each fifteen 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 thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

The Medicaid maximum rate for intermittent or part-time nursing services visit rendered in a group setting is equal to seventy-five percent 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 thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's home health intermittent or part-time nursing services fee schedule was set as of July 1, 2015, 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.

Home health aide services provided by a home health agency under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.70

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 thirty-five to sixty minutes of service delivered. "Unit rate" means the amount paid for each fifteen minute unit of service. 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 thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the services is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

The Medicaid maximum rate for home health aide services rendered in a group setting is equal to seventy-five percent 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 medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's home health aide services fee schedule was set as of July 1, 2015, 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 thirty-five to sixty minutes of service delivered. "Unit rate" means the amount paid for each fifteen 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 sixteen hours per nurse, on the same date or during a twenty-four hour time period. For an initial visit less than thirty-five minutes, Ohio Medicaid will reimburse a maximum of one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

The Medicaid maximum rate for a private duty nursing visit rendered in a group setting is equal to seventy-five percent 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 medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.
The agency's private duty nursing fee schedule was set as of July 1, 2015, 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.