§4305. Hospice Payment Rates

A. The payment rates for each level of care will be the Medicaid hospice rates that are calculated by using the Medicare hospice reimbursement methodology but adjusted to disregard cost offsets attributable to Medicare deductible and coinsurance amounts. For routine home care, continuous home care, and inpatient respite care, only one rate is applicable for each day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the recipient on that day.

1. Local Adjustment of Payment Rates. The payment rates referred to in §4301 and this §4305 are adjusted for regional differences in wages. The bureau will compute the adjusted rate based on the geographic location at which the service was furnished to allow for the differences in area wage levels, using the same method used under Part A of Title XVIII.

a. The hospice program shall submit claims for payment for hospice care only on the basis of the geographic location at which the services are furnished.

b. The nursing facility shall be considered an individual's home if the individual usually lives in the nursing facility.

2. Payment for Physician Services. The four basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness. This includes the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities are generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. 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.

a. The hospice is paid for other physicians' services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis. The physician visit for the face-to-face encounter will not be reimbursed by the Medicaid Program.

b. The hospice is reimbursed in accordance with the usual Medicaid reimbursement policy for physicians' services. This reimbursement is in addition to the daily rates.

c. Physicians who are designated by recipients as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice in accordance with 42 CFR 418.3. All direct patient care services rendered by these physicians to hospice patients are hospice physician services, and are reimbursed in accordance with the procedures outlined in §4305.A.1. Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement. The hospice may be reimbursed on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). The hospice must have a liability to reimburse the physician for those physician services rendered. In determining which services are furnished on a volunteer basis and which services are not, a physician must treat Medicaid patients on the same basis as other patients in the hospice.

d. An independent attending physician is reimbursed in accordance with the usual Medicaid reimbursement methodology for physician services.

i. The only services billed by the attending physician are the physician's personal professional services. Costs for services such as lab or x-rays are not included on the attending physician's bill.

ii. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), amended LR 34:441 (March 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015).

§4309. Limitation on Payments for Inpatient Care

A. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid patients.

1. During the 12-month period beginning November 1 of each year and ending October 31, the number of inpatient respite care days for any one hospice beneficiary may not exceed five days per occurrence.

2. Once each year at the end of the hospices' "cap period" the bureau calculates a limitation on payment for inpatient care to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid patients.

a. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are included in the calculation of this inpatient care limitation.

b. Any excess reimbursement is refunded by the hospice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1472 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 48:2294 (September 2022).