PAYMENT FOR HOSPICE SERVICES

Agency Only Services

For recipients who are not in a nursing home, Medicaid payments for hospice services will be made at one of the four predetermined rate categories that coincide with the categories established under Medicare. The hospice rates will be at least the Medicaid rates set by CMS. For each day that an individual is under the care of a Medicare-certified hospice agency, the hospice agency will be paid in accordance with the established Medicare fee schedule. Payment rates are based on the type and intensity of the services furnished to the individual for a given day according to one of the following levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. All of these levels of care are paid on a per diem basis other than continuous home care that is paid on an hourly basis. Additionally, the hospice payments will be adjusted according to recognized geographic areas to reflect differences in the wage index as published by the Centers for Medicare and Medicaid Services (CMS). Payments are made according to the area in which the service was provided, not according to the billing office location. Payment to the hospice agency may be considered retroactive to allow the hospice eligibility date to coincide with the Medicaid eligibility date, if the hospice service met the prior authorization criteria at the time service was delivered and if no other provider was reimbursed by Medicaid or any other payer for care related to the individual's terminal illness. The hospice agency must provide documentation to the Medicaid agency that demonstrates its service met all prior authorization criteria at the time of delivery.

Concurrent Care for Recipients Under 21 Years of Age

Concurrent treatment allowed under the State Plan for a terminal illness and other related conditions is available to recipients who are under 21 years of age and elect to receive Medicaid hospice care. For life-prolonging treatment provided to these recipients, Medicaid shall reimburse the appropriate Medicaid-enrolled medical care providers directly through the usual and customary Medicaid billing procedures.

Agency Services Delivered in Conjunction with Nursing Home Services

For a recipient in a nursing facility who elects to receive hospice service from a Medicare-certified hospice agency, Medicaid will pay the hospice agency an additional per diem (for routine home care days only) to cover the cost of room and board in the nursing facility. The room and board rate will be 95 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider (facility/provider "specific rate") if the recipient had not elected to receive hospice care. In the event a Medicare-certified facility provides hospice services and is not Medicaid-certified, the room and board rate will be 95 percent of the statewide average Medicaid reimbursement rate for nursing facilities. For a recipient who is under 21 years of age, the room and board rate will be 100 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider if the recipient had not elected to receive hospice care. With the election to receive hospice services, Medicaid payment to the nursing facility discontinues and the hospice agency pays the nursing facility the cost of room and board. In this context, room and board costs are for the performance of personal care services that include daily living assistance, social activities, administration of medication, room maintenance, supervising and assisting in the use of durable medical equipment and prescribed therapies, and other services associated with a nursing home inpatient stay.

PAYMENT FOR HOSPICE SERVICES (Continued)

Limitation for Inpatient Care

Total payment to a hospice agency for inpatient care (general or respite) is subject to the limitation that total inpatient care days for Medicaid recipients may not exceed 20 percent of the total days for which these individuals had elected hospice care. This limitation is applied on an agency wide basis and is not applied to individual patient stay services. At the end of each cap period, the Department calculates a limitation on payment of inpatient care for each hospice, to ensure that Medicaid payment is not made for days of inpatient care that exceed 20 percent of the total number of days of hospice care furnished to Medicaid recipients. The hospice agency then repays the Medicaid program a "prorated" share of total inpatient payment. This repayment will be computed as follows: [("Excess" Medicaid inpatient days/total paid Medicaid inpatient days) X (payment rate per diem)].

The inpatient care limitation does not apply to individuals with AIDS or to individuals who are under 21 years of age and receiving life-prolonging treatment for a terminal illness.