# TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
# CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPEICALTIES

## PART 58. HOSPICE

**317:30-5-531. Coverage**

(a) **Definition. "Hospice care"** means a comprehensive, holistic program of palliative and/or comfort care and support provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six (6) months or less.

(b) **Requirements.**

(1) Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(2) Hospice care is performed under the direction of a physician as per the member's plan of care in an approved hospital hospice facility, in-home hospice program, or nursing facility.

(c) **Eligibility.** ~~Coverage for hospice services is provided to Medicaid eligible members.(1)~~ Hospice care eligibility requires physician certification that the member is terminally ill and includes a medical prognosis with a life expectancy of six (6) months or less if the illness runs its normal course. The terminal prognosis also must be supported by clinical documentation in the medical record. The certification must be completed by the member's attending physician ~~or~~and the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, nurse practitioners may re-certify the terminal illness.

~~(2) For information regarding hospice provision provided through waivers, refer to Oklahoma Administrative Code (OAC) 317:30-5-763, 317:30-5-1200, and 317:30-5-1202.~~

(d) **Covered services.** Hospice care services can include but are not limited to:

(1) Nursing care;

(2) Physician services (e.g., physicians employed or working under arrangements made with the hospice);

(3) Medical equipment and supplies;

(4) Drugs for symptom control and pain relief;

(5) Home health aide services;

(6) Personal care services;

(7) Physical, occupational and/or speech therapy;

(8) Medical social services;

(9) Dietary counseling; and

(10) Grief and bereavement counseling to the member and/or family are required but are not reimbursable.

(e) **Prior authorization.** All services must be prior authorized, and a written plan of care must be established before services are rendered. For medical review purposes, all hospice services will be authenticated in accordance with OAC 317:30-3-30.

(f) **Service election.**

(1) For Medicaid eligible adults, the member or member's legal guardian or authorized representative must sign an election statement, choosing hospice care instead of routine medical care with the objective to treat and cure the member's terminal illness, 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.

(2) For Medicaid eligible children, hospice services are available without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness.

(3) Once the member, legal guardian, or member's authorized representative has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice.

(g) **Service revocation.**

(1) Hospice care services may be revoked by the member, family, legal guardian, or authorized representative at any time.

(2) Upon revoking the election of Medicaid coverage of hospice care for a particular election period, the member resumes Medicaid coverage of any benefits waived when hospice care was elected.

(3) The member may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(h) **Service frequency.** Hospice care services:

(1) Are available for an initial two (2) ninety-day (90-day) certification periods. After the two (2) initial ninety-day (90-day) periods, a member is allowed an unlimited number of sixty-day (60-day) certification periods during the remainder of the member's lifetime. Each certification period requires a new prior authorization.

(2) Require a hospice physician or nurse practitioner to have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter should take place prior to the one hundred eightieth (180th) day recertification and each subsequent recertification thereafter; and attest that such visit took place.

(i) **Documentation.** Initial documentation requirements for requesting services, documentation requirements for continuation of services, and the full hospice guidelines can be found at OHCA's website, https://oklahoma.gov/ohca.

(j) **Reimbursement.**

(1) SoonerCare shall provide hospice care reimbursement:

(A) For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the level, type and intensity of the services furnished to the individual for that day in accordance with the Oklahoma Medicaid State Plan.

(B) For independent physician direct services in accordance with the Oklahoma Medicaid State Plan.

(2) Through the Oklahoma Medicaid State Plan, the OHCA established payment amounts for the following categories:

(A) **Routine hospice care.** Member is at home and not receiving hospice continuous care.

(B) **Continuous home care.** Member is not in an inpatient facility and receives hospice on a continuous basis at home; primarily consisting of nursing care to achieve palliation and management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.
(C) **Inpatient respite care.** Member receives care in an approved inpatient facility on a short-term basis for respite.
(D) **General inpatient care.** Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home.
(E) **Nursing facility (NF)/intermediate care facilities for individuals with intellectual disabilities (ICF/IID) care**. Member receives hospice care in a NF or ICF/IID. Hospice nursing facility or ICF/IID room and board per diem rates are reimbursed to the in-home hospice provider at a rate equal to ninety-five percent (95%) of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the NF or ICF/IID. If Medicare is the primary payer of hospice benefits, OHCA will only reimburse the hospice provider for coinsurance and deductible amounts per the Oklahoma Medicaid State Plan and will continue to pay the room and board to the nursing facility.
(F) **Service intensity add-on**. Member receives care by a registered nurse (RN) or social worker when provided in the last seven (7) days of his/her life.
(G) **Other general reimbursement items.** The following reimbursement methodology applies to hospice:

(i) **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.
(ii) **Inpatient day cap**. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve-month (12-month) period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.
(iii) **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.

## PART. 85 ADVANTAGE PROGRAM WAIVER SERVICES

**317:30-5-764. Reimbursement**

(a) Rates for Waiver services are set in accordance with the rate-setting process by the State Plan Amendment and Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority (OHCA) Board.

(1) The rate for Nursing Facility (NF) respite is set equivalent to the rate for routine level of care NF services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health is set equivalent to the rate established by the Oklahoma Department of Human Services (OKDHS) for equivalent services provided for the OKDHS Adult Day Service Program that requires providers have equivalent qualifications.

(3) The rate for units of home-delivered meals is set equivalent to the rate established by the OKDHS for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications.

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate that requires providers have equivalent qualifications.

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) Consumer-Directed Personal Assistance Services and Supports (CD-PASS) rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the items listed in (A) B (C) of this paragraph.

(A) The IBA Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The Personal Care (PSA) and Personal Care Advanced Supportive/Restorative (APSA) service unit rates are calculated by the OKDHS Aging Services (AS) during the CD-PASS service eligibility determination process. OKDHS AS sets the PSA and APSA unit rates at a level that is not less than eighty percent (80%) and not more than ninety-five percent (95%) of the comparable PSA or APSA service rates. The allocation of portions of the PSA and/or APSA rates to cover salary, mandatory taxes, and optional benefits including Worker's Compensation insurance, when available, is determined individually for each member using the CD-PASS IBA Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. When the member's need for services changes due to a change in health/disability status or a change in the level of support available from other sources to meet needs, the case manager, based upon an updated assessment, amends the person-centered service plan to increase CD-PASS service units appropriate to meet additional member need. OKDHS AS, upon favorable review, authorizes the amended person-centered service plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member with assistance from the Financial Management Service, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three (3) per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by Uniform Comprehensive Assessment Tool, Part III (UCAT III) assessment by the member's Advantage case manager employed by a case management agency independent of the Assisted Living Services provider. ADvantage payment is not made for twenty-four (24) hour skilled care in an assisted living center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day health or environmental modifications to a member while receiving assisted living services since these services are integral to and inherent in the provision of assisted living service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage assisted living. Separate payment is not made for ADvantage respite to a member while receiving assisted living services since by definition assisted living services assume the responsibility for twenty-four (24) hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage assisted living services provider is allowed to charge a maximum for room and board that is no more than ninety (90) percent of the Supplemental Security Income (SSI) Federal Benefit Rate. When, per Oklahoma Administrative Code (OAC) 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

~~(8) The maximum total annual reimbursement for a member's hospice care within a twelve (12) month period is limited to an amount equivalent to eighty-five (85) percent of the Medicare Hospice Cap payment.~~

(b) The OKDHS AS approved ADvantage person-centered service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying the:

(1) Service;

(2) Service provider;

(3) Units authorized; and

(4) Begin and end dates of service authorization.

(c) Service time for personal care, case management services, nursing, skilled nursing, supportive/restorative assistance, and in-home respite, is documented through the use of the designated statewide Electronic Visit Verification System (EVV) when services are provided in the home. Providers are required to use the EVV system after access to the system is made available by OKDHS. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and documentation of service provisions are given to OHCA's Program Integrity Unit for follow-up investigation.

**317:30-5-1200. Benefits for members age 65 or older with disabilities or long-term illnesses**

(a) Living Choice program participants age 65 or older with disabilities or long-term illnesses may receive a range of necessary medical and home and community based services for one year after moving from an institutional setting. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.

(d) Services that may be provided through the Living Choice program for older persons with disabilities or long-term illnesses are listed in paragraphs (1) through ~~(26)~~(25) of this subsection:

(1) case management;
(2) respite care;
(3) adult day health care;
(4) environmental modifications;
(5) specialized medical equipment and supplies;
(6) therapy services including physical, occupational, speech and respiratory;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) extended duty nursing;
(10) home delivered meals;
~~(11) hospice care;~~
~~(12)~~(11) medically necessary prescription drugs;
~~(13)~~(12) personal care as described in Part 95 of this Chapter;
~~(14)~~(13) Personal Emergency Response System (PERS);
~~(15)~~(14) self-direction;
~~(16)~~(15) transition coordination;
~~(17)~~(16) community transition services as described in OAC 317:30-5-1205;
~~(18)~~(17) dental services (up to $1,000 per person annually);
~~(19)~~(18) nutrition evaluation and education services;
~~(20)~~(19) agency companion services;
~~(21)~~(20) pharmacological evaluations;
~~(22)~~(21) vision services including eye examinations and eyeglasses;
~~(23)~~(22) non-emergency transportation;
~~(24)~~(23) family training services;
~~(25)~~(24) assisted living services; and
~~(26)~~(25) SoonerCare compensable medical services.

## PART 113. LIVING CHOICE PROGRAM

**317:30-5-1202. Benefits for members with physical disabilities**

(a) Living Choice program participants with physical disabilities may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.

(d) Services that may be provided to members with physical disabilities are listed in paragraphs (1) through ~~(32)~~(31) of this subsection:

(1) case management;
(2) personal care services as described in Part 95 of this Chapter;
(3) respite care;
(4) adult day health care with personal care and therapy enhancements;
(5) architectural modifications;
(6) specialized medical equipment and supplies;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) home delivered meals;
(10) therapy services including physical, occupational, speech and respiratory;
~~(11) hospice care;~~
~~(12)~~(11) Personal Emergency Response System (PERS);
~~(13)~~(12) Self-Direction;
~~(14)~~(13) agency companion services;
~~(15)~~(14) extended duty nursing;
~~(16)~~(15) psychological services;
~~(17)~~(16) audiology treatment and evaluation;
~~(18)~~(17) non-emergency transportation;
~~(19)~~(18) assistive technology;
~~(20)~~(19) dental services (up to $1,000 per person annually);
~~(21)~~(20) vision services including eye examinations and eyeglasses;
~~(22)~~(21) pharmacotherapy management;
~~(23)~~(22) independent living skills training;
~~(24)~~(23) nutrition services;
~~(25)~~(24) family counseling;
~~(26)~~(25) family training;
~~(27)~~(26) transition coordination;
~~(28)~~(27) psychiatry services;
~~(29)~~(28) community transition services as described in OAC 317:30-5-1205;
~~(30)~~(29) pharmacological evaluations;
~~(31)~~(30) assisted living services; and

~~(32)~~(31) SoonerCare compensable medical services.