Chapter 6: Hospice Services

Executive Summary

Description

Hospice services provide an integrated program of palliative non-curative home and hospital care for those who are terminally ill. Hospice consists of a set of enhanced services available on a fee for service basis to terminally ill patients who elect to receive these services in exchange for limitations on curative care. These services include a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week. Hospice services provide personal and supportive medical care for terminally ill individuals and supportive care to the families through medical social workers, chaplain services, nutritionists and other needed service providers. Central to hospice philosophy is self-determination by the patient in choice of medical treatment and manner of death.

To be eligible for hospice services, a Medicaid beneficiary must be certified as terminally ill by the medical director or physician member of hospice as well as by the patient's attending physician. The beneficiary also must have filed an "election statement" that is completed by the attending physician and signed by the beneficiary indicating that his or her condition is terminal and that life expectancy is six months or less. Hospice services can be provided in a hospital setting, in a nursing home, skilled nursing facility, or the patient's home.

There are 68 hospice providers serving Kansas Medicaid beneficiaries. In 2007, they provided care to 3,172 Medicaid beneficiaries, resulting in 12,070 paid claims which totaled approximately $25.8 million. The largest provider accounted for $8 million of the $25.8 million of expenditures for 2007.

Key Points

- From FY 2003 to FY 2007, hospice was the fastest growing service in Medicaid, as measured by annual percentage growth through FY 2007. Although program growth slowed in FY 2008, long run growth appears unsustainable and earlier program trends reveal areas that warrant further study:
    - Hospice services volume increases from 2003 to 2006 in terms of providers, consumers, claims and expenditures.
    - In 2007, the number of consumers receiving services decreased while the number of claims and expenditures continued to rise.
    - From FY 2003 to FY 2007, expenditures grew a total of 139%.

  - The largest expenditure category and most frequently diagnosed condition for hospice services was "unspecified general debility."

- One source of increased expenditure was an increase in the average time that patients spent in hospice care, or "lengths of stay" (LOS). Between 2005 and 2007, the percentage of stays that were below 30 days declined while the total number of stays above 30 days increased significantly. Other potential sources of growth included pharmaceutical expenditures in the hospice setting (which are billed through the hospice, not separately through the state's prescription drug program).

- Increased scrutiny of hospice claims and requests for Prior Authorization may have helped slow growth in FY2008.

- Based on historical trends prior to 2008, trends for hospice costs and length of stay were continuing to increase. The KHPA will continue to evaluate whether the slowed growth that occurred in 2008 continues in 2009 and beyond.

Kansas Health Policy Authority (KHPA) Staff Recommendations

- KHPA staff will work to further analyze hospice expenditures and will confer with KHPA's hospice task force to further evaluate the program, identify sources of growth, and opportunities to improve cost-effective care.

- An initial list of policy options includes:
  - Enhance scrutiny of retroactive authorizations for hospice services to ensure appropriate eligibility and medical necessity;
  - Review of services that are provided through Home and Community-Based Services (HCBS) and hospice care concurrently;
  - Increased scrutiny of pharmaceutical coverage and spending; and
  - Potential reviews for extended patient stays.

Hospice program savings related to proposed policy changes:

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	5 Year Total
State General Fund (SGF)	$0	$-300,000	$-320,000	$-340,000	$-360,000	$-1,320,000
Total	$0	$-750,000	$-790,000	$-830,000	$-880,000	$-3,250,000

Program Overview

Definition

A hospice is a public agency or private organization (or a subdivision of either) that is primarily engaged in providing care to terminally ill individuals. Hospice care must meet the "Medicare conditions of participation" and the Kansas Medicaid Hospice Provider Manual outlines the details for how hospice services are provided. Hospice services are available to Kansas Medicaid beneficiaries who:

- Have been certified terminally ill by the medical director of the hospice or the physician member of the hospice interdisciplinary team; and
- Have been certified terminally ill by the consumer's attending physician; and
- Have filed an "election statement" with a hospice which meets Medicare Conditions of Participation for Hospices. The election statement is completed by the attending physician and signed by the beneficiary indicating that his or her condition is terminal and that the life expectancy is six months or less. The notice is then submitted to KHPA's fiscal agent, who then switches their Medicaid payment status to hospice.

Kansas Medicaid provides hospice services to terminally ill beneficiaries as an optional service under federal Medicaid rules. Hospice services provide an integrated program of appropriate home and hospital care for the terminally ill patient and are provided in accordance with 42 CFR 418. This set of Federal Regulations was originally promulgated in 1983 and has only recently been updated. Those updates will go into effect December 2008, and are not integrated fully into this report. Several major changes in the newly approved CFR include mandatory hospice participation in Quality Performance; mandatory provider qualifications required in order to provide certain services and defined time and content requirement for all hospice patients, weekly updates, monthly updates and continued stay reviews.

Hospice is a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week. Hospice services provide personal and supportive medical care for terminally ill individuals and supportive care to the families. Emphasis is on home care with inpatient beds being available for acute pain control or symptom management for the Home Care Program. Central to hospice philosophy is self-determination by the patient in choice of medical treatment and manner of death.

Hospice offers beneficiaries and their families' supportive care during the dying process and offers the family bereavement services for up to one year after the patient dies. The provision of hospice services is expected to result in lower expenditures for curative treatments, including curative drugs, acute care hospitalizations and, emergency room usage.

Coordination with **O**ther **S**ervices

Because of the extended set of services provided, when a beneficiary elects hospice care, many other Medicaid benefits are waived. The waived benefits are those Medicaid services that are considered preventive, curative, or restorative. Hospice, in contrast, provides comfort care, palliation of symptoms, and support during the dying process.

Hospice services can be offered in a number of different settings and in collaboration with other services. During the time that a beneficiary is in hospice care, a prior authorization is required for all other Medicaid services in order to ensure that Medicaid reimburses for medically appropriate, non-duplicated services. Hospice may be delivered in a hospital setting *if* the hospitalization is required for acute pain or symptom management. Hospice may also be provided in a Nursing Home, Skilled Nursing Facility or in the patient's residence. Hospice and the HCBS Waiver Services may co-exist, but hospice is the coordinator of all benefits, as well as the individually designed treatment and program plan for the patient. Contracted services may be provided to the patient, such as Home Health Care and Durable Medical Equipment. Additionally, many clients have Medi-

care benefits available for hospice services. Medicare is the primary payer in these situations; however Medicare does not cover room and board in a Nursing Facility.

Review of Program Expenditures

From 2004 to 2007, the number of Kansas hospice providers grew from 55 to 95, and then dipped in 2008 to 76 providers. However, the number of hospice providers accepting Medicaid over this time period grew slightly from 52 to 71. The number of beneficiaries using hospice grew substantially, from 1,707 in 2003 to 3,423 in 2008, a 49.8% increase. This growth trend is continuing to increase, even with a slight decrease in the number of Medicaid hospice paid claims in FY 2008.

Table 1
Hospice Services Summary

Fiscal Year	Number of Hospice Providers	Number of Hospices Participating in KS Medicaid	Rate of Participation in Kansas Medicaid	Number of Consumers Receiving Hospice Services	Number of Claims Paid	Amount of Claims Paid
2008	76	71	93.42%	3,423	11,140	$25,162,876
2007	95	68	71.6%	3,172	12,070	$25,784,602
2006	88	63	71.6%	3,297	10,969	$21,197,357
2005	86	63	73.3%	2,901	11,101	$20,227,869
2004	83	59	71.1%	1,997	6,785	$12,511,597
2003	55	52	94.5%	1,707	5,859	$10,798,171

The number of claims paid from FY 2003 to FY 2007 grew from 5,859 claims to 12,070 claims, indicating an overall growth of 106%. In one year alone, from FY 2004 to FY 2005, there was a 64% increase in claims paid. Expenditures also grew from FY 2003 to FY 2007, but at a faster rate. There was a total increase of 139% in expenditures with the fastest growth between years FY 2004 and FY 2005, at 62% growth.

Although the overall trends from FY 2003 to FY 2007 represented the fastest growth of any specific service in Medicaid, expenditures in FY 2008 were $25,162,876, 2.4% lower than FY 2007. Long-term growth in hospice expenditures, even including FY2008, still greatly exceeds growth in the Medicaid program since 2003. During the years of 2004 through 2008, the Kansas Medicaid Program experienced 9.2% overall growth. During this same time period, Hospice Services experienced an 18.4% overall growth. KHPA staff have not yet fully analyzed data from FY 2008 to explain the reduced rate of growth. Staff did initiate greater scrutiny over hospice claims beginning late in FY2007. The slight reduction in spending in FY 2008 provides at least a temporary pause in an historic era of growth in hospice expenditures. KHPA staff will continue to investigate the causes of growth over the FY 2003-2008 period as discussed in the conclusion to this review. The historic growth rate in hospice suggests the need for a review of program design and coverage to ensure medically necessary, cost-effective care.

Understanding Hospice Expenditures

Hospice services are paid using a fee for service methodology. Services that are related to the terminal diagnosis/illness are paid directly to the hospice. Expenditures that are NOT related to the terminal illness are paid directly to the non-hospice providers.

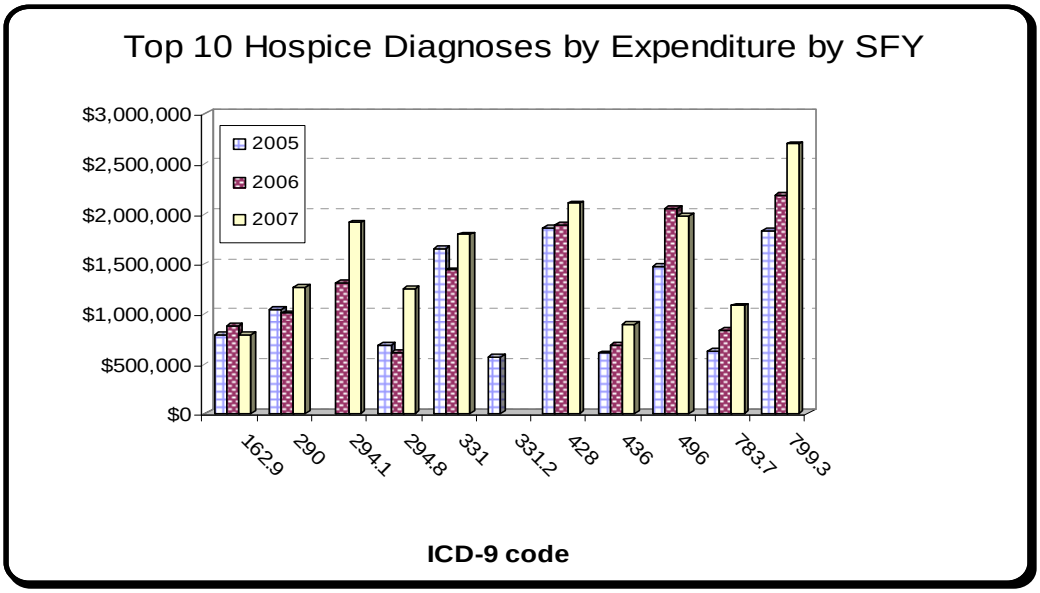
Services *related to the terminal diagnosis* and required ancillary services are paid through specific codes. Each code pays for a bundle of services and includes routine home care, continuous care, respite care, etc. Because each ancillary service that is related to the terminal diagnosis is not billed directly to Medicaid, specific services cannot be tracked and Medicaid does not have a record of the specific hospice service provided. For example, pharmacy services that are "related to terminal diagnosis" are part of the hospice payment code and thus not identified in the MMIS, making it impossible to fully review the medication management of a patient in hospice. Other examples of services related to the terminal diagnosis and included in the hospice payment code are durable medical equipment (DME), laboratory charges, and other services prescribed in the plan of care for the hospice beneficiary.

Generally, services *unrelated to the terminal diagnosis* are paid by Medicaid if they are covered services and meet program guidelines. These unrelated services are paid on a fee-for-service basis through the Medicaid Management Information System (MMIS).

Most frequent diagnoses

The physician who refers a beneficiary for a Hospice Program must certify that the individual has a prognosis of six months or less to live (assuming that the admitting disease runs its normal course or the beneficiary's health continues to decline). The admitting physician must continue to certify the patient has a terminal condition if the beneficiary stays longer than one certification period (each certification period is defined by Medicare). There is no restriction on admission diagnoses for the hospice program; many beneficiaries have chronic diseases with long term general regression, rather than abrupt terminal illnesses. Figure 1 shows the diagnoses by expenditure and fiscal year across FY 2005, 2006 and 2007 while Figure 2 shows the top 10 diagnoses by frequency, rather than expenditures.

Figure 1



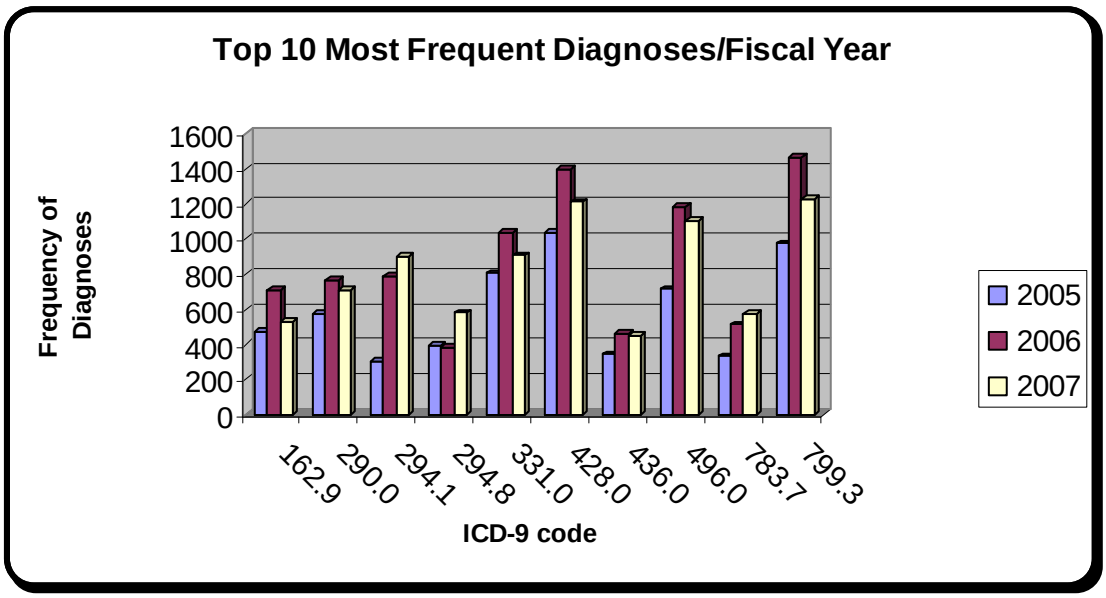
**Legend for Figure 1:	162.9	Lung Cancer	428	Congestive Heart Failure
	290	Senile Dementia	436	Atherosclerosis
	294.1	Dementia	496	Chronic Airway Obstruction
	294.8	Persistent Mental Disorders	783.7	Adult Failure to Thrive
	331	Alzheimer's	799.3	Debility
	331.2	Senile Degeneration of the Brain		

* ICD-9 code 294.1 includes just two years of data. The diagnosis, *Dementia in Conditions Classified Elsewhere, was* available in 2006 and 2007, but did not appear in 2005. However, diagnosis code 331.2, *Senile Degeneration of the Brain,* was only provided in year 2005. They are similar diagnoses so it may be that the 2005 diagnosis was replaced in the medical community with the Dementia in Conditions Classified Elsewhere diagnosis.
** Descriptions for ICD-9 diseases have been simplified.

In Figure 1, the most expensive conditions in this population for this timeframe were: Debility, Congestive Heart Failure, Chronic Airway Obstruction (such as emphysema), and Alzheimer's . The expenditures described here do not include medications.

The most frequent diagnosis (Figure 2) and the largest expenditure per diagnosis is **Unspecified Debility**. Patients with this diagnosis have a slowly worsening condition and the program data suggests that they frequently remain in the program for a year or more.

Figure 2



Legend for Figure 2:	162.9	Lung Cancer	428	Congestive Heart Failure
	290	Senile Dementia	436	Atherosclerosis
	294.1	Dementia	496	Chronic Airway Obstruction
	294.8	Persistent Mental Disorders	783.7	Adult Failure to Thrive
	331	Alzheimer's	799.3	Debility

** Descriptions for ICD-9 diseases have been simplified.

Medications in Hospice

According to program guidelines, medications related to the terminal illness or are comfort related medications are a hospice's responsibility to provide. Further, if a beneficiary is receiving hospice services in a Nursing Facility, there are also certain medications that the per diem cost is expected to cover, such as Milk of Magnesia, Tylenol, Aspirin etc. These medications are tracked separately by the Nursing Facility and are not included in this analysis.

Figure 3

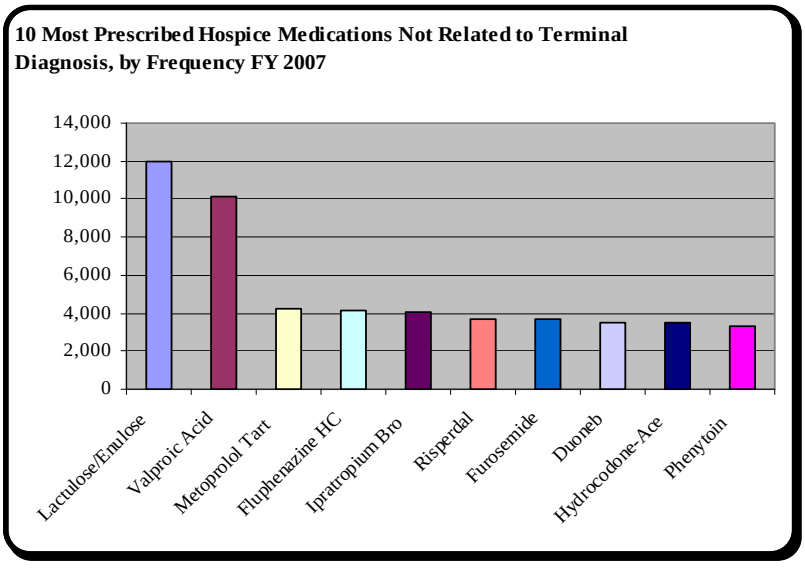


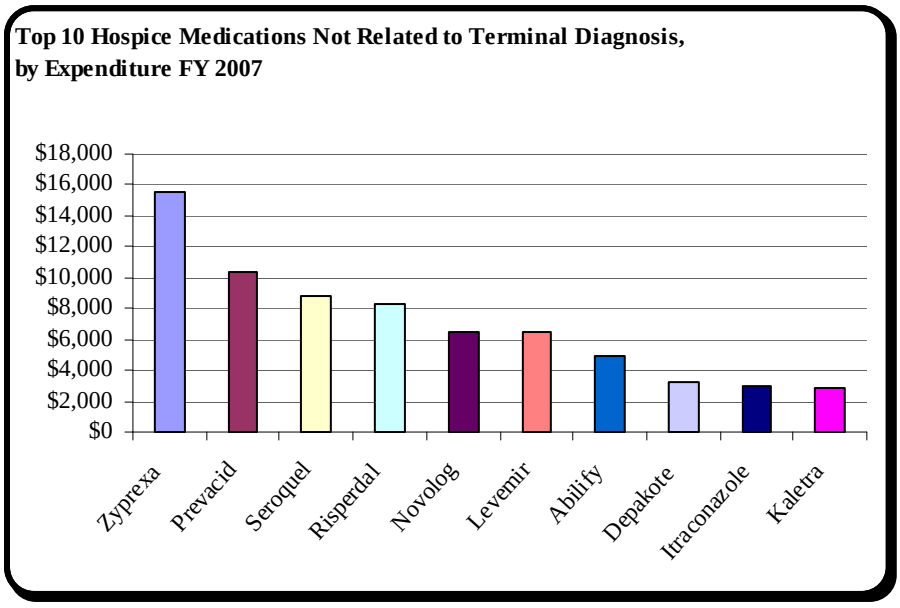
Figure 3 indicates the most frequently prescribed medications for hospice beneficiaries during Fiscal Year 2007.

Medications			
Use	**Class**	**Use**	**Class**
Lactulose Enulose Hepatic	Encephalopathy	Risperidal	Schizophrenia
Valproic Acid	Bipolar Disorder, Epilepsy	Furosemide	Treatment of Chronic Heart Failure (CHF)
Metroprol Tartrazine	Treatment of Hypertension	Duoneb	Treatment of Chronic Obstructive Pulmonary Disease (COPD)
Fluphenazine HC	Treatment of Schizophrenia	Hydrocodone	Narcotic analgesic
Phenytoin	Treatment of Epilepsy	Ipratropium Bromide	Treatment of COPD

Because ancillary services are included in the hospice payment and not identified and paid for separately, it is not possible to link the use of medication to the terminal diagnosis. Hospice pays for medications related to the terminal illness and comfort of the dying patient, including pain medication, or anti-anxiety medication. With increased numbers of patients with chronic health problems and multiple morbidities, Kansas Medicaid is paying for more medications not related to the terminal diagnosis (through the MMIS). However, the analysis here does not link medications used to treat the terminal diagnosis at the individual level (seen in Figure 1) to the MMIIS system. With enhanced data analytic capacity, KHPA will plan to examine the overall experience of hospice recipients at the individual level, including length of stay and expenditures.

The Fiscal Agent, EDS, reviews every submitted list of requested medications and has strict guidelines for approval. They follow the Preferred Drug List (PDL) guidelines, Medicare D guidelines and Hospice Program guidelines. However, Kansas Medicaid through the MMIS system appears to be reimbursing pharmacies for narcotic analgesics when pain control is clearly a responsibility of hospice. The most likely cause for this remains the issue of retroactive eligibility (to be described later), but this is an area for further review in the coming year.

Figure 4



Medications				
Use	**Class**		**Use**	**Class**
Zyprexa	Bipolar Disorder or Schizophrenia		Levimir	Insulin
Prevacid	Proton Pump Inhibitor		Abilify	Schizophrenia
Seroquel	Bipolar Disorder or Schizophrenia		Depakote	Bipolar Disorder or Epilepsy
Risperidal	Schizophrenia		Itraconazole	Anti-fungal
Novalog	Insulin		Kaletra	HIV Treatment

The prescription drug expenditures reviewed here do not include medications related to the terminal diagnosis, but rather for co-morbid conditions (non-terminal diagnosis related) that are paid for through the MMIS system. Of note, five of the top 10 medications by expenditure are psychiatric medications. The most costly drugs may not necessarily be medications related to chronic conditions and they may not match in order of frequency compared to the diagnoses.

An examination of payment for some pharmaceuticals for hospice patients has revealed some concerns. Medicaid coverage can have a retroactive date of eligibility. Once eligibility for hospice is determined to be retroactive, pharmaceutical claims from earlier dates of service have been paid through MMIS. This allows drugs to be reimbursed that Medicaid would not normally pay for during a hospice stay, such as medications that are curative in nature.

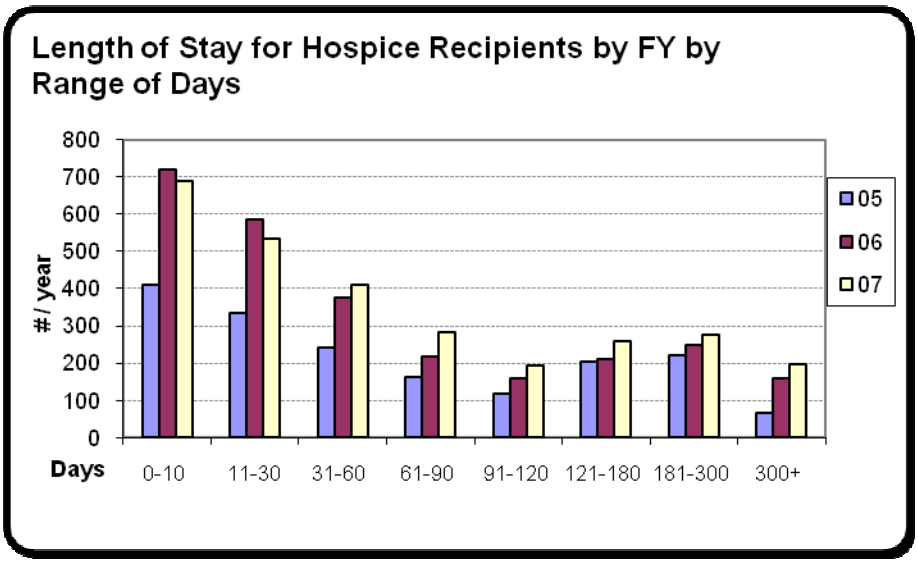
To partially address this concern, a policy was implemented in January 2006 that established a timeframe for hospice providers to submit the original election for hospice services and the initial drug requests. Requests not entered into the MMIS customer website within 10 days undergo increased scrutiny to determine an appropriate effective date for hospice services to begin, since the submission was not within the allowed timeframe. Missouri has a similar policy but it only allows five days for the hospice to provide this information. While Kansas Medicaid's policy potentially limits the number of unauthorized hospice claims, it also potentially limits unauthorized drug requests (i.e., prescription drugs that are curative in nature).

At this time, a policy clarification is being pursued that will also limit the time allowed for retroactive eligibility notifications to be made, which will impact duration and medical necessity.

Beneficiary Length of Stay

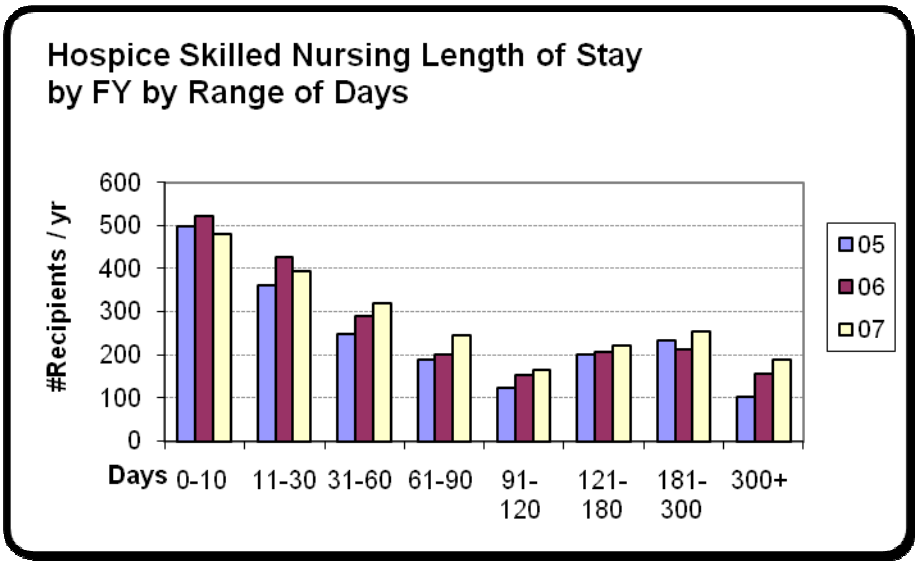
Results displayed in Figure 5 indicate that the majority of beneficiaries were in the hospice program for *less than 90 days. However,* the number of longer stays in hospice, those exceeding 30 days in length, has increased each year. The growth in length of stay (LOS) is greatest (proportionally) among those with the longest stays, e.g., those exceeding 300 days. This growth in extended stays may help explain the overall growth in costs (see Table 1).

Figure 5



Medicare certification periods are at admission, 60 days after admission and then at repeating 90 day intervals.

Figure 6



Medicare certification periods are at admission, 60 days after admission and then at repeating 90 day intervals.

Figure 7

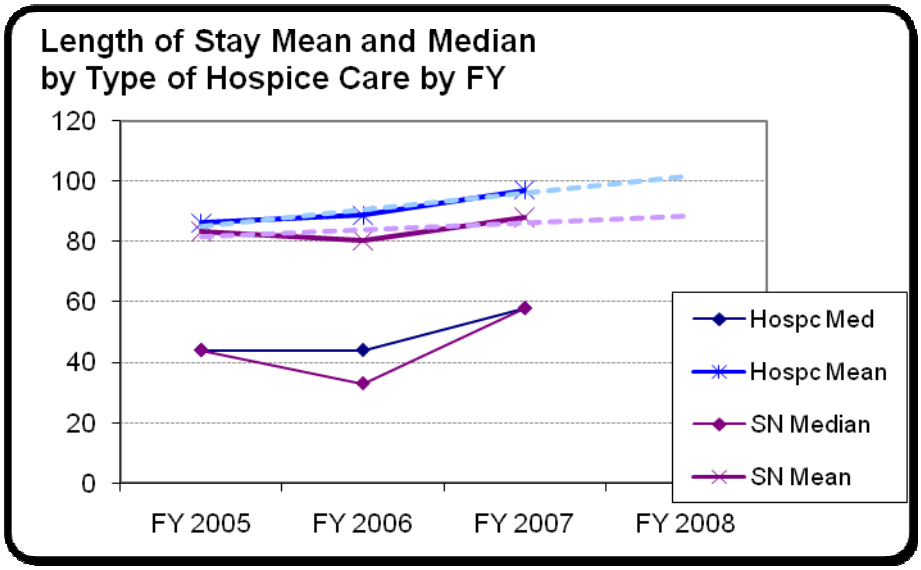


Figure 7 summarizes the comparison between length of stay at skilled nursing (SN) facilities and hospice facilities, suggesting overall growth in average length of stay in both. However, most hospice services are provided in a skilled nursing setting, which helps to explain overall programmatic trends.

Hospice Services Provided in Skilled Nursing Facilities

Figure 8 displays the number of Medicaid beneficiaries living in a Skilled Nursing Facility (SNF) who are receiving hospice. Hospice may be provided to SNF residents in two ways. A beneficiary may move to a SNF after receiving a terminal diagnosis or a beneficiary who is already in residence at a SNF may receive a terminal diagnosis and elect to remain there while receiving hospice. The percentage of hospice beneficiaries served in a SNF remained steady at about 72% during this three year period. The number of SNF hospice beneficiaries dropped slightly in 2007, yet based on data shown in Figure 6, the length of stay continued to rise. Consistent with this rise in length of stay, total expenditures also rose sharply in FY 2007. Figure 9 displays expenditures for hospice beneficiaries living in SNF for the past three fiscal years. The growth is steady, helping to explain a rise in the proportion of hospice expenditures attributable to beneficiaries residing in a skilled nursing facility (to more than 80% in FY 2007).

Figure 8

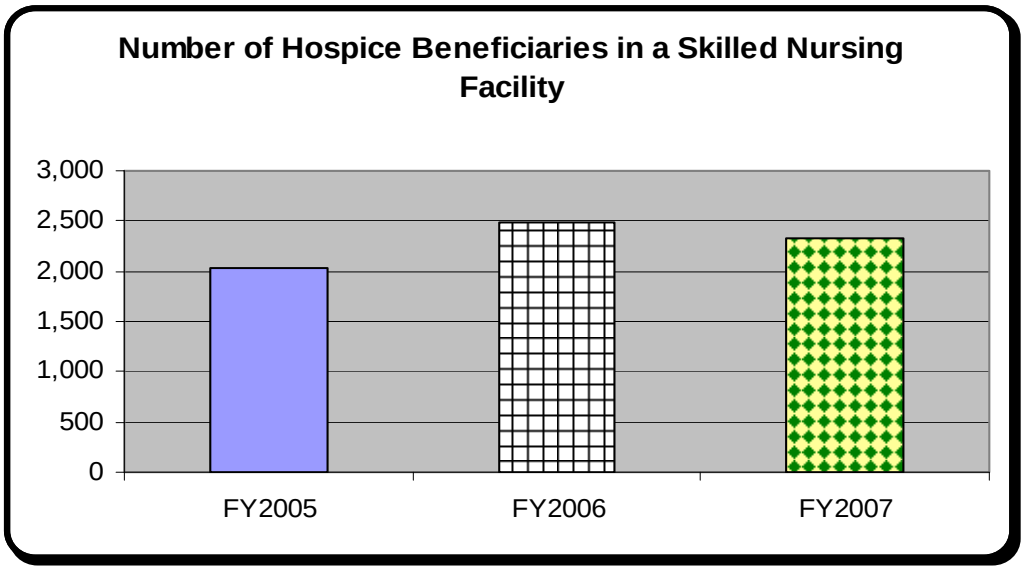
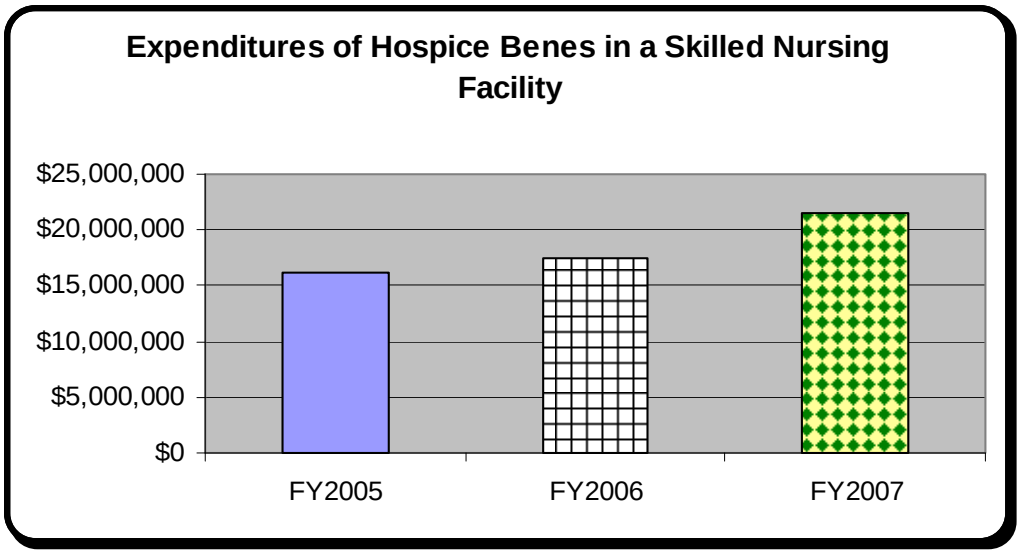


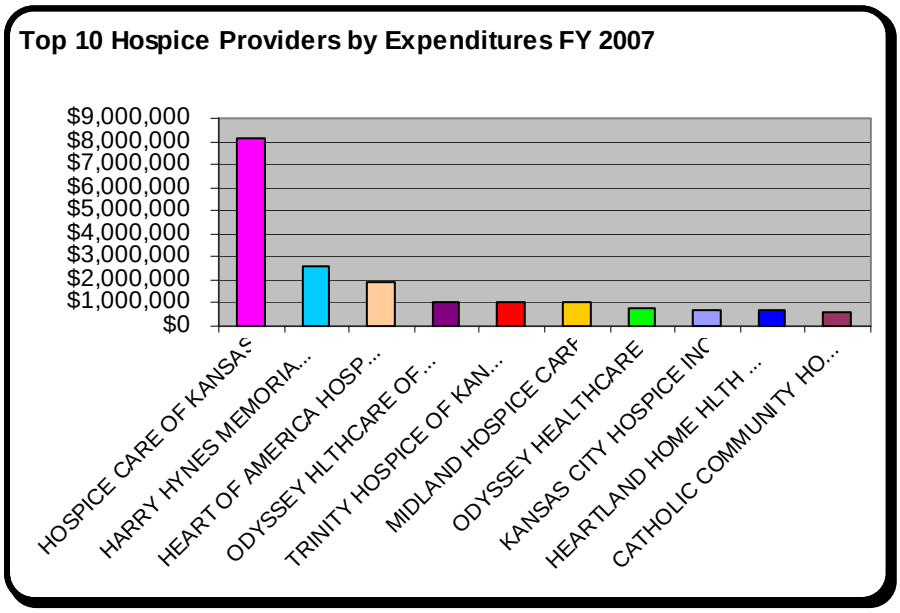
Figure 9



Hospice Expenditures by Provider

In 2007, there were 68 Medicaid participating Hospice Providers in Kansas. Of these 68 providers, the top 10 by reimbursement are displayed in Figure 10.

Figure 10



In reviewing Figure 10, Hospice Care of Kansas is the largest hospice with $8 million in reimbursement in FY 2007. The next largest provider received $2.5 million in reimbursement. Hospice Care of Kansas has 13 locations across the state whereas Harry Hynes Memorial Hospice has five locations in one city.

Figure 11

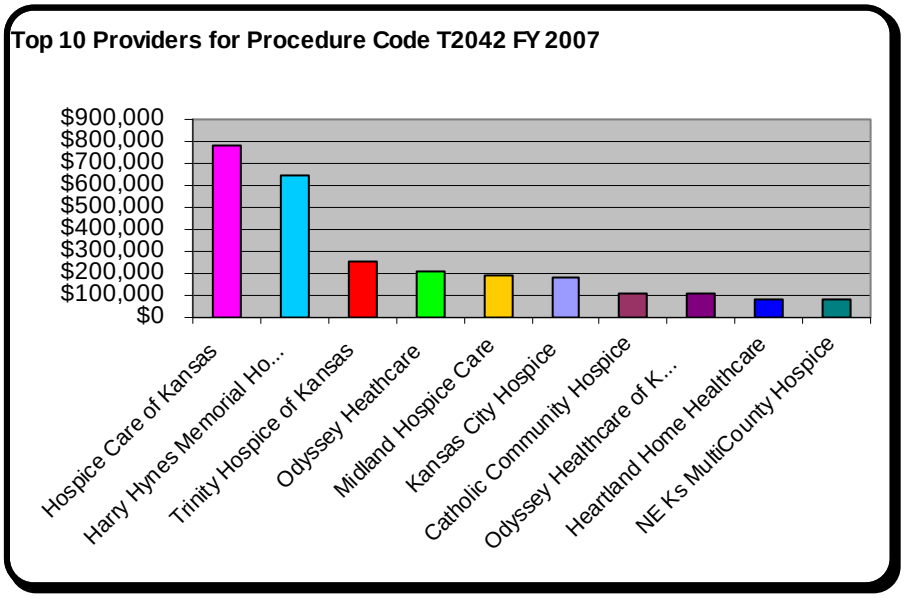


Figure 11 identifies expenditures for procedure code "Routine Home Care" **(T2042)** which includes routine nursing care, social services, DME, supplies, drugs, home heath personnel, personal care attendants, physical therapy, occupational therapy and speech language PT, included in the treatment plan and prior authorized.

Figure 12

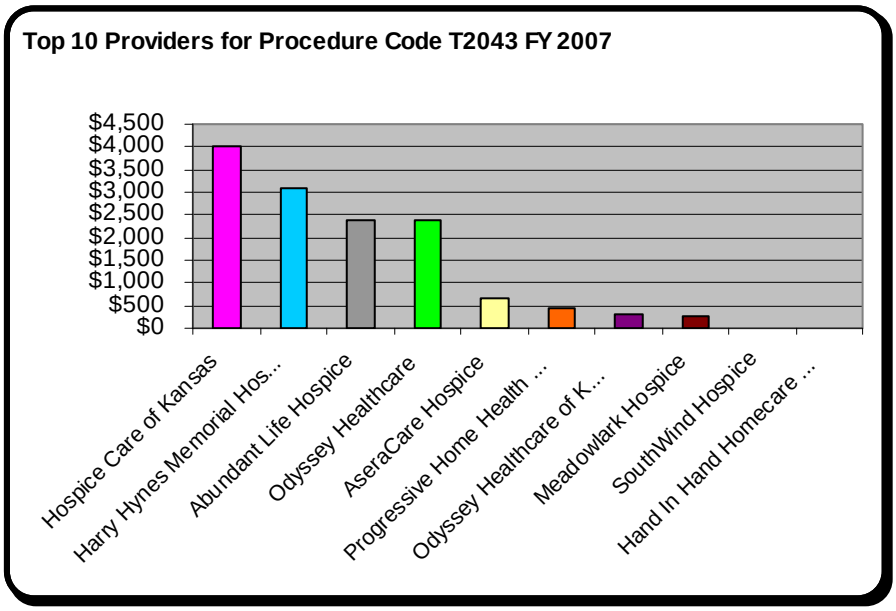


Figure 12 identifies the procedure code "Continuous Home Care" (**T2043**) which is a level of care provided under extreme circumstances only, due to the level of staffing and cost that this level represents. This is provided during periods of acute medical crisis, when 24-hr/day nursing care is provided in the home.

Figure 13

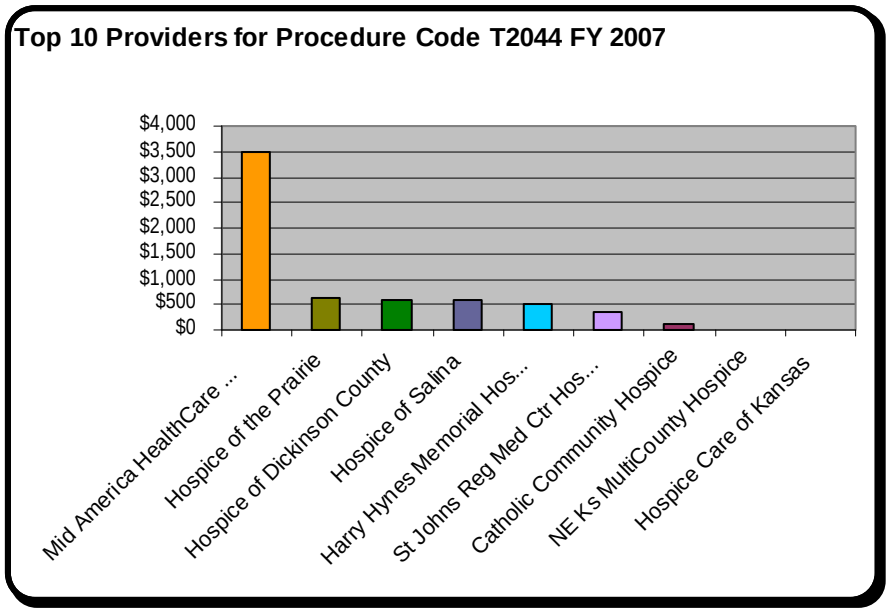


Figure 13 indicates a level referred to as "Respite Care" (**T2044**). The top three hospice providers are not among the top providers of this hospice code. This is predominantly used in rural areas and is defined as, "Respite care in a licensed nursing facility or an acute care hospital which has contracted with the hospice." The reimbursement from Kansas Medicaid is in the thousands rather than millions for this measure.

Figure 14

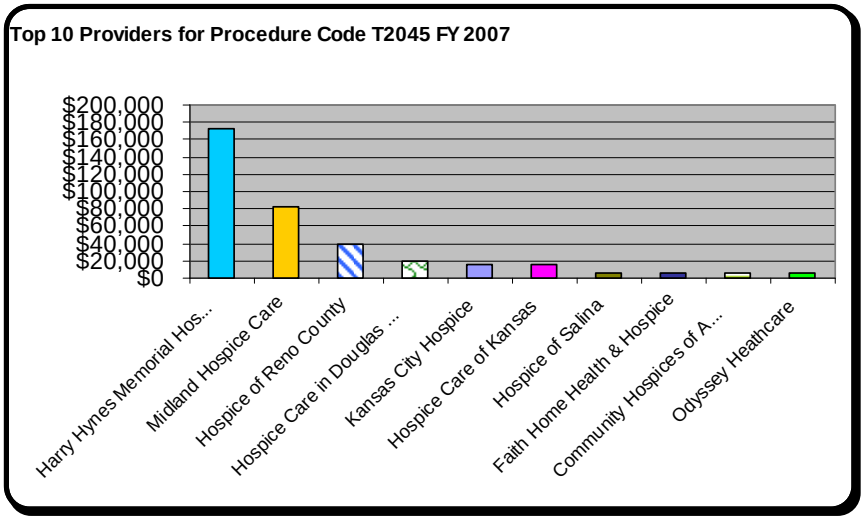


Figure 14 demonstrates the General Inpatient Care Hospital Level (**T2045**), in which a patient may be hospitalized for palliative care in periods of acute medical crisis. The reimbursement is less than other services associated with hospice. Patients can also be admitted for reasons not related to their terminal illness, for example if they fall and suffer from a broken leg. *Those lengths of stay are not measured here*.

Figure 15

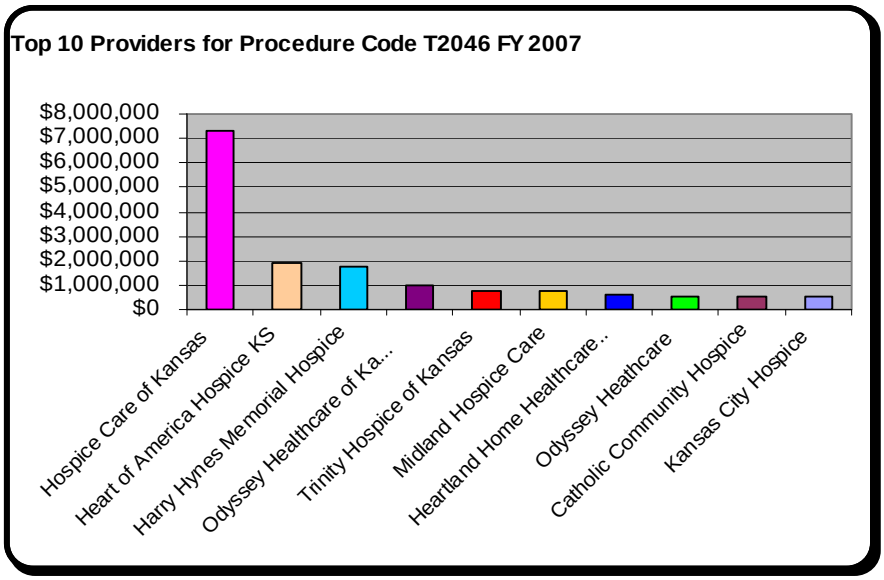


Figure 15 shows the final procedure code for Hospice care (**T2046**), which is room and board, nursing facility. Hospice bills Medicaid for room and board, Kansas Medicaid reimburses the Hospice 95% of the room and board rate as determined by the Kansas Department on Aging. This 95% reimbursement is based on federal law. The Hospice then pays the Nursing facility at a rate they have contracted for. This analysis reinforces the leading role skilled nursing facilities play in providing hospice services.

Hospice Task Force

In 2007 a Hospice Task Force was convened by KHPA that includes representatives from pharmacies, Nursing Facilities, Hospices, EDS and representatives from the Department on Aging. This Task Force has provided numerous comments, suggestions and recommendations to KHPA and to other State of Kansas programs. For example, the Task Force heard concerns from nursing facilities in Kansas that Medicaid residents receiving hospice services are not counted in the "acuity rating scale" component of the Medicaid payment rate. The nursing facility industry raised concerns about the lack of accounting for hospices' impact on costs, contending that these patients also require staff time and supplies. As a result of this discussion, this practice was changed by the Kansas Department on Aging and nursing facilities are now able to count the Kansas Medicaid hospice patients into their case mix on acuity levels.

Conclusions

1. Exceptional growth in costs and lengths of stay in the Hospice program, particularly prior to FY 2008, has become an area of significant focus for KHPA program staff and the Hospice Task Force. KHPA program staff is working with the task force to understand the trends in Hospice and address concerns about cost growth.

2. There are concerns about pharmacy expenditures for hospice beneficiaries. The Hospice Task Force has already devoted several sessions to medication usage, including discussions about which entity should be responsible for the costs. Over the next year, the goal is to develop and implement clarifications and/or changes to hospice policy in order to reduce or contain medication costs.

3. Admission criteria for hospice services, including the diagnoses, needs to be reviewed. There are currently no restrictions. Although Medicare does not restrict by diagnosis, Medicare does employ the use of audits in determining whether or not a patient meets admission criteria or length of stay criteria.

4. Length of stay (LOS) also needs to be reviewed in the coming year, including a review of FY 2008 data to determine program trends.

5. Another key area for improvement is in the area of retroactive eligibility and identifying beneficiaries with a current hospice benefit. At this time, KHPA has no mechanism in place to prevent reimbursement of services that would be inappropriate for hospice following the eligibility determination (when claims are subjected to the complete set of edits and audits in the Medicaid payment system). As a result, Kansas Medicaid may have paid for hospitalizations and other treatment services that might be non-reimbursable under Medicaid for a hospice patient (hospital care, psychotherapy, Targeted Case Management, etc.). Kansas Medicaid may have also paid claims at a different rate than would be paid if the beneficiary was properly identified as a hospice beneficiary, such as per diem rates at nursing facilities. These are paid at 95% to the hospice when a beneficiary is appropriately enrolled in hospice. In a case where MMIS has not been flagged for hospice, nursing facilities per diem is paid at 100% directly to the facility. Another example is that

Medicaid may have reimbursed pharmacy claims including curative chemotherapy, osteoporosis treatment, psychotherapeutic medications, narcotic analgesics, and other medications that either should have been paid by the hospice or that should never have been paid at all for hospice patients.

At this time, if a hospice patient is found to have retroactive eligibility, those claims are sent to the state program manager, who reviews the retroactive eligibility, and the reason for the delay in sending the authorization and Notice of Election (NOE) to EDS. The program manager can do one of three things: approve all services, in which case numerous claims which might not be appropriate for hospice care will pay; approve a portion of the retroactive eligibility request and deny the remainder for not meeting program guidelines; and finally the entire claim can be denied. In any case, all pharmacy claims will have been paid. Further review of this system is an issue the Hospice Task Force is continuing to examine in order to ensure both appropriate provision of services and appropriate cost controls.

Recommendations

1. The Kansas Medicaid Hospice Provider Manual is being reviewed and redeveloped to include many clarifications that are currently vague and/or to specify currently uncertain provisions of covered services and reimbursement. One option is the re-drafting of the manual; another option, which providers have requested, would be to incorporate the Medicare Conditions of Participation (COP's) in their entirety in the Kansas Medicaid Provider Manual. The *revised* 42 CFR 418 was published in June 2008 and is effective for Medicare coverage and reimbursement in December 2008. A number of potential policy items will likely be developed including medication monitoring for payment, prior and retrospective authorization review guidelines, admission and length of stay reviews, HCBS concurrent stay reviews, as examples.

2. Implement the Hospice Task Force's idea to develop categories of medications and assign responsibility for cost within those categories. Those categories and responsibility for payment are:

- Medications never appropriate for hospice - includes items such as unapproved drugs or therapy, such as Laetrile treatments and chelation therapy. These may also include commonly used medications that are not appropriate for terminal patients such as hormonal therapy, preventive medications such as the statin dugs used to help lower cholesterol, treatments for osteoporosis and so forth.
- Medications not covered by the hospice or by Kansas Medicaid - includes vitamins, health additives such as Bee Pollen or patient personal choice items considered not medically necessary by treatment providers (this category would be patient or family paid).
- Medications that are the responsibility of hospice - analgesics for pain control, anti-anxiety medications, oxygen. Any non-curative medications directly related to terminal disease process would be a hospice responsibility.
- Medications - that are the responsibility of Kansas Medicaid- medically necessary medications, not related to the terminal diagnosis such as prescription eye drops, insulin and other anti-diabetic medications, hormonal therapy such as Synthroid® for hypothyroidism.

- Case specific responsibility (determined on a case by case basis) – this category is patient, disease and medication specific and would include items such as: Skin and wound care products, anti-hypertensive medications, and antibiotics.

3. Place some restrictions on admission to Hospice. The KHPA could include hospice admissions criteria that relate to specific diagnosis through the Surveillance Utilization Review System (SURS) or Prior Authorization (PA) units at EDS.

4. Length of Stay (LOS) should be examined by diagnosis, days in hospice and/or certain medications still in use after designated time frames. The practice of reviewing individual hospice stays after a certain period of time (e.g. 90 days or 6 months) may help to identify patterns and may also identify inappropriate medication administration.

5. Implement the Hospice Task Force plan which includes training for hospice and pharmacy providers as well as education aimed at referral sources to hospice. This will not resolve all issues related to retroactive eligibility, but it may relieve the strain on the system until we are able to determine how to identify retroactive approvals more quickly.

Other recommendations to address retroactive eligibility include more elaborate data queries and analysis to measure length of stay and diagnoses with expenditures and medications paid for by hospice. A short term solution will be to request that the hospice furnish this information as part of admission/election process.