Revised Submission 2.19.13

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 disease) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ 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.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

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

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

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

☒ Provided: ☐ No limitations ☒ Provided in accordance with section 2302 of the Affordable Care Act

☒ With limitations*

☐ Not provided.

*Description provided on Attachment 3.1-A.

Hospice Services Limitations

Hospice services shall be covered for recipients who have been determined to be terminally ill by a physician and who have filed an election statement with a hospice enrolled to participate in the Medicaid Program. Room and board shall be paid if a person is a resident in a nursing facility.

Hospice services are provided for the complete comprehensive care and management of the terminal illness of the individual who has been certified by a physician as having a prognosis of a life expectancy of six months or less if the illness runs its normal course, and who elects hospice services. Hospice services are non-curative in nature and focus on pain management and support services for the terminally ill and their family. All care provided to the patient must be consistent with the plan of care established by the hospice interdisciplinary team.

Upon the election of hospice services the patient signs an agreement to waive those Medicaid services for curative care, treatment, or services related to their terminal illness that would be covered under the Medicaid program, other than the services provided by the elected hospice and their attending physician. However, hospice services for a child (ages 0-20) may be concurrent with the care related to the curative treatment of the child's condition for which a diagnosis of a terminal illness has been made.

An individual may elect to receive hospice care during one or more of the following election periods: (1) An initial 90-day period, (2) A subsequent 90-day period, (3) Unlimited subsequent 60-day periods. During each election period the recipient may change hospice one (1) time. Revocation of the election of hospice does not prohibit the recipient from returning to hospice in the future. A recipient is eligible to receive hospice services from date of election until death, as long as other hospice eligibility requirements are met.

Provision of hospice services will be limited to those providers who are Medicare certified.

Revised Submission 2.19.13

State/Territory: Kansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All medically needy groups

c. Intermediate care facility services.

☒ Provided: ☐ No limitations ☒ With limitations*

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.

☒ Provided: ☐ No limitations ☒ With limitations*

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

☒ Provided: ☐ No limitations ☒ With limitations*

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

☒ Provided: ☐ No limitations ☒ With limitations*

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

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

☒ Provided: ☐ No limitations ☒ Provided in accordance with section 2302 of the Affordable Care Act

☒ With limitations*

☐ Not provided.

*Description provided on Attachment 3.1-A.

Hospice Services
Methods and Standards for Establishing Payment Rates

Medicaid hospice payment rates are set prospectively by CMS based on methodology used in setting Medicare hospice rates.

The reimbursement rate for hospice services for participants age 21 and over includes all covered services related to the treatment of the terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. The reimbursement for hospice services for participants under age 21 is the same with the exclusion of reimbursement of curative covered services.

(1) The Medicaid hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by section 1814(i)(1)(C)(ii) of the Social Security Act (the Act) which also provides for an annual increase in payment rates for hospice care services. Rates for hospice physician services are not increased under this provision.

(2) Medicaid-eligible individuals residing in nursing facilities who meet the hospice eligibility criteria may elect Medicaid hospice services. The per diem amount for room and board cost is at least 95% of the per diem rate that Medicaid would have paid to the nursing facility for that individual in that facility under the State plan.

(3) Physician services will be reimbursed in accordance with Medicaid reimbursement policy for physician services based on the lower of the actual charge or the Medicaid maximum allowable amount for the specific service, and as described in section 4307 of the State Medicaid Manual.

(4) According to the State Medicaid Manual, section 4306.1, payment for hospice care is made at one of the four predetermined rates: Routine Home Care, Continuous Home Care, Inpatient Respite Care and General Inpatient Care.

Payment of hospice care and the hospice wage index are updated annually. Section 1814(i)(1)(C)(ii) of the Social Security Act stipulates the payments for hospice care for the federal fiscal years after 2002 will increase by the market basket percentage increase for the fiscal year.

For each day that an individual is under the care of a hospice, pay the hospice an amount applicable to the type and intensity of the service furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows.

A. Routine Home Care.--Pay the hospice the routine home care rate for each day the patient is under the care of the hospice and you do not pay at another rate. This rate is paid without regard to the volume or intensity of services provided on any given day.

B. Continuous Home Care.--Pay the hospice at the continuous home care rate when continuous home care is provided. (See §4305.6.) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours per day must be provided. Pay the hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

C. Inpatient Respite Care.--Pay the hospice at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. (See §4305.6.) Pay for respite care for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Pay for the sixth and any subsequent days at the routine home care rate.

D. General Inpatient Care.--Pay at the general inpatient rate when general inpatient care is provided except as described in §4306.2.

Revised Submission 6.24.13

KANSAS MEDICAID STATE PLAN

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A MR	Deductibles MR	Coinsurance
	Part B MR	Deductibles MR	Coinsurance
Other Medicaid Recipients	Part A MR	Deductibles MR	Coinsurance
	Part A MR	Deductibles MR	Coinsurance
Dual Eligible (QMB Plus)	Part A MR	Deductibles MR	Coinsurance
	Part B MR	Deductibles MR	Coinsurance

Revised Submission 6.24.13

KANSAS MEDICAID STATE PLAN

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

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