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State Territory Name: OHIO

State Plan Amendment (SPA) #: 24-0022

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
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

January 6, 2025

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: TN 24-0022

Dear Director Corcoran:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-B 24-0022, which was submitted to CMS on December 3, 2024. This plan amendment updates rates for Hospice Care.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Debi Benson at 312-886-0360 or via email at Deborah.Benson@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24-0022

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 418

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ (9,473)
b. FFY 2026 $ (9,473)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Item 18, page 1-3 of 3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Item 18, page 1-3 of 3 (TN 16-011)

9. SUBJECT OF AMENDMENT

Payment for Services: Hospice Care

10. 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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
MAUREEN M. CORCORAN

13. TITLE
STATE MEDICAID DIRECTOR

14. DATE SUBMITTED
December 3, 2024

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
December 3, 2024

17. DATE APPROVED
January 6, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

18. Hospice Care.

Reimbursement for Hospice care will be made at 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. With the exception of payment for physician services, the following categories or levels of care into which Medicaid hospice is classified are:

- Routine home care, (RHC)
- Continuous home care
- Inpatient respite care
- General inpatient care
- Service Intensity Add-On

The State pays the Medicaid Hospice rates published annually by CMS. Medicaid Hospice rates are 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 the indices published in the Federal Register and the 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 Deputy Director of the Center for Medicaid, CHIP Services Financial Management Group (FMG).

The State posts on the agency's website two separate rate tables for Medicaid hospice providers to use. The first table reflects full payment for providers that comply with quality data reporting requirements, while the second table reflects a four-percentage-point payment reduction specific for any Medicaid hospice provider that failed to comply with Section 3004 of the Affordable Care Act [Section 1814(i)(5)(A)(i)] and the Hospice Quality Reporting Program (HQRP).

Upon notice from CMS that a provider has failed to comply with HQRP the previous fiscal year, the State directs the provider to submit all hospice claims to the Ohio Department of Medicaid for the ensuing federal fiscal year using rates posted online at http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/SchedulesandRates.aspx for "Providers that Failed to Comply with Quality Reporting Requirements". The four-percentage-point payment reduction is reflected in categories of hospice care, including routine home care, continuous home care, inpatient respite, and general inpatient care.

Rates for routine home care are to be paid at a two-tiered per diem, as set by CMS based on a beneficiary's length of stay–with a higher rate for the first 60 days of hospice care and a lower rate starting on day 61. The two-tier rates are applicable irrespective of:

- the beneficiary's level of hospice care;
- whether a beneficiary revokes, transfers, or is discharged from hospice care; and/or
- whether a lapse or break in hospice service occurs. A minimum of 60 days' gap in Hospice services is required to reset the counter which determines which payment category a participant is qualified for.

In addition, a service intensity add-on (SIA) payment is payable for services provided by a registered nurse (RN) or social worker in the last seven days of a hospice beneficiary's life. The SIA is available under the following conditions:

- The day of care is a routine home care day;
- The day occurs during the last seven days of life;
- The patient's discharge is due to death;
- The direct care provided by an RN or social worker occurred during an in-person visit;
- The total hours paid for the SIA does not exceed four hours in a day for the RN and social worker combined;
- The SIA payment equals the hourly rate for continuous home care, multiplied by the number of hours of RN and social worker direct patient care visit time;
- The SIA payment is paid retrospectively by CMS claims, in addition to the routine home care rate paid by Medicaid; and
- Visits for the pronouncement of death are not be counted for the SIA payment.

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 individuals with intellectual disabilities (ICF-IID) to the Medicaid beneficiary who has elected Hospice care and resides in the NF or ICF-IID. This reimbursement amount is equal to 95 percent of the rate that the long-term care facility would have otherwise received from Medicaid if the individual was not enrolled in hospice.

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 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 12-month period beginning October 1 of each year.