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State/Territory Name: Louisiana

State Plan Amendment (SPA) #: 13-47

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

July 17, 2014

Our Reference: SPA LA 13-47

Ms. Ruth Kennedy, State Medicaid Director
Department of Health and Hospitals
Bienville Building
628 North 4th Street
Post Office Box 91030
Baton Rouge, LA 70821-9030

Attn: Darlene Budgewater
Jodie Hebert

Dear Ms. Kennedy:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 13-47. The SPA proposes to comply with the federal requirements of the Affordable Care Act (ACA) with regards to hospice. The amendment also revises the provisions governing prior authorization for hospice services in order to control escalating costs associated with the hospice program.

Transmittal Number 13-47 is approved with an effective date of November 20, 2013 as requested. A copy of the HCFA-179, Transmittal No. 13-47 dated December 30, 2013 is enclosed along with the approved plan pages.

If you have any questions, please contact Ford Blunt III at ford.blunt@cms.hhs.gov or by phone at (214) 767-6381.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

Enclosures

[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-47**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 20, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905(o) of the Social Security Act
42 CFR Part 418

7. FEDERAL BUDGET IMPACT:
FFY **2014** **$(391.98)**
FFY **2015** **$(323.16)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Item 18, Pages 1-7
Attachment 3.1-A, Item 18, Page 8
Attachment 4.19-B, Item 18, Page 1-1a
Attachment 4.19-B, Item 4b, Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same (TN 12-17)
None (New Page)
Same (TN 12-17)
Same (TN 12-17)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to comply with the federal requirements of the Patient Protection and Affordable Care Act (PPACA). This amendment also revises the provisions governing prior authorization for hospice services in order to control the escalating costs associated with the Hospice Program.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material.**

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
December 30, 2013

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 30, 2013

18. DATE APPROVED: July 17, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
November 20, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Bill Brooks

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

[redacted]

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATION ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS

Medical and Remedial Care and Services - Item 18

CITATION
1905(o) of the Social Security Act

Hospice Care

The Bureau of Health Services Financing (BHSF) will provide reimbursement for Medicaid recipients who are terminally ill. Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

42 CFR Part 418

The hospice benefit is unlimited if qualifying hospice benefit criteria are met.

Medicaid eligible children who elect hospice care must receive it concurrently with curative care for the terminal condition.

I. Election Periods

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; and
3. unlimited 60-day periods.

The election periods may be used consecutively or at different times during the recipient's life span. An individual may not designate an effective date that is earlier than the date that the election is made.

If an election has been revoked, the individual or his/her legal representative may at any time file an election, for any other election period that is still available to the individual.

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Prior Authorization

Prior Authorization is required for all election periods. A patient must have a terminal prognosis and not just certification of terminal illness. The prognosis of terminal illness will be reviewed. Authorization will be made on the basis that a patient is terminally ill as defined in 42 CFR 418. Authorization will be based on objective clinical evidence contained in the clinical record which supports the medical prognosis

that the patient's life expectancy is six months or less if the illness runs its normal course and not simply on the patient's diagnosis.

The Medicare criteria found in *Local Coverage Determination (LCD) Hospice Determining Terminal Status* (L32015) will be used in analyzing information provided by the hospice to determine if the patient meets clinical requirements for this program.

Providers shall submit the appropriate forms and documentation required for prior authorization of hospice services as designated by the Department.

In the case of a denial, a written notice of denial shall be submitted to the hospice, recipient, and nursing facility, if appropriate.

Claims will only be paid from the date of the Hospice Notice of Election if the prior authorization request is received within 10 days from the date of election and is approved. If the prior authorization request is received 10 days or more after the date on the Hospice Notice of Election, the approved begin date for hospice services is the date the completed prior authorization packet is received.

II. Election Statement

An election statement must be filed with the specific hospice for the individual who meets the eligibility requirements. An election to receive hospice care will be considered to continue through the initial election period and the subsequent election periods without a break in care as long as the individual (1) remains in the care of the hospice; (2) does not revoke the election; and (3) is not discharged from hospice.

The election statement must include:

1. identification of the particular hospice that will provide care to the individual;
2. the individual's or his/her legal representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness;
3. acknowledgment that certain Medicaid services, defined on Attachment 3.1A, Item 18, Page 8 , are waived by the election;
4. the effective date of the election, which may be the first day of hospice

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care or a later date, but may be no earlier than the date of the election statement; and

5. the signature of the individual or his/her legal representative.

Medicaid eligible children who elect hospice care must receive it concurrently with curative care for the terminal condition.

Dually eligible (Medicare and Medicaid) recipients must elect hospice care in both Medicare and Medicaid programs simultaneously to receive Medicaid hospice care.

Requirements for Coverage

1. Certification of Terminal Illness;
2. Election of Hospice Care Form; and
3. Plan of Care.

A. Certification of Terminal Illness

The hospice must obtain written certification of terminal illness from:

1) the patient's referring physician for each of the certification periods even if a single election continues in effect for two or more periods and
2) the individual's attending physician.

The attending physician is:

a) a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care; and

b) is identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice benefits.

c) A written narrative from the referring physician explaining why the patient has a prognosis of six months or less must be included in the Certification of Terminal Illness.

For the first 90-day period of hospice coverage, the hospice must obtain a verbal certification no later than two calendar days after hospice care is initiated. If the verbal certification is not obtained within two calendar days following the initiation of hospice care, a written certification must be made within 10 calendar days following the initiation of hospice care.

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The written certification and Notice of Election must be obtained before requesting prior authorization for hospice care. If these requirements are not met, no payment is made for the days prior to the certification. Instead, payment begins with the day of certification, i.e., the date all certification forms are obtained.

For the subsequent periods, a written certification must be included in an approved Prior Authorization packet before a claim may be billed.

Face-to-face Encounter

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must occur no more than 30 calendar days prior to the third benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

The physician or nurse practitioner who performs the face-to-face encounter with the patient must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

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Content of Certifications

Certifications shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements:

1. The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

2. Written clinical information and other documentation that support the medical prognosis must accompany the Certification of Terminal Illness and must be based on the physician's clinical judgment regarding the normal course of the individual's illness filed in the medical record with the written certification.

3. The physician must include a brief written narrative explanation of the clinical findings that support a life expectancy of six months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

    a) The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.

    b) The narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less, and shall not be the same narrative as previously submitted.

All certifications and re-certifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.

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B. Plan of Care

A written plan of care (POC) must be established and maintained for each individual admitted to a hospice program. The care provided to an individual must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The plan of care must be established before services are provided. The plan of care is reviewed and updated at intervals specified in the plan of care and when the patient's condition changes.

When developing the POC, the hospice provider must consult with, and collaborate with the recipient, his/her caregiver, his/her long-term personal care services provider, and if the recipient is under age 21, his/her extended home health nursing provider and/or pediatric day health care provider. If the recipient is receiving any of these services at the time of admission to hospice, the hospice provider must ensure that the POC clearly and specifically details the services and tasks, along with the frequency, to be performed by the non-hospice provider(s), as well as the services and tasks, along with the frequency, that are to be performed by the hospice provider to ensure that services are non-duplicative and that the recipient's needs are being met.

Medicaid eligible children who elect hospice care must receive it concurrently with curative care for the terminal condition.

III. Covered Services

Hospice services are provided in accordance with section 1905(o) of the Social Security Act and meet the minimal criteria of section 4305 of the State Medicaid Manual.

Medicaid eligible children elect hospice care must receive it concurrently with curative care for the terminal condition.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATION ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS

The following are levels of care for reimbursement of hospice services:

A. Inpatient Respite Care Day

An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis, not to exceed five days in any one election period, to relieve the family members or other persons caring for the individual at home. An approved facility is one that meets the standards as provided in 42 CFR 418.98(b). This service cannot be delivered to individuals already residing in a nursing facility.

B. General Inpatient Care Day

A general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility that meets the standards as provided in 42 CFR 418.98(a) and for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings.

C. Routine Home Care

A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid for each day the recipient is under the care of the hospice and not receiving one of the other categories of care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

D. Continuous Home Care

Continuous home care is only furnished during brief periods of medical crisis and only as necessary to maintain the terminally ill recipient at home. A period of medical crisis is when a recipient requires continuous care, which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care.

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IV. Waiver of Payment for Other Services

Individuals who are 21 and over may, however, be eligible for additional personal care services as defined in the State plan. Services furnished under the Medicaid personal care services benefit may be used to the extent that the hospice provider would routinely use the services of the hospice patient's family in implementing a patient's plan of care. The hospice provider must provide services to the individual that are comparable to the services they received through Medicaid prior to their election of hospice. These services include, but are not limited to:

1. Pharmaceutical and biological services;
2. Durable medical equipment; and
3. Any other services permitted by federal law.

Individuals who are under age 21 and who are approved for hospice may continue to receive curative treatments for their terminal illness; however, the hospice provider is responsible to coordinate all curative treatments related to the terminal illness, including:

1. Curative treatment shall be defined as medical treatment and therapies provided to a patient with the intent to improve symptoms and cure the patient's medical problem.
2. Curative care has its focus on the curing of an underlying disease and the provisions of medical treatments to prolong or sustain life.
3. The hospice provider is responsible to provide durable medical equipment or contract for the provision of durable medical equipment. Personal care services, extended home health, and pediatric day health care must be coordinated with hospice services.
4. Individuals who elect hospice services may also receive EPSDT personal care services concurrently. The hospice provider and the PCS provider must coordinate services and develop the patient's plan of care.

The hospice provider is responsible for making a daily visit to all clients under the age of 21 and for the coordination of care to assure there is no duplication of services. The daily visit is not required if the person is not in the home due to hospitalization or inpatient respite or inpatient hospice stays.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION
42 CFR Part 418
Subpart G

State Medicaid
Manual, Chapter 4,
Sections 4306 & 4307

P.L. 105.33

Medical and Remedial Care
and Services
Item 18

Hospice Care

Method of Payment

Hospice care is reimbursed utilizing the principles of reimbursement as detailed in the State Medicaid Manual, Chapter 4, Sections 4306 and 4307 as amended by Public Law 105-33, "Balanced Budget Act of 1997".

Payment Rates

The Louisiana Medicaid Hospice Program pays Medicaid hospice rates that are calculated by using the Medicare hospice methodology but adjusted to disregard cost offsets allowed for Medicare deductible/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.

Payment rates 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. These adjusted rates are published on the agency's website at www.lamedicaid.com.

The hospice will be paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility for Medicaid recipients residing in a nursing facility or intermediate care facility for persons with intellectual disabilities (ICF/ID). Effective for dates of service on or after February 1, 2009, the room and board rate reimbursed to hospice providers shall be 95 percent of the per diem rate that would have been paid to the facility for the recipient if he/she had not elected to receive hospice services.

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

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

for the face-to-face encounter will not be reimbursed by the Medicaid Program.

The number of inpatient days (both for general inpatient care and inpatient respite care) for any one hospice recipient may not exceed five days in any one election period. Additional days may be allowed for inpatient services through appeal.

Governmental and non-governmental providers are paid the same rates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION
42 CFR
447.304
447.200-205
and Section
1905(r)(5) of
the Act

Medical and Remedial Care and Services
Item 4.b.(contd.)

II. The following services that are not otherwise covered under the Louisiana State Plan will be reimbursed when provided to an EPSDT recipient:

A. Hospice Services

Hospice care will be reimbursed utilizing the principles of reimbursement as detailed in the State Medicaid Manual, Chapter IV, Sections 4305 and 4307.

Effective for the dates of service on or after May 1, 2012, reimbursement for hospice services are pursuant to the methodology as outlined under Attachment 4.19-B, Item 18.

B. Personal Care Services

Personal Care (PCS) for EPSDT eligibles shall be paid the lesser of billed charges or the maximum unit rate set by BHSF. The maximum rate is a prospective flat rate for each approved unit of service that is provided to the recipient. One quarter hour is the standard unit of service--, exclusive of travel time to arrive at the recipient's home.

Effective February 9, 2007, an hourly wage enhancement payment in the amount of $2 will be reimbursed to providers for personal care workers who provide services to Medicaid recipients.

The rate methodology is uniform for both governmental and non-governmental providers. The fee schedule is published on the Medicaid Provider Website www.lamedicaid.com.

C. Chiropractors

1. Method of Payment

Reimbursement is only for manual manipulation of the spine (procedure codes 97260 and 97261). Chiropractors are reimbursed under the same methodology used to reimburse physicians. Reimbursement is made at the lower of the provider's billed charge for the services or the maximum allowable fee for chiropractic services under the Bureau's provider reimbursement fee schedule.

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