AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations [X] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [X] No limitations [ ] With limitations* [ ] Not Provided:

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

[ ] Provided [ ] No limitations [X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* ~~[X]~~ [ ] Not Provided:

*Description provided on attachment

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Early and Periodic Screening. Diagnosis and Treatment of Conditions Found (continued)

~~d. Hospice - Payment for services will be based on the state-wide procedure based reimbursement methodology established by the State. Reimbursement will be made utilizing established rates for procedures which have been identified by the American Medical Association, Health Care Financing Administration, Medicare Carriers or the Oklahoma Department of Human Services. When no reimbursement rate is available, the rate will be set utilizing basic procedures used in establishing Medicare and Medicaid rates. A Procedure Review Committee consisting of medical professionals will make the final determination. Reimbursement limits per procedure are determined based on a review of comparable services under comparable circumstances as set by DHS and Medicare methodologies. Adjustments to the payment limits on an individual procedure will be periodically considered by the Procedure Review Committee on an as-needed basis as requested by medical providers. Consideration may be given to a payment adjustment to assure availability and accessibility of services primarily due to possible limited availability of services in some geographic locations.~~

Hospice Services

With the exception of payment for physician services, reimbursement for hospice care will be made at one (1) of five (5) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. A description of the payment for each level of care is as follows:

(a) **Routine home care.** The hospice will be paid one of two routine home care rates for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The two-rate payment methodology will result in a higher based payment for days one (1) through sixty (60) of hospice care and a reduced rate for days sixty-one (61) to infinity. A minimum of sixty (60) days gap in hospice services is required to reset the counter, which determines the payment category for the service.

(b) **Continuous home care.** Continuous home care is to be provided only during a period of crisis. A period of crisis is the period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Either a registered nurse or a licensed practical nurse must provide care and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day, which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

(c) **Inpatient respite care.** The hospice will be paid at the inpatient respite care rate for each day the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate: routine, continuous, or general inpatient rate. Inpatient respite care may be provided in hospital or nursing facility.

(d) **General inpatient care.** Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general inpatient care except as described in the section of this plan which discusses payment of physician services.

(e) **Service intensity add-on.** Effective January 1, 2016, payment for the Service Intensity Add-On (SIA) will be made for a visit by a registered nurse (RN) or Social Worker when provided in the last seven (7) days of life. Payment for the SIA will be equal to the continuous home care incremental rate multiplied by the increments of nursing provided (up to four [4] hours/sixteen [16] increments total) per day for each day in the last seven (7) days of life.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Early and Periodic Screening. Diagnosis and Treatment of Conditions Found (continued)

Other General Reimbursement Items

(a) **Date of discharge.** For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

(b) **Hospice payment rates.** The Medicaid hospice payment rates will not be less than the Medicaid hospice rates established under Medicare, adjusted by the wage index. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients.

Obligation of continuing care

After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

Payment for physician services

The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the member's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. The physician serving as the medical director and the physician member of the hospice interdisciplinary group would generally perform these activities. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These rates cover hospice care including nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.

Reimbursement for an independent physician's direct patient services is made in accordance with the usual SoonerCare reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice.

Effective for services provided on or after April 1, 2014, the rates will be decreased by 3.25%. Effective for services on or after July 1, 2014, the rates will be reduced by an additional 7.75%. Rates will not be less than Medicaid hospice rates established under Medicare adjusted by the wage index.