Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:129 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1563 (November 2020).

§3503. Waiver of Payment for Other Services

A. Hospice providers must provide services to beneficiaries that are comparable to the Medicaid-covered services that could have been received prior to the election of hospice. This requirement refers to all Medicaid-covered services including, but not limited to, durable medical equipment, prescription drugs, and physician-administered drugs.

B. Beneficiaries who are age 21 and over may be eligible for additional personal care services as defined in the Medicaid State Plan. Services furnished under the personal care services benefit may be used to the extent that the hospice provider would otherwise need the services of the hospice beneficiary's family in implementing the plan of care.

C. Beneficiaries under age 21 who are approved for hospice may continue to receive life-prolonging treatments. Life-prolonging treatments are defined as Medicaid-covered services provided to a beneficiary with the purpose of treating, modifying, or curing a medical condition to allow the beneficiary to live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. The hospice provider and other providers must coordinate life-prolonging treatments and these should be incorporated into the plan of care.

D. Beneficiaries under the age of 21 who are approved for hospice may also receive early and periodic screening, diagnostic and treatment personal care, extended home health, and pediatric day health care services concurrently. The hospice provider and the other service providers must coordinate services and develop the patient's plan of care as set forth in §3705.

E. For beneficiaries under the age of 21, the hospice provider is responsible for making a daily visit, unless specifically declined by the beneficiary or family, to coordinate care and ensure that there is no duplication of services. The daily visit is not required if the beneficiary is not in the home due to hospitalization or inpatient respite or inpatient hospice stays.

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 28:1467 (June 2002), amended by the

§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 days for any one hospice recipient 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).