Auditor of State
Betty Montgomery

Ohio Medicaid Program

Analysis of Medicaid Hospice Services

Prepared by the:

Fraud and Investigative Audit Group
Health Care/Contract Audit Section

September 2003 *AOS/HCCA-04-001R*

Auditor of State
Betty Montgomery

September xx, 2003

Tom Hayes, Director
Ohio Department of Job and Family Services
30 East Broad Street, 32nd Floor
Columbus, OH 43266-0423

Dear Director Hayes:

This report discusses the results of our analysis of services delivered under the Medicaid Hospice program. It focuses on hospice services delivered to Medicaid recipients who died in calendar year 2001. During that year, the Ohio Department of Job and Family Services (ODJFS) allowed $48.2 million in claims for Hospice-related services. The review was requested by ODJFS' Office of Ohio Health Plans (OHP) and performed in cooperation with the Ohio Department of Aging (ODA), Ohio Council for Home Care (OCHC), and Ohio Hospice and Palliative Care Organization (OHPCO). One objective of the review was to analyze hospice services to help determine the effects of legislation proposed to allow recipients of Medicaid home and community based waiver services concurrent access to hospice services. Although the legislation was not enacted and has not been reintroduced in the 125th General Assembly, the report contains data not previously available about hospice services that should prove useful to hospice stakeholders.

The report includes a detailed discussion of services delivered to 108 hospice recipients who died during calendar year 2001. It also includes comparative data obtained from three states who offer concurrent home care and hospice services. In addition, the report contains observations relating to the content of hospice cost reports, which became a requirement for hospices for cost periods beginning after April 1999.

We want to thank members of the stakeholders group and the eighteen providers who participated in our review for their participation and cooperation. Any questions about this review should be directed to Cynthia Callender, Director of the Fraud and Investigative Audit Group, who can be reached at (614) 466-4858.

Sincerely,

Betty Montgomery

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EXECUTIVE SUMMARY

The Ohio Department of Job and Family Services (ODJFS) Office of Ohio Health Plans (OHP), in cooperation with other Hospice stakeholders, requested that the Auditor of State review selected aspects of the Medicaid Hospice program. One objective of the review was to analyze the services being provided to hospice recipients for use in determining the effects of legislation that would allow recipients of Medicaid home and community based waiver services concurrent access to hospice services. Although the legislation was not enacted and has not been reintroduced in the 125th General Assembly, the report contains data not previously available about hospice services that should prove useful to hospice stakeholders.

In performing our review, we (1) analyzed paid claims data residing in the Medicaid Management Information System (MMIS) and hospice provider records to identify and summarize the services provided to hospice recipients, (2) reviewed cost reports prepared by providers and (3) gathered information from three states (Indiana, Michigan, and Wisconsin) who offer concurrent home-based and hospice services.

Using the most recent data available at the time of our review (calendar year 2001), we determined that 92 hospice providers rendered services to Ohio Medicaid recipients during 2001, and ODJFS approved $48.2 million in allowed charges[1] for these services. The 92 providers serviced 4,122 hospice recipients who died during 2001. We selected the 4,122 hospice recipients who died during calendar year 2001 as our study population. These study population recipients received 231,222 units of care[2] with an allowed charge of $30,203,540 during their entire hospice stay (which may have extended to years prior to 2001). Of the 92 providers, 82 had facilities in Ohio and recipients who both received services and died in 2001.

Following are some demographic indicators for the Medicaid hospice recipients in our study population.

- ***The median age at the time of entrance into hospice was 81 and ranged from less than 1 year old to 110.***
- ***Length of stay in the Medicaid hospice program averaged 52.7 days, with a median of 18 days, and ranged from 1 day to 973 days.***
- ***2,858 (69.3%) of the 4,122 hospice recipients were female and 1,264 (30.7%) were male.***
- ***Medicaid allowed charges for the 4,122 recipients were $30.2 million, of which $26 million, or 86 percent, were to cover room and board for recipients in nursing facilities.***

To obtain a more detailed picture of services provided to hospice recipients, we conducted a case study review of patient records for a sample of 108 recipients, hereafter referred to as our

[1] Allowed charge is the amount approved for payment prior to deducting any third party insurance and adding any Medicare co-payments. The average amount of third party insurance for the 4,122 recipients was $2.17 per service.
[2] The term units of care is used throughout the report to identify specific discrete service items hospice providers billed ODJFS for the care of hospice recipients. A unit of care for items billed on a per diem basis represents a day of service. For other items outside of the five Hospice codes, Misc. Codes represents specific instances of services.

sample group, chosen from 18 of the 82 Ohio-based providers. The 18 providers included a mix of large, medium and small-sized providers, and providers that were both independent (stand-alone) and institution-based (affiliated with another health facility such as a hospital).

Field Study Results

- ***Demographics of the 108 Recipients in our Sample Group***
  - ***The recipients received 6,509 hospice services.***
  - ***The recipients consisted of 72 (66.67%) females and 36 (33.33%) males.***
  - ***Mean and median length of stay in the hospice program was 37.9 days and 14.5 days, respectively (see additional discussion below).***
  - ***The median age at entry into hospice was 76 and ranged from age 21 to 99.***
  - ***The most common terminal illnesses were cancer (53 of the 108 recipients), heart ailments (6 recipients), and dementia associated with terminal illness (6 recipients).***

- ***Medicaid Length of Stay Was Usually Less than Total Length of Stay. Our sample group field reviews determined that length of stay as defined by MMIS service days did not coincide with actual length of stay in the hospice program for 107 of the 108 persons in our sample. This included at least 44 patients who entered the hospice program before receiving hospice services through the Medicaid program. We believe this occurred because some patients initially entered hospice as private pay or Medicare patients, and subsequently began receiving nursing home room and board payments through the Medicaid program. Hospice services outside the period paid by Medicaid accounted for 1,792 (27.5%) of the 6,509 hospice services and 1,115 (21.4%) of the 5,208 patient days in our review.***

  The total length of stay (non-Medicaid plus Medicaid) in hospice had a mean of 48.2 days and a median of 23.5 days. The Medicaid length of stay in hospice had a mean of 37.9 days and a median of 14.5 days. Mean and median lengths of stay (both total and Medicaid) were shorter for patients serviced by independent hospices than institution related hospices.

- ***Type of Contact Varied by Type of Care. When reviewing patient records, we captured whether a service was delivered through personal contact, by telephone, by mail, or via a team meeting. About 63% of all hospice services observed in our study resulted from direct personal visits. Nursing visits accounted for 41.65% (2,711 of 6,509 services) of all hospice services, of which 68.6% (1,859 of 2,711 services) were personal visits and 31.6% (829 of 2,711 services) were telephone contacts.***

  Bereavement and spiritual counseling accounted for 11.7% (760 services) and 5.1% (330 services) of all hospice services recorded in our review, respectively. Bereavement counseling services occurred primarily through mail contacts (55.7%) and telephone calls (30.79%), while most spiritual counseling occurred through personal visits (93.0%).

Patient files for the 108 recipients in our sample group did not show any services involving occupational therapy, speech therapy and x-ray services.

- ***Medicaid Services for Patients in Nursing Homes Differed from Services Provided to Home-based Recipients.*** ***Data from the MMIS system and from individual patient medical records does not currently allow a consistent and accurate identification of whether recipients receive hospice benefits in a home or institutional setting on a daily basis. As a result, we separated the service days for the 108 recipients in our sample based on whether Medicaid room and board was paid (indicating a patient in an institutional setting) or not (indicating a patient usually in a home setting). This analysis showed that 2,997 patient days (73.2 percent of 4,093 total patient days) took place in a nursing home and 1,014 patient days (24.8 percent) took place in a home setting. (The balance of 82 patient days represented "inpatient" patient days.) Based on documentation in patient files, we then compared the services given to nursing home and home-based hospice recipients. For example, we noted that hospice nurses provided 0.641 visits per patient day to patients in a home setting and 0.458 visits to patients in an institutional setting. Conversely, we noted that nursing home patients seemed to receive more personal care services than home-based patients, 0.296 vs. 0.172 visits per patient day, respectively.***

- ***Services Per Patient Day were Generally Comparable to those found by the Milliman Study.*** ***We compared the results of our study with an August 2001 study prepared by Milliman USA, Inc., which was retained by the National Hospice and Palliative Care Organization to analyze services and costs of hospice care for Medicare patients. When limited to services delivered by personal contact, the number of nursing and home health aide services per patient day were about the same for our 108 recipients and the Milliman study. Our study showed a slightly lower number of social services per patient day and a higher number of counseling (spiritual) services per patient day.***

- ***Limited Information Available on DME Equipment/Supplies & Pharmaceuticals.*** ***We recorded DME equipment/supplies and pharmaceuticals received by the 108 Hospice recipients in our review, where available. However, hospice providers did not routinely capture this information in patient files. We were able to record medical items in most cases for recipients who received services in a family home, but had more difficulty obtaining the data for recipients in other living arrangements.***

  We were unable to obtain any DME equipment or supplies information on 48 (44.4%), of the 108 recipients in our study. The lack of DME information occurred with all six categories of hospice providers.

  Pharmaceutical information was available for 100 (92.6%) of the hospice recipients studied, but was often incomplete, making any overall analysis problematic.

  Hospices are not required to record charges for individual patients because routine care services are paid as a per diem rate, not as a fee for service. To facilitate any future compilation of hospice services and costs, ODJFS may want to consider requiring that Hospice providers record services involving medical equipment, supplies and pharmaceuticals on a per-patient basis.

- ***Providers continue to be concerned about late referrals to the hospice program.*** ***An individual can receive hospice care as long as a doctor certifies that he or she is terminally ill and probably has less than 6 months to live. Because hospice costs are greatest at the beginning and end of a patient's stay in the hospice program, late referrals and late enrollments create cost pressures for the hospice program. Several providers in our study expressed concern about hospice recipients entering the program towards the later stages of their terminal illness. Our data indicates that late enrollment may be an issue. The median length of stay for patients who died in 2001 in our study population was 18 days, and the median stay for the 108 patients in our sample group was 14.5 days.***

Provider Cost Reporting

We received and reviewed the 2001 Medicare cost reports for each of the 18 providers in our case study. Because the preparation of cost reports is a recent requirement for hospices (it became a requirement for cost reporting periods beginning after April 1, 1999), our objective was to offer observations that would result in more consistent reporting and lead to more accurate determinations of hospice costs.

Hospice providers are required to complete one of four different HCFA cost report forms annually, depending on provider type: Freestanding Providers, Home Health Agency Providers, Hospital and Hospice Health Care Providers, and Skilled Nursing Facilities Providers. Ten (10) of the 18 providers in our study completed the Freestanding Providers cost report (HCFA-1984-99), five (5) providers completed the Hospital and Hospice Health Care Providers cost report, and three (3) completed the Home Health Agency Providers cost report.

Based on our review of the 18 cost reports and our discussions with the 18 preparers, we identified several inconsistencies in reporting practices that could reduce the value and accuracy of cost reporting.

- ***5 providers reported all of their volunteer services as reimbursable costs instead of non-reimbursable costs, and 7 providers had a paid volunteer coordinator but did not break out costs associated with volunteer services anywhere on their cost report;***

- ***11 providers reported fund raising activities as reimbursable costs instead of non-reimbursable costs;***

- ***6 providers reported no costs for physician services, however, these providers had either a medical director on staff or paid a fee for service to a physician;***

- ***4 providers reported bereavement counseling as reimbursable costs instead of non-reimbursable cost; and***

- ***2 providers showed either no cost or a negative cost associated with drugs, biological, and infusion therapy.***

Volunteer services, fund raising activities and bereavement counseling should be reported as non-reimbursable services. Reporting these costs as reimbursable costs may overstate actual reimbursable costs and understate non-reimbursable costs. Under the current "market basket" rate setting method, overstating reimbursable costs does not necessarily inflate hospice rates. However, CMS has proposed a change to the rate setting process that is a cost-based "prospective payment" system (PPS). If the change occurs, overstating reimbursable costs could inflate rates paid to hospice providers.

In addition, only two of the three hospice providers associated with Home Health Agency (HHA) providers reported the statistical data required for worksheet S-3, Part I and Part II. The statistical data required for form HCFA-1728-94 worksheet S-3, Part I and Part II is used by CMS in developing a PPS reimbursement rate for a home health visit. Failure to report the statistical data required may effect the PPS reimbursement rate for Medicare HHA visits for future years.

Finally, six providers offered suggestions on improving the cost reporting process. Their suggestions are included in the body of the report. One provider suggested that providers would benefit from feedback from CMS on the 2001 cost reports submitted by Ohio hospices. In the provider's opinion, sharing this feedback with the providers would help them better understand the cost report and decrease the number of inconsistencies in reporting information.

Peer State Experiences

We contacted three states (Indiana, Michigan and Wisconsin) that offer some form of concurrent home care (waiver) and hospice services. Indiana and Michigan allow hospice patients and recipients of home and community based waiver programs to receive services concurrently. Wisconsin recipients who receive personal care services and who elect the hospice benefit are able to continue receiving personal services from the personal care agency in addition to hospice services.

All three peer states have instituted policies and procedures to link concurrent delivery of hospice and waiver services. In Indiana and Michigan, the state waiver agency and the hospice provider each create plans of care, and a coordinated plan of care is then created to minimize duplication of services. Wisconsin coordinates the delivery of services by requiring personal care agencies to submit prior authorization requests along with copies of the hospice plan of care. The hospice plan of care must identify the need for continued personal care services as well as the specific services to be provided directly by the hospice provider.

Lessons learned from these states lead us to believe that should Ohio elect to offer similar concurrent services, ODJFS should consider creating edit checks that will flag claims for waiver recipients who have been approved to receive hospice services. The creation and implementation of such edits will help reduce overpayments and/or duplication of services. Indiana has implemented edit checks in order to catch overpayments for duplicated services. As noted above, Wisconsin relies on prior authorization edit checks.

Stakeholders' Comments

A draft copy of this report was provided to the Ohio Department of Job and Family Services (ODJFS), Office of Ohio Health Plans (OHP), the Ohio Council for Home Care (OCHC), and Ohio Hospice and Palliative Care Organizations (OHPCO). Recommendations from these organizations to clarify or correct factual information were reviewed and incorporated into this report where appropriate.

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

BACKGROUND 1

- House Bill 372 1
- Medicaid Hospice Services 2
- Medicaid Billing Components 3
- Relationship to Medicare Hospice 5
- Medicaid Home and Community-Based Services 5

OBJECTIVES, SCOPE AND METHODOLOGY 6

RESULTS 9

- Demographic Data from MMIS Analysis 9
- Observations from Hospice Provider Record Reviews 9
  - Medicaid Length of Stay Usually Less than Total Length of Stay 10
  - Sample Group Type of Contact Varied by Type of Service 12
  - Medicaid Services for Patients in Nursing Homes Differed from Services Provided to Home-based Recipients 14
  - Services Per Patient Per Day Compared to the Milliman Study 15
  - Bereavement Counseling 16
  - DME Equipment/Supplies and Pharmaceuticals Not Generally Available on a Per Patient Basis 16
  - Late Referrals or Late Election of Services Increase Hospice Cost Pressures 17
- Provider Cost Reporting 17
  - Cost Reporting Inconsistencies 19
- Peer State Experiences 20
  - Indiana 20
  - Michigan 22
  - Wisconsin 23
  - Summary of Peer State Experiences 23

Appendix 1a/e Summary Statistics on Hospice Services-1999 to 2001 25
Appendix 2a/b Detailed Analysis of Hospice Services-in AOS Sample 30
Appendix 3 Summary Statistics on Hospice Services Provided By Service Category 37
Appendix 4 Calculation of Overall Per Patient Per Day Services (PPPD) 38
Appendix 5 Pharmaceuticals Received by Hospice Recipients 39
Appendix 6 Recorded Medical Equipment & Supplies 41

ABBREVIATIONS USED IN THIS REPORT

AOS	Auditor of State
CFR	Code of Federal Regulations
CPT	Current Procedural Terminology
CMS	Centers for Medicare and Medicaid Services
DME	Durable Medical Equipment
HB 372	House Bill 372
HCBS	Home and Community Based Services
HCCA	Health Care/Contract Audit Section
HCFA	Health Care Financing Administration
OAC	Ohio Administrative Code
OCHC	Ohio Council for Home Care
ODA	Ohio Department of Aging
ODJFS	Ohio Department of Job and Family Services
OHP	Ohio Health Plans
OHPCO	Ohio Hospice and Palliative Care Organization
OMRDD	Ohio Department of Mental Retardation and Developmental Disabilities
ORC	Ohio Revised Code
PASSPORT	Pre-Admissions Screening System Providing Options and Resources Today

BACKGROUND

The Ohio Department of Job and Family Services (ODJFS) Office of Ohio Health Plans (OHP), in cooperation with other Hospice stakeholders, asked the Auditor of State to review selected aspects of the Medicaid Hospice program. One objective of the review was to help assess the effects of proposed legislation (House Bill 372), which proposed to allow recipients of Medicaid home and community based waiver services access to hospice services. Currently, Medicaid recipients must waive all rights to the home and community based waiver services if they elect to receive hospice services.

House Bill 372

Senator Dennis Stapleton introduced HB 372 in the 124th General Assembly of Ohio on September 18, 2001. As introduced, HB 372's proposed goal was as follows: "To enact section 5111.89 of the Revised Code to allow a Medicaid recipient eligible for home and community-based services and hospice services to receive the services concurrently."

Pursuant to Ohio Administrative Code (OAC) 5101:1-39-83 (F), "An individual cannot concurrently receive home and community-based waiver services and hospice."

Pursuant to OAC 5101:3-12-04, "Before a consumer can receive home care services through the Ohio home care program, the consumer must be enrolled in one of the ODJFS-administered home care benefit packages, or be enrolled in one of the HCBS waiver programs administered by the Ohio department of aging or the Ohio department of mental retardation and developmental disabilities (ODMR/DD). Consumers are not eligible for home care benefits if they are receiving hospice services through medicare or medicaid, or services through the program of all inclusive care for the elderly (PACE) reimbursed by medicaid."

Before an approved hospice provider can be reimbursed for a hospice service, the Medicaid client must, in a written statement, voluntarily elect to use the hospice benefit and for the duration of hospice care, waive all rights to other Medicaid services related to the treatment of the terminal condition for which hospice care was elected.

According to sec. 5111.89(B) of HB 372:

> A medicaid recipient receiving home and community-based services shall not be denied hospice services on the basis that the recipient receives home and community-based services. A medicaid recipient receiving hospice services shall not be denied home and community-based services on the basis that the recipient receives hospice services. A medicaid recipient eligible for home and community-based services and hospice services may receive the services concurrently. If a medicaid recipient receives home and community-based services and hospice services concurrently, the provider of the hospice services is responsible for assessing, planning, monitoring, directing, and evaluating the recipient's care that relates to the recipient's terminal illness and shall maintain communications with the provider of the home and community-based services to assure that the recipient receives appropriate care. The providers of the home and community-based services and hospice services shall develop a coordinated plan of care regarding the medicaid recipient's terminal illness.

Although HB 372 was not enacted in 124th General Assembly and had not been reintroduced in the 125th General Assembly as of the release date of this report, this report contains data previously unavailable about hospice services that should be useful to hospice stakeholders, particularly if similar legislation is introduced in the future.

Medicaid Hospice Services

Pursuant to OAC 5101:3-56-01, "The medicaid hospice program is an optional benefit available to individuals who are terminally ill as defined in this rule. Hospice care incorporates an interdisciplinary team approach that emphasizes supportive/palliative services rather than active or curative care. The goal of the hospice program is to meet the physical, psychological, social, and spiritual needs of the individual and the individual's family during the final stages of illness, dying and bereavement."

Hospice providers must provide all of the following services if medically indicated for the hospice patient: nursing care, medical social services, physicians' services, dietary counseling, spiritual counseling, bereavement counseling, short-term inpatient care, medical appliances and supplies, including drugs and biologicals, home health aide and homemaker services, physical therapy, occupational therapy, and speech-language pathology, and all other medical treatment and diagnostic procedures provided in relation to the terminal condition. "Nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. These core hospice services must be available as needed on a twenty-four-hour basis."

The remaining services covered under the hospice benefit are considered non-core services. Non-core services may be provided directly by the hospice organization or indirectly under the arrangement of the hospice organization.

Hospice providers must also provide or arrange for transportation services if they are needed in order for the individual to receive medical care for the terminal condition. Transportation cannot be provided if the hospice determines that the individual's need for transportation is for other than receiving care related to the terminal illness. Other services, such as complementary therapies (massage, music, aromatherapy, and art) may also be available to hospice clients in addition to the traditional hospice services to improve the comfort and well-being of patients and family members.

Pursuant to OAC 5101:3-56-05(A)(1)(a) and (b), the hospice must have established a written plan of care for the individual before services were provided and must provide services in accordance with the individual's plan of care. The plan of care must be established and maintained in accordance with 42 CFR 418.58 (October 1, 2001); that is by the attending physician, the medical director or physician designee and the interdisciplinary group. As enumerated in 42 CFR 418.68 (October 1, 2001), the interdisciplinary group shall include a physician, a registered nurse, a social worker, and a spiritual or other counselor.

An individual can receive hospice care as long as a doctor certifies that he or she is terminally ill and probably has less than 6 months to live. Care is given in "periods of care," two 90-day periods followed by unlimited 60-day periods. In order for the beneficiary to continue receiving

hospice care, a doctor must certify at the start of each period of care that the beneficiary is terminally ill. The decision to enter the hospice program can be revoked at any time.

A hospice provider cannot "discontinue or diminish the hospice care it provides to an individual because of the inability of the individual to pay or receive Medicaid reimbursement for such care pursuant to section 1861 (dd) (2) (D) of the Social Security Act, January 1, 2001."

Medicaid Billing Components

Pursuant in part to OAC 5101:3-56-06:

> ODJFS shall reimburse the hospice directly for the costs of all covered services related to the treatment of the individual's terminal illness with the exception of reimbursement for physician services that are for direct patient care.
>
> (A) Medicaid payment for hospice services are made at one of four predetermined rates. Medicaid hospice program rates are established by CMS and set forth in the state medicaid manual and shall be adjusted in accordance with CMS's determined area wage adjustments.
>
> Each rate covers all services rendered by the hospice (either directly or under contractual arrangement), the administrative and general supervisory activities performed by physicians, and travel expenses and supervision provided by other hospice staff.
>
> (B) The hospice shall bill ODJFS the appropriate code and unit(s) for the appropriate level of care. The rate paid for any particular day depends on the level of care furnished to the individual on that day."

When non-core hospice services are not directly provided by the hospice organization, but are provided by other providers, the hospice organization is responsible for reimbursing the other providers.

Table 1 shows the five basic components of the Hospice program.

Table 1: Components of the Medicaid Hospice Program

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 care. **Billing Methodology:** One unit per day allowed. Billed as procedure code X0101.
Continuous Home Care	A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and received hospice care consisting predominately of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. **Billing Methodology:** Hospice payment varies on a continuous home care day depending on the number of hours of continuous services provided. The rate is billed as an hourly rate. A minimum of 8 hours of continuous care must be furnished to qualify for the continuous home care rate. Billed as procedure code X0102.
Inpatient Respite Care	An inpatient respite care day is a day on which an individual who has elected hospice care receives care in an approved facility on a short-term basis for respite. **Billing Methodology:** One unit per day allowed.* Billed as procedure code X0103.
General Inpatient	A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management, which cannot be managed in other settings. **Billing Methodology:** One unit per day allowed. * Billed as procedure code X0104.
Room and Board	Room and board includes the performance of personal care services and assistance in the activities of daily living, socializing activities, administration of medication, and maintaining the cleanliness of the patient's room, supervision and assistance in the use of durable medical equipment and prescribed therapies and supplies and equipment. **Billing Methodology:** When X0101 or X0102 are billed and the recipient resides in a long-term care facility, an additional per diem rate may be billed at one unit per day, otherwise billed as procedure code X0105.
*Note: During the twelve month period beginning November first of each year and ending October thirty-first, the aggregate number of inpatient days (for both the general inpatient and inpatient respite care) provided by the hospice may not exceed twenty percent of the aggregate total number of days of hospice care provided to all Medicaid patients of that hospice during the same period.	

Source: Ohio Department of Job and Family Services, April 2003.

The first four components listed are considered "level of Hospice care" components. The last component is considered a "room and board" component. For each day of an individual's enrollment, the hospice is reimbursed a single all-inclusive rate for all the services (listed above) based on the appropriate level of hospice care furnished to the individual. The per diem rate for each service is determined by the CMS.

Payment is made for only one of the four levels of Hospice care described in Table 1 regardless of the amount of services furnished on any particular day. For the continuous care day level, Hospice payment varies depending on the number of hours of services that were personally furnished by, or under arrangement, with a Hospice.

A minimum of 8 hours of continuous services must be furnished for the continuous care level to be billed. For this component of hospice care, the number of hours must be reported in the unit field rather than the one unit for each day reported for the other level components.

When the individual is a resident of a Nursing Facility (NF), the Hospice receives the reimbursement for room and board. The hospice organization is then responsible for paying the nursing facility for room and board in addition to any other hospice care. This additional per diem amount is reimbursable only to the hospice organization on routine home care and continuous home care days.

To receive reimbursement, the Hospice must have a written signed agreement with the NF in accordance with rule 5101:3-56-05 of the OAC. For each day covered, bills to ODJFS must equal ninety-five per cent of the Medicaid NF per diem rate as obtained from the NF. Billings should only cover days that the individual is in the NF overnight and is Medicaid eligible. For individuals who have elected the hospice benefit under Medicare but are Medicaid eligible and reside in a Medicaid-reimbursed NF, ODJFS will pay the hospice the room and board allowance, but will not pay the Medicaid hospice care payment.

Relationship to Medicare Hospice

Hospice is a Medicare Part A benefit only. There is no patient cost sharing (i.e., no co-insurance, co-payments or deductibles with the exception of drugs). This means for dual eligibles (covered by both Medicare and Medicaid), Medicare's payment is payment in full. Medicaid makes no additional payments, with the exception of the room and board payments. For dual eligibles who reside in a long-term care facility, Medicaid must make the room and board payment to the hospice and the hospice must reimburse the facility. Medicaid policy requires that dual eligibles enroll in Hospice under Medicare to enroll in Hospice under Medicaid.

Medicaid Home and Community-Based Services

Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), section C, established a waiver program under which states can be reimbursed for providing home and community-based services (HCBS). Under the HCBS waivers, states can designate specific target populations that can receive a wider range of HCBS than are normally covered under the non-waiver state plan.

Eligibility for the HCBS waiver program is limited to Medicaid recipients who, in the absence of home and community services, would require long-term care in a NF, intermediate care facility for the mentally retarded (ICF/MR) or hospital as designated by the specific waiver. Regular HCBS waivers must be limited to one of the following target groups or any subgroup defined by the state: (1) Aged or disabled, (2) Mentally retarded or developmentally disabled, (3) Mentally ill. ODJFS currently oversees the following HCBS waiver programs.

Ohio Home Care Waiver~ The Ohio Home Care Waiver is designed to meet the home care needs of consumers whose medical condition and/or functional abilities would otherwise require them to live in a nursing home. It is also designed for consumers of any age whose unstable medical condition would otherwise require long-term hospital care. At the end of SFY 2003 this waiver's maximum capacity will be 8,208, including the approximately 2,000 people served through the Transitions Waiver.

Transitions Waiver~ The Transitions waiver was created exclusively for individuals who are currently enrolled on the Ohio Home Care Waiver and who receive an ICF-MR/DD level of care at their annual eligibility reassessment. This is a “no-growth” waiver intended to preserve funding for those who already had it when the ICF-MR/DD level of care changed in November 2002. The Transitions Waiver provides services that are identical to those provided by the Ohio Home Care Waiver and uses the same providers at the same payment rates and the same case managers. The Transitions Waiver is administered by ODJFS and will have a maximum capacity of 2,000 at the end of SFY 03.

Pre-admission Screening System Providing Resources Today (PASSPORT)~ Administered by the Ohio Department of Aging, this waiver serves people aged 60 and over who are unable to function independently and would otherwise require nursing home services. At the end of SFY 2003, this waiver’s maximum capacity will be nearly 28,000.

Choices~ The Choices waiver serves people aged 60 and over who are unable to function independently and would otherwise require nursing home services. This waiver is unique in that it allows consumers to direct their care. Consumers who elect this option must receive training and demonstrate their ability to direct their care. At the end of SFY 2003, this waiver’s maximum capacity is 296 slots.

Individual Options Waiver (IOW)~ This waiver serves people who would otherwise require institutionalization in an intermediate care facility for the mentally retarded. This waiver is administered by the Department of MR/DD. At the end of SFY 2003, this waiver’s maximum capacity will be 7,435.

Residential Facility Waiver (RFW)~ This waiver is administered by the Department of MR/DD and serves people who would otherwise require institutionalization in an intermediate care facility for mentally retarded. Recipients must live in a facility, i.e. a group home that is licensed by MRDD. At the end of SFY 2003, this waiver’s maximum capacity will be 3,043.

OBJECTIVES, SCOPE AND METHODOLOGY

The overall goal of this review was to gather information to help determine how proposed legislation might affect services delivered under Ohio’s Medicaid Hospice program, including services that might involve overlapping coverage. The project had three objectives: (1) quantify by type and number each hospice service provided to a sample of hospice recipients, (2) review cost reports prepared by hospice providers in our sample and (3) summarize the experiences of three peer states who offer concurrent home care and hospice services similar to the services proposed by HB 372.

To accomplish our review objectives we:

- Reviewed Ohio Medicaid rules and regulations relating to the Hospice and Waiver programs.
- Analyzed Ohio Medicaid claims history for hospice and waiver-based services.

- Reviewed the Milliman Study (August 2001) & Medicare Payment Advisory Commission Report (May 2002).
- Performed a case study of 108 hospice patients from 18 randomly selected Hospice providers to identify services currently performed under the Hospice per-diem rate.
- Reviewed cost reports of hospice providers in our sample.
- Solicited comparable practices from three peer states (Indiana, Michigan and Wisconsin) that offer concurrent home-based waiver and Medicaid hospice services.

We performed a case study of hospice recipients to gain a better understanding of the hospice services currently delivered by hospice providers. Information about actual services delivered to hospice recipients is not typically available, in part because the hospice per diem rate covers a "basket" of potential services and is paid regardless of which services are actually delivered. We used a case study approach because it allowed us to describe the services provided to the patients throughout their hospice stay, while keeping the cost and time expenditure of the review within reasonable limits. This study describes hospice services given to case study recipients and was not designed to generalize the entire population of hospice recipients. It is intended to assist policy makers and facilitate further analysis and study.

This case study was performed by selecting a sample of 108 hospice recipients from 18 providers. To take advantage of the most recent information available and to obtain a complete picture of services, our 108 recipients were randomly chosen from recipients who died during calendar year 2001. The 18 providers in the sample were chosen from 82 hospice providers who met two criteria: (1) they have facilities within the state of Ohio and (2) they provided services in calendar year 2001 to a hospice recipient who died in that year.

We divided the 82 hospice providers into six groups: (1) small-sized providers associated with a nursing home or hospital; (2) small-sized providers operating as a standalone hospice; (3) medium-sized providers associated with a nursing home or hospital; (4) medium- sized providers operating as a stand-alone hospice; (5) large-sized providers associated with a nursing home or hospital; and (6) large-sized providers operating as a stand-alone hospice.

For purposes of this study, large hospices were defined as hospice providers with over 400 patients (which made up 7 of the 82 providers); medium hospices as those with between 65 and 400 patients (36 of the 82 providers); and small hospices as those with 64 or fewer patients during our three year audit period (39 of the 82 providers).

We then selected 18 providers from the hospice groups as follows: four from the five large-sized institutional hospices, both (2) large sized stand-alone hospices; four from each medium size hospice group; and two from each small hospice group. The patients for each selected provider were divided into two strata: those receiving hospice services in an institutional setting (to include both dual eligible and Medicaid only recipients) and those receiving services in a non institutional setting (limited to Medicaid only recipients). We then randomly chose three recipients from each stratum for the selected providers.

If a selected provider did not have at least 3 recipients in a given stratum, additional recipients were randomly selected from the other stratum to give a total of six hospice recipients per provider. The following matrix (Table 2) lays out the case study design.

Table 2: Sample Group Design Matrix

Recipient Location						
Hospice Types	**Stand-alone Hospice**			**Nursing Home/Hospital Hospice**		
	# of Providers	**# of Nursing Home Recipients**	**# of Home-based Recipients**	**# of Providers**	**# of Nursing Home Recipients**	**# of Home-based Recipients**
Large	**4**	**12**	**12**	**2**	**6**	**6**
Medium	**4**	**12**	**12**	**4**	**12**	**12**
Small	**2**	**6**	**6**	**2**	**6**	**6**
Totals Providers	**10**			**8**		
Total Recipients		**30**	**30**		**24**	**24**

Source: AOS Hospice Project Plan, December 2002

Subsequently, we determined that MMIS data did not accurately identify "recipient location." Therefore, to compare services offered to patients in a nursing home setting with those in a home setting, we compared the services given to patients on days that the hospice billed for room and board (the assumption being these days represented times when a hospice patient was in a nursing home) with the services on days when only home care was claimed.

We reviewed patient files for each recipient from the time they entered the hospice program until the time they left the program (generally the date of death), and recorded the services received by the recipient for each day they were in the program. To the extent documented in provider files and to the extent they can be associated with specific patients, we captured the following types of services:

Nursing Visits
Medical Social Services
Physician Services
Physical Therapy
Occupational Therapy
Personal Care/Aide Visits
Case Management
Volunteer Services
Dietary Counseling
Speech Therapy
Bereavement Counseling
Spiritual Counseling
Lab Services
Other
X-Ray Services

In addition to data on services, we also captured:

Length of stay in the Hospice program (according to each hospice's medical records);
Type of contact (whether a service was rendered by phone, mail, or in person);
Names and specialty of individuals providing services;
Hours of services rendered by type of service (where available);
Durable medical equipment and consumable medical supplies (when supported by an invoice);
Pharmaceutical name, quantity dispensed, dosage (when supported by an invoice); and
Other, e.g. ambulance.

We performed our work between April 2002 and March 2003.

RESULTS

Demographic Data from MMIS Analysis

During early stages of this project, we analyzed MMIS hospice data for the three-year period ending December 31, 2001. Some key indicators of that analysis are included as Appendices 1a thru 1e.

Table 3A shows some demographic data for our study population -- hospice recipients who received Medicaid services and who died in 2001 – the population from which we drew our sample of 108 recipients. This data was consistent with our three-year analysis and shows, for example that about 85 percent of Medicaid services and 86 percent of Medicaid dollars went to cover room and board charges for patients in a nursing home setting.

Table 3A: Demographic Data for Study Population Medicaid Hospice Recipients Who Died In 2001

Total Number of Recipients	4,122 (100%)	
Number of Female Recipients	2,858 (69.3 %)	
Number of Male Recipients	1,264 (30.7 %)	
Median Age at Entry to Hospice Program	81	
Range of Age at Entry	1 to 110	
Medicaid Length of Stay in Hospice Program	52.7 days (mean)	18 days (median)
Range in Medicaid Length of Stay	1 day to 973 days	
Total Hospice Units of Care	231,222	$30,203,539.58
Room and Board Units of Care	196,523 Units (84.99%)	$25,975,661.50 (86.00%)
Routine Homecare Units of Care	32,597 Units (14.10%)	$3,368,434.08 (11.15%)
General Inpatient Units of Care	1,689 Units (0.73 %)	$762,913.90 (2.53%)
Continuous Homecare Units of Care	158 Units (0.07%)	$74,523.78 (0.25%)
Misc. Codes	158 (0.07%)	$11,375.97 (0.04%)
Inpatient Respite Care Units of Care	97 Units (0.04%)	$10,630.35 (0.04%)

Source: MMIS claims history file
Note: percentages may not add to 100% due to rounding

Observations from Hospice Provider Record Reviews

Table 3B shows demographic data for our sample group (per MMIS data). At each of the 18 provider sites, we reviewed the medical records of six randomly selected recipients who died in CY 2001.

Table 3B: Demographic Data for 108 Medicaid Hospice Recipients in Sample Group

Total Number of Recipients	**108 (100%)**	
Number of Female Recipients	**72 (66.7%)**	
Number of Male Recipients	**36 (33.3%)**	
Median Age at Entry to Hospice Program	**76**	
Range of Age at Entry	**21 to 99**	
Medicaid Length of Stay in Hospice Program	**37.9 days (mean)**	**14.5 days (median)**
Total Hospice Units of Care	**4,364 Total Units**	**$539,406.14**
Room and Board Units of Care	**3,152 Units (72.23%)**	**$369,950.46 (68.58%)**
Routine Homecare Units of Care	**1,113 Units (25.50%)**	**$122,739.45 (22.75%)**
General Inpatient Units of Care	**73 Units (1.67%)**	**$32,237.68 (5.98%)**
Continuous Homecare Units of Care	**25 Units (0.57%)**	**$14,364.32 (2.66%)**
Inpatient Respite Care Units of Care	**1 Unit (0.02%)**	**$114.23 (0.02%)**

Source: MMIS claims history file. Medicaid length of stay for the 108 patients in our sample, calculated using data from MMIS. Note percentages may not add to 100% due to rounding.

As shown in Table 4, the most prevalent primary diagnoses for recipients in our sample were cancer-related. Fifty-three (53), or 49.1%, of the 108 recipients in our sample were diagnosed with a cancer-related illness.

Table 4: Primary Diagnoses for 108 Recipients in AOS Sample

Diagnosis	ICD-9 Codes	Number of Recipients
Cancer	146.0 149.0 185.0 204.0 148.9 149.9 150.9 151.9 154.0 154.1 157.9 161.9 162.9 174.9 180.9 184.4 185.0 188.9 191.9 192.1 195.0 202.8 204.0 208.0 208.90 237.71	53
Heart	428 428.0	6
Dementia	290.0 290.4 294.1 331.0	6
Kidney	585.0 586.0 584.9	4
Liver	155.0 571.5 518.81	3
Stroke	436.0 434.01	2
Other	262.0 263.0 294.8 310.9 332.0 348.1 348.3 426.0 438.12 441.2 443.9 486.0 496.0 516.3 560.9 710.1 783.4 783.7 786.6 799.3 799.9	34
	Total:	108

Source: MMIS data and field review data for 108 recipients in study.
Note: Dementia by itself is not considered a terminal illness; however, this diagnosis in combination with another condition, i.e. a secondary diagnosis, may make a patient eligible for hospice.

Medicaid Length of Stay Usually Less than Total Length of Stay

During our reviews, we calculated two Length of Stay (LOS) statistics. Total LOS was defined as the number of days a patient was enrolled in the hospice program, or the number of days from the admission date to the discharge or revocation date for a specific hospice provider. We defined Medicaid LOS as the total days of hospice service paid by Medicaid. We noted that the

Total LOS for 107 of the 108 recipients did not coincide with the Medicaid LOS calculated from MMIS data. The different LOS spans included at least 44 patients who entered the hospice program before receiving hospice services through the Medicaid program.

We believe several factors contributed to the shorter Medicaid LOS. Initially, some hospice patients relied solely on Medicare or private insurance to cover hospice costs. However, after entering the hospice program, hospice providers typically complete a financial review, which may determine a patient's eligibility for Medicaid. Thus, Medicaid service days may begin after a patient's entry into the hospice program. Another factor reducing the number of Medicaid days is that patients may have moved from a home setting covered by Medicare to a nursing home setting, where Medicaid is then billed to pay Room and Board. We also identified gaps in Medicaid service days because of Medicaid "spend down". Medicaid spend down requires the use of other resources (e.g. a monthly social security check) to cover hospice costs, resulting in Medicaid only being billed for the days after spend down resources were exhausted. Finally, the fact that Medicaid does not cover costs on a patient's date of death meant that Medicaid LOS was usually at least one day less that total hospice LOS.

Of 6,509 total services, we found that 1,792 services were provided to recipients prior to or after the Medicaid Hospice Service period as defined in MMIS. The average Total Hospice LOS was 48.2 days and the average Medicaid Hospice LOS was 37.9 days, a 21.4 percent (or 10.3 days) difference. Table 5 compares the Medicaid length of stay with total length of stay for the 108 patients in our sample.

Table 5: Comparison of Sample Group Total and Medicaid Length of Stay

	Medicaid LOS (days)		Total LOS (days)	
	Mean	**Median**	**Mean**	**Median**
108 Recipients	37.9	14.5	48.2	23.5

Source: MMIS data and field review data for 108 recipients in study. Medicaid LOS calculated using paid hospice service days in MMIS. Total LOS calculated from data in provider patient medical records.

Our data also indicated that mean and median lengths of stay (both total and Medicaid) were shorter for patients served by independent hospices than institution related hospices. Table 6 summarizes the differences in the total and Medicaid LOS by type of hospice facility.

Table 6: Sample Group Length of Stay by Facility Type

Summary Statistics on Average Length of Stay (LOS) in Hospice Broken Down by Facility Type and Medicaid versus Total Length of Stay			
Hospice Facility Type	**Summary Statistic**	**Medicaid Hospice Length of Stay**	**Total Hospice Length of Stay**
All Facilities	**Number of Recipients**	108	108
	Mean LOS Patient	37.90	48.22
	Median LOS Patient	14.50	23.50
Large Independent	**Number of Recipients**	24	24
	Mean LOS Patient	26.04	41.50
	Median LOS Patient	10.50	11.50
Medium Independent	**Number of Recipients**	24	24
	Mean LOS Patient	27.79	38.87
	Median LOS Patient	14.50	28.00
Small Independent	**Number of Recipients**	12	12
	Mean LOS Patient	33.83	46.33
	Median LOS Patient	11.00	13.00
Large Institution Related	**Number of Recipients**	12	12
	Mean LOS Patient	48.17	51.42
	Median LOS Patient	17.50	23.50
Medium Institution Related	**Number of Recipients**	24	24
	Mean LOS Patient	50.33	58.92
	Median LOS Patient	25.50	28.50
Small Institution Related	**Number of Recipients**	12	12
	Mean LOS Patient	50.75	57.67
	Median LOS Patient	19.00	26.00

Source: MMIS data and field review data for 108 recipients in study.

The average (mean) Medicaid Hospice LOS for large independent hospice providers was 26.04 days, and the average Medicaid Hospice LOS for large institution related was 48.17 days, a difference of 22.13 days (45.9%). The Medicaid Hospice LOS mean for medium independent hospice providers was 27.79 days, and the medium institution related mean was 50.33 days, a difference of 22.54 days (44.8%).

Sample Group Type of Contact Varied by Type of Service

Table 7 summarizes the 6,509 services we identified from our review of patient records by type of service and type of contact. Appendix 2a gives a detailed break out for each service by recipient.

Table 7: Sample Group Hospice Services and Contact Types

HOSPICE SERVICE TYPE		NUMBER of SERVICES	CONTACT TYPES				
			PV	TC	M	TM	O
Nursing Visit	**NV**	**2,711**	1,859	829	0	0	23
Personal Care/Aide Visits	**PC**	**1,277**	1,277	0	0	0	0
Bereavement Counseling	**BC**	**760**	84	234	423	0	19
Medical Social Services	**MSS**	**513**	375	132	0	0	6
Case Management	**CM**	**496**	0	0	0	496	0
Spiritual Counseling	**SC**	**330**	307	21	2	0	0
Physician Services	**PS**	**183**	24	159	0	0	0
Volunteer Services	**VS**	**153**	139	9	5	0	0
Lab Services	**LS**	**51**	0	0	0	0	51
Physical Therapy	**PT**	**13**	12	1	0	0	0
Dietary Counseling	**DC**	**12**	8	4	0	0	0
Other	**OTH**	**10**	1	0	0	0	9
Occupational Therapy	**OT**	**0**	0	0	0	0	0
Speech Therapy	**ST**	**0**	0	0	0	0	0
X-Ray Services	**XS**	**0**	0	0	0	0	0
TOTAL SERVICES		**6,509**	**4,086**	**1,389**	**430**	**496**	**108**

KEY: PV = personal visit; TC = telephone call, M = mailing, TM = team meeting, O = other.
Source: MMIS data and field review data for 108 recipients in study

For the 6,509 services in our sample group, Table 8 shows the per patient per day (PPPD) service rate for the different types of hospice services. See Appendix 4 for a more detailed PPPD breakout by service and contact type.

Table 8: Overall Sample Group Services Per Patient Per Day (PPPD)

HOSPICE SERVICE TYPE	Contact Type	Average Patient Services within Medicaid Service Period	Average Medicaid Hospice LOS	Average Medicaid Hospice PPPD	Average Patient Services within Total Hospice Service Period	Average Overall Hospice LOS	Average Overall Hospice PPPD
Nursing Visit	All	20.4	37.9	0.538	25.1	48.2	0.521
Personal Care/Aide Visits	All	10.0	37.9	0.264	11.8	48.2	0.245
Medical Social Services	All	3.8	37.9	0.101	4.8	48.2	0.099
Physician Services	All	1.40	37.9	0.037	1.7	48.2	0.035
Spiritual Counseling	All	2.5	37.9	0.067	3.1	48.2	0.063
Bereavement Counseling	All	0.15	37.9	0.004	7.0	48.2	0.146
Case Management	All	3.9	37.9	0.102	4.6	48.2	0.095
Volunteer Services	All	0.93	37.9	0.024	1.4	48.2	0.029
Lab Services	All	0.33	37.9	0.009	0.47	48.2	0.010
Dietary Counseling	All	0.10	37.9	0.003	0.11	48.2	0.002
Physical Therapy	All	0.07	37.9	0.002	0.12	48.2	0.002
Other	All	0.07	37.9	0.002	0.09	48.2	0.002

Source: MMIS data and field review data for 108 recipients in study

Medicaid Services for Patients in Nursing Homes Differed from Services Provided to Home-based Recipients.

We also analyzed whether the types and number of services varied depending on the location of the patient. To perform this analysis, we compared the number of services per patient per day provided to patients in nursing home and home settings. This analysis was based on the assumption that a patient resided in a nursing home on those days that a hospice billed for Room and Board. Our analysis was confined to those days in which a hospice patient was in the Medicaid program. For our 108 recipients, we identified 4,093 patient days of service, of which 2,997 patient days of service, or 73.2 percent, were delivered in a nursing home setting. Table 9 breaks out these patient days by patient location.

Table 9: Analysis of Sample Group Patient Days by Patient Location

Patient Location	Number of Patient Days	Percent
Home	1,014	24.8%
Hospital Inpatient	82	2.0%
Institutional (nursing home)	2,997	73.2%
Total	4,093	100.0%

Source: MMIS data for 108 recipients in study.

Table 10 compares the number of services per patient day by patient location. Although differences cannot be characterized as "significantly different" because of the small sample size, the data does seem to indicate that some services occur less frequently for patients in a nursing home setting. For example, patients in a home setting seem to receive more nursing visits per patient day than nursing home patients do. Conversely, we noted that nursing home patients seemed to receive personal care services more frequently than patients in a home setting.

Table 10: Analysis of Sample Group Services per Patient Day by Patient Location

Type of Service	Patient Location	
	Nursing Home Services PPPD	Home Services PPPD
Nursing Visits	.458	.641
Personal Care	.296	.172
Medical Social Services	.096	.108
Physician Services	.027	.045
Spiritual Counseling	.077	.037
Bereavement Counseling	.002	.007
Case Management	.100	.093
Volunteer Services	.028	.013
Lab Services	.006	.010
Dietary Counseling	.002	.004
Physical Therapy	.003	.000

Source: MMIS data and field review results for 108 recipients in study.

Appendix 4 further breaks out this analysis by considering whether the services were delivered by personal contact, telephone, mail, etc.

Services Per Patient Per Day Compared to the Milliman Study

The National Hospice and Palliative Care Organization retained Milliman USA, Inc. to compare the current cost and reimbursement of hospice care for Medicare patients. The resulting report, issued in August 2001, focused on expenses and reimbursements for hospice care for routine home care services. The Milliman study captured average visits per patient day in six categories: Registered Nurse, Licensed Practical Nurse, Home Health Aide, Social Service, Homemaker Visits, Counseling Visits, and Other Visits. As a point of interest, we compared our results with the Milliman report results.

Table 11 shows our results for all types of contacts (personal, telephone, mail, team meeting, and other) and for just personal visits. We believe the best comparison is with the personal contact only visit data; and it seems to generally fall in line with the Milliman study results.

Table 11: Comparison of AOS Services per Patient Day with those Reported by Milliman USA, Inc.

Type of Service	Services Per Patient Day		
	All Contact Types (AOS Study)	Personal Contacts Only (AOS Study)	Milliman Study
Registered Nurse Visits & Licensed Practical Nurse Visits	.521	.357	.33
Home Health Aide Visits	.245	.245	.20
Social Service Visits	.099	.072	.09
Counseling (Spiritual)Visits	.063	.059	.02
Other Visits (DC, PT, OT, ST, RT)	.004	.004	.00

Source: MMIS data and field review data for 108 recipients, and "The Cost of Hospice Care: An Actuarial Evaluation of the Medicare Hospice Benefit"; Milliman USA, Inc; August 1, 2001.

Bereavement Counseling

Bereavement counseling is a required hospice service and consists of counseling services provided to a recipient's family after the recipient's death. All 18 providers in our case study provided some type of bereavement services for at least 12 months after the recipient's death. We identified bereavement services for 98 of the 108 recipients in our study. As noted in Table 7, about 11 percent or 84 services of the 760 bereavement services were personal visits. Those visits were made to the families of 43 of the 98 recipients. The remaining 89 percent of bereavement services occurred through telephone contacts, mailings, and staff attending memorial services.

DME Equipment/Supplies and Pharmaceuticals Not Generally Available on a Per Patient Basis

Individual patient records did not generally include a complete list of DME supplies, pharmaceuticals, oxygen equipment, and miscellaneous supplies received by or given to each patient. Hospice providers gave us invoices representing the purchase or rental of these items, but they are not required and generally do not track these items on a per patient basis. In some instances, providers were able to cross-reference invoices to recipients in our sample; however, if a patient resided in a nursing facility or other type of institution, DME and pharmacy information was generally not available for review. See Appendix 5 for a summary of drugs and Appendix 6 for summary of supplies we recorded during our reviews.

When a person is admitted into the Hospice program, providers create a plan of care, which includes physician orders that list pharmaceuticals that may be made available to the patient during their stay in the program. However, these orders do not necessarily reflect medications actually dispensed to recipients. Therefore, when available, we relied upon pharmacy invoices that listed the drug prescribed, dosage, quantity, date filled when it was available for individual recipients.

In an effort to curtail escalating drug costs, some providers created preferred drug lists intended to meet the patient palliative care needs. We also found that some providers create "Medicine Packages", which contain the typical medical items that may be needed by a dying patient.

Similarly, some providers had durable medical goods "Package Sets" that might include, for example, a bed, bed table, and other commonly used items.

Late Referrals or Late Election of Services Increase Hospice Cost Pressures.

Hospice patients are often referred to the hospice program by their primary care physician or by family members. Because, according to hospice providers, hospice costs are greatest at the beginning and end of a patient's stay in the hospice program, late referrals and late enrollments create cost pressures for the hospice program. Hospice providers in our study gave the following reasons why they believe patients are referred late to hospice programs:

- Due to continuous changes in technology and drugs available, patients often seek aggressive treatment longer.
- Patient and family do not understand end-of-life care.
- Physicians are reluctant to sign a certificate stating the patient will expire within 6 months.
- Patient and family are not ready to admit that the patient is dying.

Hospice providers reported that they constantly have to educate patients, families, physicians and nursing home staff on end-of-life care. Several hospice providers have staff actively committed to outreach programs such as educational seminars for hospital and nursing home staff. Hospice providers associated with hospitals have instituted education programs for medical and nursing students that require them to work with hospice patients. Other hospice providers employ teaching staff who go out to hospitals, nursing homes, physician offices and the community to educate them on end-of-life care.

Provider Cost Reporting

In accordance with 42 CFR 418.310, Hospice must provide reports and keep records as the Secretary determines necessary to administer the program. In addition, 42 CFR 413.20 requires cost reports from hospice providers on an annual basis. Besides determining program reimbursement, the data submitted on the cost reports supports management of Federal programs, (e.g., data extraction in developing cost limits). Except for the compensation information, the cost report is considered public record under the freedom of information act 45 CFR Part 5.

The filing of the cost report is mandatory and failure to do so results in all payments being deemed overpayments, and 100 percent of these payments are withheld until the cost report is received. According to 42 CFR 413.24(f)(2)(ii) a 30-day extension of the due date may be granted by the intermediary only when the provider's operations are significantly affected due to extraordinary circumstances over which the provider has no control (e.g., fire or flood). There are no provisions for an extension of the cost report due date with respect to termination or change in ownership. CMS has designated regional intermediaries to process bills, make payments, audit cost reports and other fiscal functions for hospice providers. Palmetto GBA (Columbia, South Carolina) is Ohio's designated hospice intermediary.

There are four different CMS cost report forms used by hospice providers. The provider type determines the type of form completed by the hospice provider. Table 12 shows the hospice type, the required CMS form and the start date for filing the cost reports:

Table 12: Hospice Provider Type, CMS Form and Start Date

Hospice Provider Type	HCFA Form	Start Date
Freestanding Hospice Providers	HCFA 1984-99	April 1, 1999
Home Health Agencies not Hospital-based	HCFA 1728-94	July 1, 1985
Hospital and Health Care Providers	CMS 2552-96	October 1, 1982
Skilled Nursing Facilities (SNFs) and SNF Health Care Providers	HCFA 2540-96/2540S-97	December 31, 1986

Source: Health Care Financing Administration (HCFA), now CMS
Note: The term "a freestanding Hospice" refers to a hospice that is not part of any other type of participating provider.

We requested and received Medicare cost reports from each of the 18 providers included in our case study. The purpose for obtaining this information stems from earlier work that indicated hospice providers have had limited experience capturing cost information by patient and services. The lack of experience suggests there may be some benefit in gaining an overview of how cost reports are being prepared, and in sharing "lessons learned" with project stakeholders. Our work focused on what general elements were being included in cost reports and what type of backup documentation was kept to support cost report figures. Table 13 shows the hospice provider type, cost report form type, and the number by type of cost reports collected from the providers included in our case study:

Table 13: Cost Reports Collected from Providers in the Case Study

Hospice Provider Type	HCFA Form	Number of Reports
Freestanding Hospice Providers	HCFA 1984-99	10
Home Health Agencies not Hospital-based	HCFA 1728-94	3
Hospital and Hospice Health Care Providers	CMS 2552-96	5
Skilled Nursing Facilities (SNFs) and SNF Health Care Providers	HCFA 2540-96/2540S-97	0
	Total	**18**

Source: AOS Hospice Provider reviews performed during December 2002 thru January 2003.

Overall, 55.6 percent (10 out of 18) providers in our case study completed HCFA Form 1984-99. As shown in Table 13, freestanding hospice providers were required to begin filing HCFA 1984-99 starting April 1, 1999. The remaining eight providers have been filing cost reports since October 1, 1982 or July 1, 1985.

AOS surveyed the 18 providers for suggestions or ideas that would improve the cost reporting process or the report. Six providers gave the following suggestions or ideas to improve the cost reporting process and/or reporting:

- Feedback from CMS based on 2001 submission would be helpful.
- Cost report could be more tailored to hospice organizations.
- More informative instructions are needed.
- Simplify the data collection and reporting tool.
- Hospice could use a cost report which provides them with cost by level of care provided, to follow reimbursement levels of care and to help manage expenses rather than one lump number.
- Total cost is divided by days and does not take into account those hospices with large inpatient units that incur additional costs for "brick and mortar". It assumes that all days, no matter which level of care, should be divided by total costs and unfairly gives the larger providers higher average costs per day.
- Micro Hospice Software (MHS) and online "help" should be more specific or user friendly for each worksheet. For example, when browsing the Web, information should be worksheet-specific and should facilitate drilling down to a specific column and line address. In addition, when working in the MHS, one should be able to right-click on a cell and get help or clarification of that "cell" or "field" (column and line address).
- For cells that show calculated amounts, especially for worksheet B, worksheet B-1 and for worksheet D, it would be helpful if the software had footnotes stating how certain numbers are derived, and from which worksheet the information is being pulled.
- A telephone number should be provided for a contact person at HCFA, from whom assistance can be requested, free of cost.

Cost Reporting Inconsistencies

During our review of providers cost reports, we noted several inconsistencies and omissions in how information was reported. For example, we identified the following instances where providers did not report costs in the appropriate category. Of the 18 providers in our case study:

- Six providers reported no costs for physician services, although these providers had either a medical director on staff or paid a fee for service to a physician.
- Two providers showed either no cost or a negative cost associated with drugs, biological, and infusion therapy.
- Seven providers had a paid volunteer coordinator but did not break out costs associated with volunteer services anywhere on their cost report.

In other instances, some providers reported non-reimbursable costs as reimbursable costs. For example, of the 18 providers in our study:

- Five providers reported all of their volunteer services as reimbursable costs instead of non-reimbursable costs.
- Eleven providers reported fund raising activities as reimbursable costs instead of non-reimbursable costs.
- Four providers reported bereavement counseling as reimbursable costs instead of non-reimbursable costs.

Bereavement counseling, volunteer services and fund raising services are non-reimbursable under the Medicaid program. Presently, rates paid to hospice providers are determined by a hospital "market basket" approach, Under the current market-basket rate setting method,

overstating reimbursable costs does not necessarily inflate hospice rates. However, CMS has proposed a change to the rate setting process that is a cost-based "prospective payment" system. If the change occurs, overstating reimbursable costs could inflate rates paid to hospice providers.

Another inconsistency in the reporting of cost data involved providers in our case study that are associated with Home Health Agencies (HHA) and are required to file HCFA Form 1728-94. HCFA Form 1728-94 worksheet S-3, Part I captures statistical data for the number of patients and services provided by the agency. Providers are to report the number of program visits, total number of agency visits, number of program home health aide hours, total agency home health aide hours, program unduplicated census count and total unduplicated census count, program patient count, and total agency patient count. Of the three providers in our case study, only two reported this information.

In addition, HCFA Form 1728-94 worksheet S-3, Part II provides statistical employment data related to the human resources. The providers are to report full-time equivalents (FTE) for employee staff, contracted staff, and total staff. Only two of the three providers captured the data required for worksheet S-3, Part II. For example, one provider grouped all staff under the caption "hospice staff" without designating the category breakdown.

Statistical data reported on HCFA Form 1728-94, worksheet S-3, is used by CMS in developing a prospective payment system of reimbursement for a home health visit. According to 42 CFR 413.20(a), 42 CFR 413.24(a) and 42 CFR 413.24(c) home health agencies are required to maintain statistical records for proper determination of cost payable under the Medicare program.

Peer State Experiences

We distributed surveys and held telephone interviews with Medicaid administrators in eight states considered by ODJFS to be peer states with Ohio. Our purpose was to ascertain whether any of these states offered concurrent hospice services to recipients of home and community based services, if so, how they administrated these services. The states included:

Illinois	Indiana	Kentucky	Michigan
Minnesota	Pennsylvania	West Virginia	Wisconsin

Based on this work, we identified three states (Indiana, Michigan and Wisconsin) that offer some form of concurrent home care (waiver) and hospice services. Indiana and Michigan allow hospice patients and recipients of home and community based services waiver programs to receive hospice services concurrently. Wisconsin recipients who receive personal care services and elect the hospice benefit are able to continue receiving personal services from the personal care agency in addition to hospice services.

Indiana

As of March 1998, Indiana Medicaid waiver recipients who receive home and community-based services (HCBS), offered through one of five waiver programs are also eligible for hospice services. Waiver recipients who elect to receive hospice can still receive waiver services that are not related to the terminal condition and are not duplicative of hospice care services.

Waiver recipients who elect to receive hospice benefits do not have to dis-enroll from the waiver program, but they must come under the direct care of the hospice provider for those services that are common to both programs. The hospice provider prepares a hospice plan of care that includes all services that the hospice provider would have covered had the Medicaid recipient not been in a waiver program. The waiver provider prepares a waiver plan of care that includes all services the hospice provider would have provided if the Medicaid recipient had not been in the hospice program. The two plans are then modified to eliminate duplication of services. The hospice provider serves as the case manager and is expected to interface with the non-hospice provider to ensure that the recipients' overall care is met. The hospice provider, the waiver provider and the local Area Agency on Aging are to collaborate and communicate on a regular basis in order to provide the best overall care to the waiver/hospice recipient.

Indiana hospice and waiver services that relate to the terminal condition as well as those services that both programs have in common are paid the per diem hospice rate. Waiver services that do not related to the terminal condition and do not duplicate the hospice services are reimbursed on a fee for services basis. Those common services include the following;

- Attendant care or personal assistance (by qualified home health aides)
- Respite care (provided by the above)
- Homemaker
- Respite-Homemaker
- Respite care-Nursing facility limited to five days
- Physical therapy
- Occupational therapy
- Speech or language therapy

Indiana minimizes duplication of services by system edits. If a recipient receives services from both hospice and a waiver program for the same dates of service, payment for the specific waiver services are denied to the waiver provider and approved for the hospice provider.

During implementation, Indiana's eligibility verification system was not updated to reflect if a Medicaid recipient was in the hospice program or in the waiver program; therefore, a system modification was necessary to correct this problem. Representatives from the Medicaid agency stated that they "did not do a pilot program prior to permitting HCBS members to receive hospice concurrently." They recommended that Ohio consider a pilot program before fully implementing any changes, "since the duplication of services is a nationwide problem" according to CMS experts. Indiana has an edit check that helps identify overpayments, but they also noted that it takes a lot of backend work to review and determine if there was an actual duplication of services.

Section 1115 of the Social Security Act (see also Title 42 , Chapter 7 , Subchapter XI , Part A , Sec. 1315 of the U.S. Code) provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute. Section 1115 gives states the flexibility to test new ideas. In addition, it allows the Secretary to fund services that are not otherwise matchable and may expand Medicaid eligibility to persons not otherwise eligible. CMS retains the responsibility to evaluate the project, including state specific and cross-state analyses of effects on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction.

Indiana currently has a pending application seeking authorization to get approval for a "1115 Waiver Research and Demonstration Project". The project includes the review of room and board payment for hospice residential facilities. Currently, states are not funding "room & board" payment to hospice residential facility providers. The waiver would allow hospice residential facilities to receive payment for "room & board" at 95% of the average nursing facility case-mix rate. The waiver project will allow Indiana to test the process (i.e., licensing and reimbursement) for hospice residential facilities before opening the benefit to all hospice members.

Michigan

In 1992, Michigan implemented the Elderly and Disabled waiver program known as MI Choice, which allows in home and community-based services to be offered to eligible Medicaid recipients. Michigan performed a study of end of life issues for MI Choice participants during the years of 1997 and 1998. This study resulted in a policy change to allow access to hospice care. In year 2000, 289 MI Choice waiver recipients also received hospice care coverage.

Michigan waiver providers are reimbursed a fee for service for those services that are not a duplication of hospice services and are not related to the terminal illness. Hospice providers are reimbursed a per diem rate for all services related to the terminal illness and those services held in common with waiver programs.

MI Choice recipients who elect to receive the hospice benefit do not have to dis-enroll from the waiver programs. Both waiver and hospice agencies must work together to establish one all-inclusive plan of care (POC) for the delivery of services to the recipients. The POC must document that there are no duplication of services. The MI Choice waiver agents and hospice agencies both establish a combined POC. Each develops a POC and then work together to make one all-inclusive plan for the delivery of services to the recipient.

Post payment audits of hospice services when waiver services are also included determine if services overlapped. Audits of MI Choice waiver agencies also determine if services were duplicated when hospice is provided. Both waiver and hospice providers are informed that their services will be monitored and that post-payment audits will be performed to evaluate service claims for duplications.

The Michigan Legislature has funded hospice and palliative care initiatives for several years. One such initiative was the "Hospice Residency Research Project", which was a pilot project to assess the long-term feasibility of paying the cost of room and board in a licensed hospice residence for individuals who qualified for hospice care and were low income. The individuals participating could not remain at home, did not have a home, or did not need or want to move into a nursing home. Because Medicaid and Medicare cover only hospice routine care costs and not housing costs, this project sought to demonstrate savings to the state by allowing the patients to remain in the residence and avoid a nursing home stay that may eventually be paid by Medicaid. Unfortunately, due to the insufficient numbers of participants the results were inconclusive.

Wisconsin

Wisconsin recipients receiving personal care services who elect the hospice benefit may be eligible to continue receiving personal care services in addition to hospice services if the personal care services are not directly related to the terminal illness. Personal care agencies continue to bill for services the same way they did before the recipient began hospice care and the hospice provider is reimbursed a per diem rate.

Wisconsin coordinates the delivery of services and minimizes the duplication of services by requiring personal care agencies to submit a prior authorization amendment request with a copy of the POC. The hospice POC must identify the need for continued personal care services as well as the specific services provided directly by the hospice provider. Any increase in personal care services are assumed to be related to the hospice services. The prior authorization amendment request must be submitted within one week of the recipient's election of hospice care. When the personal care prior authorization needs to be renewed, a current hospice POC must be included.

Wisconsin requires prior authorization for waiver services. Wisconsin officials indicated that they have not seen evidence of duplication or overpayment in linking hospice and waiver services because the prior authorization component eliminated the possibility of duplication of services.

Summary of Peer State Experiences

All three peer states instituted policies and procedures to link concurrent delivery of hospice and waiver services. Indiana discovered that some services provided under the hospice benefit duplicated certain services already provided by their various HCBS waivers. Post-payment review processes were implemented for hospice providers in 2000 and waiver providers in 2002. However, despite several policy directives and system edits, overpayment and coordination issues continue to be problems.

The Center for Medicare and Medicaid Services (CMS) advises that in the event a waiver recipient elects the hospice benefit, the State agency must ensure that there is no duplication of services. CMS suggests the case manager for the waiver recipient adjust the waiver services by deleting or reducing them, thereby preventing any duplication of services provided under the hospice benefit.

Lessons learned from the three states we spoke with lead us to believe that should Ohio elect to offer similar concurrent services, ODJFS should consider creating edit checks that will flag claims for waiver recipients who have been approved to receive hospice services. The creation and implementation of such edits will help reduce overpayments and/or duplication of services. Indiana has implemented edit checks in order to catch overpayments for duplicated services. As noted above, Wisconsin relies on prior authorization edit checks.

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Appendix 1a
Ohio Hospice Allowed Amounts

For the selected review period of January 1, 1999 to December 31, 2001, OHP Hospice had Allowed Amounts of $99,306,516.20, covering 786,105 units of care to 14,022 recipients. Table A1 presents the allowed amounts per year, the number of recipients per year, and the units of care that they received per year for Hospice.

Table A1: Annual Breakdown of Frequency of Hospice Billed Units and Allowed Amounts

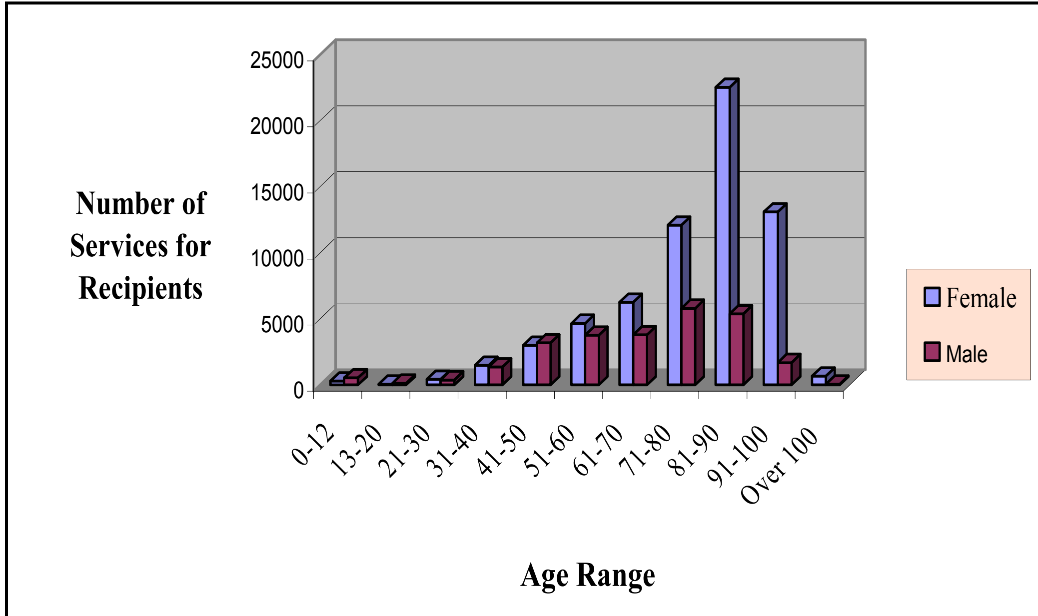
Year	Number of Recipients	Units of Care	Allowed Amount
1999	2,873	160,299	$18,438,435.70
2000	4,742	264,075	$32,707,197.25
2001	6,407	361,731	$48,160,883.25
TOTAL	**14,022**	**786,105**	**$99,306,516.20**

Source: MMIS Claims Processing (Hospice Charges) for January 1, 1999 – December 31, 2001.

Appendix 1b
Service Distribution by Recipient Age and Sex

The median age of hospice recipients was 81 years. Chart A1 shows the distribution of hospice services by age and gender.

Chart A1: Distribution of Services by Recipient Age and Gender



Source: MMIS Claims Processing (Hospice Charges) for January 1, 1999 – December 31, 2001.

Appendix 1c
Analysis Hospice Procedure Codes

Table A2 presents the five Hospice procedure codes and a Misc. Code category field that consolidates a grouping of various procedure codes charged. Out of $99,306,516.20 in allowed amounts, 80 percent of those charges were for Room and Board.

Table A2: Procedure Codes for Allowed Payments

Procedure Codes	Total Units by Procedure Codes	Allowed amounts	% of Allowed amounts	1999 Allowed amounts	2000 Allowed amounts	2001 Allowed amounts
X0105 - Room and Board Rate	629,974	$80,433,836.46	80.99%	$13,534,151.22	$26,570,642.14	$40,329,043.10
X0101 - Routine Homecare	146,431	$14,870,153.15	14.97%	$3,816,248.77	$4,888,734.05	$6,165,170.33
X0104 - General Inpatient	8,377	$3,717,109.38	3.74%	$1,054,276.05	$1,177,449.17	$1,485,384.16
X0102 - Continuous Homecare	483	$210,325.52	.21%	$18,354.49	$48,533.72	$143,437.31
X0103 - Inpatient Respite Care	507	$53,841.13	.05%	$13,938.26	$20,835.41	$19,067.46
* Misc. Codes	333	$21,250.56	.02%	$1,466.91	$1,002.76	$18,780.89
Totals	**786,105**	**$99,306,516.20**	**100.00%**	**$18,438,435.70**	**$32,707,197.25**	**$48,160,883.25**

*Any other CPT other than the five Hospice per diem codes.

Source: MMIS Claims Processing (Hospice Allowed Payments) for January 1, 1999 – December 31, 2001.

Appendix 1d
Analysis of the Five Largest Primary Diagnosis Codes

Table A3: Top Five Primary Diagnosis Codes for Hospice Services

Primary Diagnosis (Top Five)	Units of Care	Allowed amounts	% of Total Allowed amounts	1999 Allowed amounts	2000 Allowed amounts	2001 Allowed amounts
1629-Mal Neo Bron/Lung NOS	67,816	$8,263,743.04	8.32%	$1,925,324.82	$2,830,352.61	$3,508,065.61
7993-Debility NOS	57,397	$7,426,812.45	7.48%	$1,150,391.73	$2,608,482.20	$3,667,938.52
3310-Alzheimer's Disease	50,536	$6,718,285.27	6.77%	$700,586.40	$2,134,435.61	$3,883,263.26
2900-Senile Dementia	50,465	$6,500,478.48	6.55%	$771,561.91	$1,694,497.51	$4,034,419.06
4280-Congestive Heart Failure	40,439	$5,007,359.33	5.04%	$829,645.21	$1,858,241.72	$2,319,472.40
Totals	**266,653**	**$33,916,678.57**	34.16%	**$5,377,510.07**	**$11,126,009.65**	**$17,413,158.85**

Note: Some of the above primary diagnosis codes are not by themselves considered terminal illnesses. However, patients with these illnesses in combination with other illnesses could be eligible for the hospice program.

Source: MMIS Claims Processing (Hospice Allowed Amounts) for January 1, 1999 – December 31, 2001.

Appendix 1e
Analysis of the Top Five Hospice Providers by Units of Care and Allowed Amounts

We determined that hospice claims were paid to 99 hospice providers during our review period. These providers supplied 786,105 services, and had allowed charges of $99,306,516.20. As shown in Table 4, two Hamilton County providers supplied 26% of the total services, and accounted for almost 28% of the allowed amounts.

Table A4: Top Five Hospice Providers

Provider-Location (Top Five)	Units of Care	Allowed amounts	% of Total Allowed amounts	1999 Allowed amounts	2000 Allowed amounts	2001 Allowed amounts
Vitas Healthcare Corp.-Hamilton	162,865	$21,554,393.88	21.70%	$4,594,648.36	$7,688,087.18	$9,271,658.34
Hospice of Western Reserve-Cuyahoga	98,758	$12,977,291.23	13.07%	$1,718,850.78	$4,437,741.06	$6,820,699.39
Hospice of Cincinnati-Hamilton	40,970	$5,777,503.83	5.82%	$468,238.58	$2,036,912.45	$3,272,352.80
Hospice of Dayton Inc.-Montgomery	36,251	$4,795,503.97	4.83%	$1,080,533.27	$1,205,495.33	$2,509,475.37
Heartland Hospice of Dayton-Greene	39,518	$4,735,157.22	4.77%	$631,281.03	$1,263,519.38	$2,840,356.81
Totals	**378,362**	**$49,839,850.13**	50.19%	**$8,493,552.02**	**$16,631,755.40**	**$24,714,542.71**

Source: MMIS Claims Processing (Hospice Allowed Amounts) for January 1, 1999 – December 31, 2001.

Appendix 2a
Table A5: Detailed Analysis of Hospice Services Provided to Each Recipient Included in AOS Sample

	LOS	LOS	NV			PC	MSS			CM	SC			PS		VS			LS	PT		DC		OTH			BC				
	Total Stay	Medicaid Stay	O	PV	TC	PV	O	PV	TC	TM	M	PV	TC	PV	TC	M	PV	TC	O	PV	TC	PV	TC	O	PV	Client Services	M	O	PV	TC	Total Services
1	468	204	0	60	19	85	0	30	4	13	0	1	0	0	0	0	33	0	0	0	0	0	0	0	0	245	1	0	0	4	250
2	228	225	0	51	13	59	0	12	2	17	0	16	0	0	0	0	0	0	0	0	0	0	0	0	0	170	0	0	0	0	170
3	209	197	0	69	27	25	0	13	0	16	0	2	0	0	1	0	0	1	1	0	0	0	0	0	0	155	6	0	3	5	169
4	192	277	0	69	29	80	0	20	0	27	0	4	0	0	6	2	3	0	0	0	0	0	0	0	0	240	3	1	0	3	247
5	192	124	0	64	63	0	1	12	6	18	0	0	0	0	0	0	0	4	3	0	0	0	0	2	0	173	2	0	0	0	175
6	187	186	0	46	18	51	0	11	1	14	0	5	0	0	2	0	0	0	0	0	0	0	0	0	0	148	12	1	1	4	166
7	160	114	0	52	9	43	0	8	0	22	0	10	2	0	5	0	1	0	0	0	0	0	0	0	0	152	9	0	0	1	162
8	157	156	0	27	4	39	0	6	2	20	0	12	0	0	2	0	0	0	2	0	0	0	0	0	0	114	5	0	0	0	119
9	151	149	0	57	51	14	0	9	11	12	0	3	2	0	1	0	2	0	2	0	0	0	0	0	0	164	0	0	1	7	172
10	140	95	0	15	2	75	0	9	7	12	0	19	0	0	2	0	0	0	0	3	0	0	0	0	0	144	1	1	2	1	149
11	131	115	0	51	0	0	0	2	0	10	0	0	0	0	3	0	0	0	2	0	0	0	0	0	0	68	4	0	0	5	77
12	120	89	0	47	2	15	0	1	0	9	0	15	0	2	0	0	0	0	0	0	0	0	0	0	0	91	11	0	0	0	102
13	119	62	0	29	29	28	0	9	10	8	0	1	0	0	0	0	1	0	1	0	0	0	0	0	0	116	2	0	1	3	122
14	118	31	0	54	61	43	0	1	0	6	0	6	2	0	10	0	37	0	5	0	0	0	0	0	0	225	7	0	1	1	234
15	113	112	0	32	2	64	0	18	0	9	0	16	0	0	0	0	0	0	0	0	0	0	0	0	0	141	0	0	0	0	141
16	105	83	0	27	25	0	0	9	2	3	0	7	0	0	0	0	0	0	0	0	0	0	0	3	0	76	0	0	0	0	76
17	103	102	0	44	20	58	0	15	4	8	0	3	3	0	2	0	2	0	0	0	0	0	0	0	0	159	12	0	2	5	178
18	101	100	0	30	8	26	0	9	3	8	0	4	0	0	2	0	11	0	1	0	0	0	0	0	0	102	0	0	1	0	103
19	101	68	0	33	5	40	0	6	0	10	0	5	0	0	2	0	0	0	0	0	0	0	0	0	0	101	0	0	0	3	104
20	96	82	0	19	14	0	0	5	0	5	0	7	0	0	0	0	5	0	0	0	0	0	0	0	0	55	1	0	1	2	59
21	94	80	0	32	11	20	0	4	2	12	0	25	2	0	1	0	5	0	0	0	0	2	2	0	0	118	7	0	4	0	129
22	93	56	0	11	0	22	0	4	0	11	0	3	0	0	3	0	0	0	3	0	0	0	0	0	0	57	0	0	0	0	57
23	92	90	0	33	2	26	0	8	1	1	0	2	0	1	4	0	0	0	0	1	0	0	0	0	0	79	0	0	6	0	85
24	84	80	0	12	3	32	0	9	0	7	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	66	0	1	3	3	73
25	83	73	0	24	6	21	0	3	0	11	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	69	2	0	0	0	71
26	76	32	0	24	7	42	0	8	1	6	0	11	0	0	0	0	0	0	0	1	0	0	0	0	0	100	1	1	0	2	104
27	70	76	0	20	9	12	0	14	1	7	0	12	0	0	1	0	0	0	0	0	0	0	0	0	0	76	1	0	2	4	83
28	69	68	0	114	9	34	0	6	1	8	0	3	0	9	11	0	0	0	0	0	0	0	0	1	0	196	6	0	2	1	205
29	62	24	0	21	6	39	0	3	0	2	0	3	0	0	1	0	2	0	0	0	0	0	0	0	0	77	0	0	0	3	80
30	51	39	0	21	21	7	0	4	10	4	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	71	0	0	0	0	71
31	47	30	0	11	8	8	0	6	3	3	0	2	0	0	2	0	3	0	2	0	0	0	0	0	0	48	2	0	0	2	52
32	45	38	0	20	10	13	0	6	2	6	0	6	0	0	1	0	1	1	7	0	0	0	0	0	0	73	0	0	1	1	75
33	44	43	0	8	20	0	0	0	1	5	0	1	2	0	0	0	0	0	0	0	0	2	1	0	0	40	10	0	1	1	52
34	39	17	0	13	14	8	0	1	1	5	0	6	0	0	0	1	6	0	1	0	0	1	1	0	0	58	8	1	0	2	69
35	38	36	0	11	15	5	0	2	0	4	0	9	0	0	0	0	5	0	0	0	0	1	0	0	0	52	0	0	0	0	52
36	34	33	0	7	7	10	0	2	2	2	0	0	0	0	1	0	3	0	0	0	0	0	0	0	0	34	0	0	0	0	34
37	33	10	0	17	14	5	0	2	3	4	0	2	1	0	1	0	0	0	0	0	0	0	0	0	0	49	2	0	0	2	53
38	30	28	0	10	4	10	0	1	0	4	1	2	0	0	1	0	1	0	0	0	0	0	0	0	0	34	8	0	0	5	47

	LOS	LOS	NV			PC	MSS			CM	SC			PS		VS			LS	PT		DC		OTH			BC				
	Total Stay	Medicaid Stay	O	PV	TC	PV	O	PV	TC	TM	M	PV	TC	PV	TC	M	PV	TC	O	PV	TC	PV	TC	O	PV	Client Services	M	O	PV	TC	Total Services
39	29	27	0	15	7	7	0	4	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	39	10	2	1	4	56
40	29	16	0	7	3	4	0	2	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21	2	0	0	2	25
41	29	13	0	15	1	0	0	0	0	3	0	6	0	0	2	0	0	0	0	0	0	0	0	0	0	27	0	0	0	0	27
42	28	24	0	10	4	10	0	2	0	3	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	31	0	0	0	3	34
43	28	3	0	27	0	1	0	12	0	2	0	5	0	0	1	0	1	0	2	5	0	0	0	0	1	57	6	0	1	0	64
44	27	25	0	9	1	4	0	1	0	4	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	22	3	0	1	0	26
45	27	16	0	8	2	3	0	1	0	3	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	20	10	0	6	0	36
46	27	7	0	16	8	7	0	4	1	4	0	4	0	0	0	2	1	1	0	0	0	1	0	0	0	49	9	0	0	0	58
47	25	23	0	7	4	3	0	0	4	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	19	11	0	0	2	32
48	25	23	0	5	0	1	0	1	0	2	0	1	0	2	0	0	1	0	3	0	0	0	0	1	0	17	5	0	0	0	22
49	25	21	0	6	2	6	0	2	3	3	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	24	0	0	0	3	27
50	25	19	0	6	1	15	0	1	0	0	0	2	1	0	2	0	0	0	0	0	0	0	0	0	0	28	8	0	0	2	38
51	25	18	16	82	1	25	2	1	0	18	0	3	0	6	4	0	0	0	8	0	0	0	0	0	0	166	7	1	7	1	182
52	25	12	0	7	9	6	0	1	0	3	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	27	4	0	0	0	31
53	24	22	0	10	7	16	0	2	1	2	0	2	0	0	0	0	0	0	0	1	1	0	0	0	0	42	0	0	0	3	45
54	24	7	1	18	18	9	0	1	0	4	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	55	1	0	1	4	61
55	23	18	0	6	1	9	0	3	2	2	0	0	0	0	0	0	4	1	0	0	0	0	0	0	0	28	9	0	0	4	41
56	22	20	0	9	2	8	0	4	1	2	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	30	10	0	0	4	44
57	21	8	0	9	4	8	1	3	2	3	0	2	0	0	1	0	2	0	0	0	0	0	0	0	0	35	6	0	0	0	41
58	20	18	0	4	0	2	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	9	1	1	0	0	11
59	19	18	0	3	6	0	0	1	0	2	0	1	0	0	5	0	0	0	0	0	0	0	0	0	0	18	6	1	2	1	28
60	16	15	0	16	9	0	0	1	10	3	0	1	0	0	6	0	0	0	6	0	0	0	0	0	0	52	2	0	1	0	55
61	16	14	0	4	3	4	0	1	0	1	0	2	1	0	5	0	3	0	0	0	0	0	0	0	0	24	0	0	0	5	29
62	15	14	1	14	21	5	0	1	0	1	0	5	0	0	7	0	0	0	0	0	0	0	0	0	0	55	3	0	1	3	62
63	15	13	0	7	10	2	0	3	10	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35	2	0	1	9	47
64	13	11	0	9	6	5	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24	0	0	0	5	29
65	13	7	0	4	1	5	0	1	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	14	1	0	1	1	17
66	13	2	1	5	6	3	1	0	2	2	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	23	0	1	1	2	27
67	13	1	0	10	6	0	0	1	6	4	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	28	2	0	0	5	35
68	12	11	1	7	2	6	0	1	0	4	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	24	2	1	2	0	29
69	12	11	0	20	0	1	0	1	1	2	0	0	0	0	2	0	0	0	1	0	0	0	0	0	0	28	0	0	1	0	29
70	12	11	0	7	2	2	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	14	0	1	1	3	19
71	12	10	0	2	1	0	0	2	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	8	1	1	0	0	10
72	12	6	0	7	16	8	0	1	1	1	0	1	0	0	4	0	0	0	0	0	0	0	0	0	0	39	1	0	0	5	45
73	12	6	0	4	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	8	8	0	2	4	22
74	11	19	0	6	1	0	0	0	0	2	0	2	0	1	3	0	0	0	0	0	0	0	0	0	0	15	9	0	0	0	24
75	11	10	0	24	2	3	0	1	0	3	0	3	0	0	2	0	0	0	0	0	0	0	0	0	0	38	5	0	8	1	52
76	11	9	0	6	3	3	0	2	0	2	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	18	3	0	1	4	26
77	10	9	0	7	16	4	0	1	0	2	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0	33	2	0	0	0	35
78	10	8	0	4	0	1	0	1	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	9	0	0	0	0	9
79	10	8	0	23	0	0	0	1	0	2	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	31	2	0	0	0	33
80	10	6	0	4	8	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	16	7	0	0	1	24

	LOS	LOS	NV			PC	MSS			CM	SC			PS		VS			LS	PT		DC		OTH			BC				
	Total Stay	Medicaid Stay	O	PV	TC	PV	O	PV	TC	TM	M	PV	TC	PV	TC	M	PV	TC	O	PV	TC	PV	TC	O	PV	Client Services	M	O	PV	TC	Total Services
81	9	7	0	8	0	0	0	0	0	4	0	0	0	0	5	0	0	0	1	0	0	0	0	0	0	18	0	0	1	0	19
82	9	6	0	3	5	2	0	0	0	1	0	1	0	0	0	0	2	1	0	0	0	0	0	0	0	15	1	0	0	1	17
83	8	7	0	6	8	0	0	0	0	1	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	18	2	1	0	4	25
84	8	6	0	7	1	0	0	1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	11	11	0	0	0	22
85	8	1	0	5	0	0	0	2	1	3	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	14	5	0	0	0	19
86	7	6	0	4	2	0	0	1	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	10	6	0	0	8	24
87	7	5	0	5	0	0	0	0	0	2	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0	10	6	0	1	0	17
88	7	5	0	7	1	2	0	1	0	3	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	16	1	0	1	3	21
89	7	4	0	13	16	1	1	1	0	1	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0	36	2	1	0	2	41
90	6	4	0	5	4	0	0	0	0	1	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	13	1	0	4	1	19
91	6	4	0	4	1	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	8	18	1	0	0	27
92	6	4	0	3	2	0	0	1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	8	0	0	1	0	9
93	5	5	1	0	2	2	0	1	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	9	0	0	0	0	9
94	5	4	0	4	2	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	9	13	0	1	4	27
95	5	4	2	2	1	2	0	0	0	1	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	11	7	0	0	2	20
96	5	3	0	4	7	2	0	0	0	1	0	1	0	0	4	0	0	0	0	0	0	0	0	0	0	19	4	0	0	1	24
97	4	3	0	0	1	0	0	1	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	8	13
98	4	3	0	0	4	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	6	0	0	4	15
99	4	2	0	2	0	0	0	3	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	7	8	0	0	0	15
100	4	2	0	2	2	0	0	1	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9	3	0	0	6	18
101	4	2	0	1	1	1	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	5	9	0	0	0	14
102	4	2	0	3	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	9	0	2	16	33
103	3	2	0	2	1	0	0	1	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	7	3	0	1	1	12
104	3	1	0	4	1	0	0	0	1	1	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	9	0	0	1	4	14
105	3	1	0	2	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	6	5	0	0	2	13
106	2	10	0	5	4	4	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16	9	0	0	3	28
107	2	6	0	2	0	1	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	6	8	1	0	3	18
108	2	1	0	2	0	0	0	1	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	7	5	0	0	10	22
Total:	5,208	4,093	23	1859	829	1277	6	375	132	496	2	307	21	24	159	5	139	9	51	12	1	8	4	9	1	5,749	423	19	84	234	6,509
Mean:	48.222	37.898	0.213	17.213	7.676	11.824	0.056	3.472	1.222	4.593	0.019	2.843	0.194	0.222	1.472	0.046	1.287	0.083	0.472	0.111	0.009	0.074	0.037	0.083	0.009	53.231	3.917	0.176	0.778	2.167	60
			O	PV	TC	PV	O	PV	TC	TM	M	PV	TC	PV	TC	M	PV	TC	O	PV	TC	PV	TC	O	PV	Client	M	O	PV	TC	Services
			NV			PC	MSS			CM	SC			PS		VS			LS	PT		DC		OTH		Services	BC				Total

NV	Nurse Visits	**PC**	Personal Care	**BC**	Bereavement Counseling	**MSS**	Medical Social Services	PV	Personal Visit	TC	Telephone Call
CM	Case Management	**SC**	Spiritual Counseling	**PS**	Physician Services	**VS**	Volunteer Services	TM	Team Meetings	OTH	Other Services
LS	Laboratory Services	**PT**	Physical Therapy	**DC**	Dietary Counseling	**OTH**	Other	M	Mail		

Source: AOS Hospice Provider reviews, performed during December 2002 thru January 2003.
Note: AOS did not find services during the field reviews for; X-ray, Occupational Therapy or Speech Therapy services.

Appendix 2b
Table A6: Analysis of Dual Eligibility, Service Location, and Medicaid Billing Statistics for Each Recipient Included in AOS Sample

	Age	Medicare Eligible Indicator (MMIS)	Medicare Active (Field Review)	Home Stay	Institution Stay	Inpatient Stay	**Total Stay**	Medicaid Start Date	Medicaid End Date	**Total Medicaid Billed Days**	X0101- Routine Homecare	X0102 - Continuous Homecare	X0103 - Inpatient Respite Care	X0104 - General Inpatient	X0105 - Room and Board Rate	Non Hosp. CPT
1	99	Y	Y	0	1	0	**1**	4/18/2001	4/18/2001	**1**	0	0	0	0	1	0
2	99	Y	Y	0	5	0	**5**	9/19/2001	9/23/2001	**5**	0	0	0	0	5	0
3	98	Y	Y	0	28	0	**28**	4/16/2001	5/13/2001	**28**	0	0	0	0	28	0
4	97	Y	Y	0	186	0	**186**	9/26/2000	3/30/2001	**186**	0	0	0	0	186	0
5	96	Y	Y	0	19	0	**19**	12/11/2000	12/29/2000	**19**	0	0	0	0	19	0
6	93	Y	Y	0	25	0	**25**	6/7/2001	7/1/2001	**25**	0	0	0	0	25	0
7	93	Y	Y	0	6	0	**6**	5/5/2001	5/10/2001	**6**	0	0	0	0	6	0
8	93	Y	Y	0	11	0	**11**	1/17/2001	1/27/2001	**11**	0	0	0	0	11	0
9	92	Y	Y	0	7	0	**7**	4/6/2001	4/12/2001	**7**	0	0	0	0	7	0
10	91	Y	Y	0	24	0	**24**	8/24/2001	9/30/2001	**24**	0	0	0	0	24	0
11	91	Y	Y	0	27	0	**27**	2/2/2001	2/28/2001	**27**	0	0	0	0	27	0
12	91	Y	Y	0	156	0	**156**	9/12/2000	2/14/2001	**156**	0	0	0	0	156	0
13	89	Y	Y	0	23	0	**23**	4/13/2001	5/5/2001	**23**	0	0	0	0	23	0
14	89	Y	Y	0	11	0	**11**	4/18/2001	4/28/2001	**11**	0	0	0	0	11	0
15	89	Y	Y	0	56	0	**56**	7/5/2000	9/30/2000	**56**	0	0	0	0	56	0
16	89	Y	Y	0	11	0	**11**	1/18/2001	1/28/2001	**11**	0	0	0	0	11	0
17	89	Y	Y	0	4	0	**4**	5/17/2001	5/20/2001	**4**	0	0	0	0	4	0
18	89	Y	Y	0	20	0	**20**	4/6/2001	4/25/2001	**20**	0	0	0	0	20	0
19	87	Y	Y	0	24	0	**24**	2/15/2001	3/12/2001	**24**	0	0	0	0	24	0
20	86	Y	Y	0	3	0	**3**	10/19/2001	10/21/2001	**3**	0	0	0	0	3	0
21	86	Y	Y	0	4	0	**4**	10/6/2001	10/9/2001	**4**	0	0	0	0	4	0
22	86	Y	Y	0	4	0	**4**	3/21/2001	3/24/2001	**4**	0	0	0	0	4	0
23	86	Y	Y	0	16	0	**16**	8/16/2001	8/31/2001	**16**	0	0	0	0	16	0
24	86	Y	Y	0	73	0	**73**	11/4/2000	1/21/2001	**73**	0	0	0	0	73	0
25	85	Y	Y	0	80	0	**80**	11/9/2000	2/8/2001	**80**	0	0	0	0	80	0

	Age	Medicare Eligible Indicator (MMIS)	Medicare Active (Field Review)	Home Stay	Institution Stay	Inpatient Stay	**Total Stay**	Medicaid Start Date	Medicaid End Date	**Total Medicaid Billed Days**	X0101- Routine Homecare	X0102 - Continuous Homecare	X0103 - Inpatient Respite Care	X0104 - General Inpatient	X0105 - Room and Board Rate	Non Hosp. CPT
26	84	Y	Y	0	2	0	**2**	8/13/2001	8/14/2001	**2**	0	0	0	0	2	0
27	84	Y	Y	0	17	0	**17**	1/31/2001	2/28/2001	**17**	0	0	0	0	17	0
28	82	Y	Y	0	204	0	**204**	6/16/2000	4/30/2001	**204**	0	0	0	0	204	0
29	82	Y	Y	0	3	0	**3**	7/16/2001	7/18/2001	**3**	0	0	0	0	3	0
30	82	Y	Y	0	8	0	**8**	9/27/2001	10/14/2001	**8**	0	0	0	0	8	0
31	81	Y	Y	0	30	0	**30**	6/22/2001	7/30/2001	**30**	0	0	0	0	30	0
32	81	Y	Y	0	7	0	**7**	5/25/2001	5/31/2001	**7**	0	0	0	0	7	0
33	80	Y	Y	0	6	0	**6**	2/23/2001	2/28/2001	**6**	0	0	0	0	6	0
34	79	Y	Y	0	12	0	**12**	9/19/2001	9/30/2001	**12**	0	0	0	0	12	0
35	79	Y	Y	0	89	0	**89**	6/9/2001	9/26/2001	**89**	0	0	0	0	89	0
36	79	Y	Y	0	7	0	**7**	7/25/2001	7/31/2001	**7**	0	0	0	0	7	0
37	79	Y	Y	0	38	0	**38**	8/8/2001	9/19/2001	**38**	0	0	0	0	38	0
38	79	Y	Y	0	10	0	**10**	3/22/2001	3/31/2001	**10**	0	0	0	0	10	0
39	79	Y	Y	0	68	0	**68**	2/16/2001	5/25/2001	**68**	0	0	0	0	68	0
40	78	Y	Y	0	115	0	**115**	11/4/2000	3/11/2001	**115**	0	0	0	0	115	0
41	78	Y	Y	0	19	0	**19**	1/1/2001	1/19/2001	**19**	0	0	0	0	19	0
42	78	Y	Y	0	8	0	**8**	7/26/2001	8/2/2001	**8**	0	0	0	0	8	0
43	78	Y	Y	0	114	0	**114**	1/18/2000	4/30/2001	**114**	0	0	0	0	114	0
44	77	Y	Y	0	5	0	**5**	1/26/2001	1/30/2001	**5**	0	0	0	0	5	0
45	77	Y	Y	0	225	0	**225**	2/25/2001	10/8/2001	**225**	0	0	0	0	225	0
46	77	Y	Y	0	10	0	**10**	1/24/2001	2/2/2001	**10**	0	0	0	0	10	0
47	77	Y	Y	0	2	0	**2**	6/20/2001	6/21/2001	**2**	0	0	0	0	2	0
48	76	Y	Y	0	23	0	**23**	5/8/2001	5/30/2001	**23**	0	0	0	0	23	0
49	76	Y	Y	0	4	0	**4**	7/24/2001	7/27/2001	**4**	0	0	0	0	4	0
50	76	Y	Y	0	8	0	**8**	7/12/2001	7/19/2001	**8**	0	0	0	0	8	0
51	75	Y	Y	0	7	0	**7**	2/22/2001	2/28/2001	**7**	0	0	0	0	7	0
52	75	Y	Y	0	22	0	**22**	8/9/2001	8/30/2001	**22**	0	0	0	0	22	0
53	75	Y	Y	0	13	0	**13**	6/18/2001	6/30/2001	**13**	0	0	0	0	13	0
54	74	Y	Y	0	80	0	**80**	4/1/2001	6/19/2001	**80**	0	0	0	0	80	0

	Age	Medicare Eligible Indicator (MMIS)	Medicare Active (Field Review)	Home Stay	Institution Stay	Inpatient Stay	**Total Stay**	Medicaid Start Date	Medicaid End Date	**Total Medicaid Billed Days**	X0101- Routine Homecare	X0102 - Continuous Homecare	X0103 - Inpatient Respite Care	X0104 - General Inpatient	X0105 - Room and Board Rate	Non Hosp. CPT
55	73	Y	Y	0	124	0	**124**	9/26/2000	3/9/2001	**124**	0	0	0	0	124	0
56	73	Y	Y	0	18	0	**18**	3/23/2001	4/12/2001	**18**	0	0	0	0	18	0
57	72	Y	Y	0	18	0	**18**	2/8/2001	2/25/2001	**18**	0	0	0	0	18	0
58	71	Y	Y	0	6	0	**6**	8/9/2001	8/14/2001	**6**	0	0	0	0	6	0
59	71	Y	Y	0	32	0	**32**	5/25/2001	6/25/2001	**32**	0	0	0	0	32	0
60	69	Y	Y	0	82	0	**82**	2/12/2001	5/16/2001	**82**	0	0	0	0	82	0
61	68	Y	Y	0	14	0	**14**	4/5/2001	4/18/2001	**14**	0	0	0	0	14	0
62	68	Y	Y	0	39	0	**39**	1/26/2001	3/14/2001	**39**	0	0	0	0	39	0
63	67	Y	Y	0	90	0	**90**	12/12/2000	3/11/2001	**90**	0	0	0	0	90	0
64	66	Y	Y	0	1	0	**1**	3/23/2001	3/23/2001	**1**	0	0	0	0	1	0
65	65	Y	Y	0	112	0	**112**	4/12/2001	8/1/2001	**112**	0	0	0	0	112	0
66	89			0	95	0	**95**	8/28/2001	11/30/2001	**95**	0	0	0	0	95	0
67	85			0	9	0	**9**	8/20/2001	8/28/2001	**9**	0	0	0	0	9	0
68	81			3	0	0	**3**	7/13/2001	7/15/2001	**3**	3	0	0	0	0	0
69	80			0	2	0	**2**	2/22/2001	2/23/2001	**2**	0	0	0	0	2	0
70	79			4	0	0	**4**	10/4/2001	10/7/2001	**4**	4	0	0	0	0	0
71	77			0	10	0	**10**	12/28/2000	1/6/2001	**10**	0	0	0	0	10	0
72	76			4	0	0	**4**	10/9/2001	10/12/2001	**4**	4	0	0	0	0	0
73	67			2	0	0	**2**	6/29/2001	6/30/2001	**2**	2	0	0	0	0	0
74	65			102	0	0	**102**	3/22/2001	7/1/2001	**102**	102	0	0	0	0	0
75	64			5	0	0	**5**	3/16/2001	3/20/2001	**5**	5	0	0	0	0	0
76	64			13	0	0	**13**	6/17/2001	6/29/2001	**13**	13	0	0	0	0	0
77	64			0	0	9	**9**	8/9/2001	8/17/2001	**9**	0	0	0	9	0	0
78	64			0	16	0	**16**	2/21/2002	3/8/2002	**17**	0	0	0	0	16	1
79	63			4	32	0	**36**	12/19/2000	1/23/2001	**68**	36	0	0	0	32	0
80	62			2	0	0	**2**	9/13/2001	9/14/2001	**2**	2	0	0	0	0	0
81	62			6	0	0	**6**	3/27/2001	4/1/2001	**6**	6	0	0	0	0	0
82	62			1	0	0	**1**	5/9/2001	5/9/2001	**1**	1	0	0	0	0	0
83	61			3	0	0	**3**	10/18/2001	10/20/2001	**3**	2	1	0	0	0	0

	Age	Medicare Eligible Indicator (MMIS)	Medicare Active (Field Review)	Home Stay	Institution Stay	Inpatient Stay	**Total Stay**	Medicaid Start Date	Medicaid End Date	**Total Medicaid Billed Days**	X0101- Routine Homecare	X0102 - Continuous Homecare	X0103 - Inpatient Respite Care	X0104 - General Inpatient	X0105 - Room and Board Rate	Non Hosp. CPT
84	61			3	59	0	**62**	2/7/2001	6/4/2001	**86**	27	0	0	0	59	0
85	60			0	7	0	**7**	8/3/2001	8/9/2001	**7**	0	0	0	0	7	0
86	60			0	6	0	**6**	8/2/2001	8/7/2001	**11**	6	0	0	0	5	0
87	60			1	20	0	**21**	3/9/2001	4/1/2001	**40**	21	0	0	0	19	0
88	60			3	0	8	**11**	4/18/2001	4/28/2001	**11**	3	0	0	8	0	0
89	59			0	83	0	**83**	3/1/2001	5/22/2001	**165**	76	0	1	6	82	0
90	58			33	0	0	**33**	8/29/2001	9/30/2001	**33**	33	0	0	0	0	0
91	57			29	64	7	**100**	12/28/2000	4/6/2001	**164**	93	0	0	7	64	0
92	50			0	0	18	**18**	3/16/2001	4/8/2001	**18**	0	0	0	18	0	0
93	50			0	0	2	**2**	8/4/2001	8/5/2001	**2**	0	0	0	2	0	0
94	50			197	0	0	**197**	1/31/2000	12/30/2000	**197**	197	0	0	0	0	0
95	50			125	24	0	**149**	1/3/2001	5/31/2001	**173**	149	0	0	0	24	0
96	49			1	0	0	**1**	5/31/2001	5/31/2001	**1**	1	0	0	0	0	0
97	48			43	0	0	**43**	3/16/2001	4/27/2001	**43**	43	0	0	0	0	0
98	48			0	31	0	**31**	8/1/2001	8/31/2001	**31**	0	0	0	0	31	0
99	46			58	8	10	**76**	8/20/2001	11/3/2001	**84**	66	0	0	10	8	0
100	43			18	0	0	**18**	4/18/2001	5/5/2001	**18**	18	0	0	0	0	0
101	43			0	0	6	**6**	2/27/2001	3/5/2001	**6**	0	0	0	6	0	0
102	42			65	0	3	**68**	6/22/2001	8/28/2001	**68**	41	24	0	3	0	0
103	41			258	1	18	**277**	7/24/2000	5/30/2001	**278**	259	0	0	18	1	0
104	38			6	8	0	**14**	3/30/2001	6/9/2001	**22**	14	0	0	0	8	0
105	36			15	0	0	**15**	9/16/2001	9/30/2001	**15**	15	0	0	0	0	0
106	30			0	6	0	**6**	1/26/2001	1/31/2001	**11**	6	0	0	0	5	0
107	26			10	0	0	**10**	7/26/2001	8/4/2001	**10**	10	0	0	0	0	0
108	21			0	0	1	**1**	2/15/2001	2/15/2001	**1**	0	0	0	1	0	0

Source: AOS Hospice Provider reviews, performed during December 2002 thru January 2003.

Appendix 3

Table A7: Summary Statistics on Hospice Services Provided By Service Category Overall Summary for All Facility Types				
Service Type	**Summary Statistic**	**Medicaid Hospice Service Period**	**Non Medicaid Hospice Service Period**	**Total Hospice Services Rendered**
Nursing Visits	**Number of Services**	2,203	508	2,711
	Mean Services/Patient	20.40	4.70	25.10
	Median Services/Patient	9.50	1.00	14.50
Personal Care	**Number of Services**	1,080	197	1,277
	Mean Services/Patient	10.00	1.82	11.82
	Median Services/Patient	2.50	0.00	4.00
Medical Social Services	**Number of Services**	414	99	513
	Mean Services/Patient	3.83	0.92	4.75
	Median Services/Patient	1.00	0.00	2.00
Physician Services	**Number of Services**	152	31	183
	Mean Services/Patient	1.41	0.29	1.69
	Median Services/Patient	1.00	0.00	1.00
Spiritual Counseling	**Number of Services**	273	57	330
	Mean Services/Patient	2.53	0.53	3.06
	Median Services/Patient	1.00	0.00	1.00
Bereavement Counseling	**Number of Services**	16	744	760
	Mean Services/Patient	0.15	6.89	7.04
	Median Services/Patient	0.00	6.00	6.00
Case Management	**Number of Services**	416	80	496
	Mean Services/Patient	3.85	0.74	4.60
	Median Services/Patient	2.00	0.00	3.00
Volunteer Services	**Number of Services**	100	53	153
	Mean Services/Patient	0.93	0.49	1.42
	Median Services/Patient	0.00	0.00	0.00
Lab Services	**Number of Services**	36	15	51
	Mean Services/Patient	0.33	0.14	0.47
	Median Services/Patient	0.00	0.00	0.00
Dietary Counseling	**Number of Services**	11	1	12
	Mean Services/Patient	0.10	0.01	0.11
	Median Services/Patient	0.00	0.00	0.00
Physical Therapy	**Number of Services**	8	5	13
	Mean Services/Patient	0.07	0.05	0.12
	Median Services/Patient	0.00	0.00	0.00
Other	**Number of Services**	8	2	10
	Mean Services/Patient	0.07	0.02	0.09
	Median Services/Patient	0.00	0.00	0.00
	Total Number of Services	**4,717**	**1,792**	**6,509**

Source: AOS Hospice Provider reviews, performed during December 2002 thru January 2003. Note: AOS did not find services during the field reviews for; X-ray, Occupational Therapy or Speech Therapy services.

Appendix 4

Table A8: Calculation of Overall Per Patient Per Day Services (PPPD) Breakout by Service and Contact Type							
HOSPICE SERVICE TYPE	**Contact Type**	**Average Patient Services within Medicaid Service Period**	**Average Medicaid Hospice LOS**	**Average Medicaid Hospice PPPD**	**Average Patient Services within Total Hospice Service Period**	**Average Overall Hospice LOS**	**Average Overall Hospice PPPD**
Nursing Visit	Personal Visit	14.3519	37.8981	0.038	17.2130	48.2222	0.357
	Telephone Call	5.8333	37.8981	0.154	7.6759	48.2222	0.159
	Other	0.2130	37.8981	0.006	0.2130	48.2222	0.004
Personal Care/Aide Visits	Personal Visit	10.0000	37.8981	0.264	11.8240	48.2222	0.245
Medical Social Services	Personal Visit	2.8796	37.8981	0.076	3.4722	48.2222	0.072
	Telephone Call	0.9167	37.8981	0.024	1.2222	48.2222	0.025
	Other	0.0370	37.8981	0.001	0.0556	48.2222	0.001
Physician Services	Personal Visit	0.1944	37.8981	0.005	0.2222	48.2222	0.005
	Telephone Call	1.2130	37.8981	0.032	1.4722	48.2222	0.031
Spiritual Counseling	Personal Visit	2.3704	37.8981	0.063	2.8426	48.2222	0.059
	Telephone Call	0.1389	37.8981	0.004	0.1944	48.2222	0.004
	Mail	0.0185	37.8981	0.000	0.0185	48.2222	0.000
Bereavement Counseling	Personal Visit	0.0741	37.8981	0.002	0.7778	48.2222	0.016
	Other	0.0370	37.8981	0.001	0.1759	48.2222	0.004
	Telephone Call	0.0278	37.8981	0.001	2.1667	48.2222	0.045
	Mail	0.0093	37.8981	0.000	3.9167	48.2222	0.081
Case Management	Team Meetings	3.8519	37.8981	0.102	4.5926	48.2222	0.095
Volunteer Services	Personal Visit	0.8611	37.8981	0.023	1.2870	48.2222	0.027
	Telephone Call	0.0370	37.8981	0.001	0.0833	48.2222	0.002
	Mail	0.0278	37.8981	0.001	0.0463	48.2222	0.001
Lab Services	Other	0.3333	37.8981	0.009	0.4722	48.2222	0.010
Dietary Counseling	Personal Visit	0.0648	37.8981	0.002	0.0741	48.2222	0.002
	Telephone Call	0.0370	37.8981	0.001	0.0370	48.2222	0.001
Physical Therapy	Personal Visit	0.0648	37.8981	0.002	0.1111	48.2222	0.002
	Telephone Call	0.0093	37.8981	0.000	0.0093	48.2222	0.000
Other	Other	0.0741	37.8981	0.002	0.0833	48.2222	0.002

Source: AOS Hospice Provider reviews, performed during December 2002 thru January 2003. Note: AOS did not find services during the field reviews for; X-ray, Occupational Therapy or Speech Therapy services.

Appendix 5

Table A9: Pharmaceuticals Received by Hospice Recipients	
Drug Classification	**Drug Name**
Anticoagulant	Aspirin Plavix
Appetite	Metoclopramide (Reglan)
Anxiety/Agitation/Sleep/Mental Status	Alprazolam (Xanax) Ambien Buspirone Hydrocloride (Buspar) Diazepam (Valium) Diphenhydramine HCI (Benadryl) Doxepin HCI (Sinequan) Haloperidol (Haldol Concentrate) Hydrocodone (Hycodan) Lorazepam (Ativan) Sonata Temazepam (Restoril) Trazadone HCI Zyprexa
Asthenia (weakness)	Dexamethasone Prednisone
Cough	Benzonatate (Tessalon Perles) Guaifenesin (Robitussin) Guaifenesin Dextromethorphan (Robitussin DM) Hydrocodone (Hycodan) Hyoscyamine Sulfate (Levsin) O2 Via Cannula
Constipation	Bisacodyl (Ducolax) Colyte Powder Docusate (Colace) Fleets Enema Fleets Oil Lactulose (Chronulac) Magnesium Citrate Magnesium Hydroxide (Milk of Magnesia) Senna (Senokot)
Depression	Amitriptyline Paxil Prozac Zoloft
Diarrhea	Attapulgite (Kaopectate) Loperamide Hydrochloride (Imodium AD)
Dyspnea	Albuterol Atrovent Inhaler Flovent Ipratropium Inhaler Prednisone Proventil Inhaler Oxygen Morphine Solution (Roxanol)
Hiccups	Aluminum Hydroxide (Maalox Plus) Metoclopramide (Reglan)
Indigestion/Nausea/Vomiting	Aciphex Aluminum Hydroxide (Maalox)

Table A9: Pharmaceuticals Received by Hospice Recipients	
Drug Classification	**Drug Name**
	Chlorpromazine (Thorazine) Diphenhydramine Haloperidol Maalox Metoclopramide (Reglan) Pepcid Prevacid Prilosec Promethazine HCI (Phenergan) Protonix Ranitidine Titrate & Anti-Emetic Trimethobenzamide (Tigan)
Infections	Amoxicillin Augmentin Cephalexin Cipro Ceftin Levaquin Tequin
Mucositis/Candida/Mouthcare	Artificial Saliva BMX (Benadryl/Maalox/Xylocaine) (oral rinse) Diflucan HCO3 or H2O (oral rinse) Mouthkote Spray Mycostatin (oral rinse)
Pain Management ***mild non-opiod** ***mild/moderate opiod & non-opiod** ***moderate/severe opiod** ***neuropathic pain**	Acetaminophen (Tylenol) -mild Amitriptyline –neuropathic Carbamezapine -neuropathic Dexamethasone-mild Duragestic Patch Gabapentin –neuropathic Hydrocodone (Vicodin) + APAP-mild/moderate Hydromorphone -moderate/severe Ibuprofen-mild Methadone -moderate/severe Morphine -moderate/severe Naproxen-mild Oxycodone +APAP-mild/moderate Oxycodone -moderate/severe Predisone-mild Propoxphene Napsylate (Darvocet) -mild/moderate Nortriptyline –neuropathic
Secretions	Atropine Liquid Hyoscyamine Levsin Tranderm Scop
Skin Care	Aloevesta Duoderm Lubriderm Ointment

Source: AOS Hospice Provider reviews, performed during December 2002 thru January 2003.

Appendix 6

Table A10: Recorded Medical Equipment & Supplies	
Bed-Semi Electric/Manual	Bed Table
Oxygen	Wheel Chair
Bench, Shower	Breath Nebulizer
Cannula	Commode
Cylinder Cart	Dressing Supplies
Ensure Drinks	Finger Sticks
Gauze	Hospital Egg Crate Mattress
Humidifier	Incontinence Supplies
IV Fluids	IV Pole & Pump
Latex Exam Gloves	Linen
Mattress Alt Pressure	Oxygen Concentrator
Portable Oxygen System	Shower Bench
Suction Machine	Suture Strip
Swab Sticks	Syringe

Source: AOS Hospice Provider reviews, performed during December 2002 thru January 2003.

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ANALYSIS OF MEDICAID HOSPICE SERVICES

STATEWIDE

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
SEPTEMBER 23, 2003