Ohio Administrative Code

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

Effective: October 1, 2024

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

(A) The designated hospice will 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 will 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 will ensure covered services provided to the individual are furnished by qualified personnel pursuant to 42 C.F.R. 418.114 (October 1, 2023), 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:

(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 or physician assistants 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:

(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, 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 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf).

(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 can 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 will 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 will 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 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf).

(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 should:

(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.