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HUMAN RESOURCES
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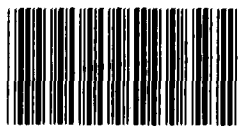

The Honorable Bill Archer
House of Representatives

Dear Mr. Archer:

Subject: Comments on the Legislative Intent of Medicare's Hospice Care Benefit (GAO/HRD-83-72)

Your June 2, 1983, letter asked us a number of questions concerning the recently enacted Medicare hospice care benefit. As agreed to with your office, this report will address the legislative intent behind the hospice reimbursement requirements contained in Medicare law, the payment cap set by the law, and the discretion the Department of Health and Human Services (HHS) has in setting the payment rate. Your other questions will be addressed at a later time.

BACKGROUND

There is no standard definition of what a hospice is or what services an organization must provide to be considered a hospice. However, it is generally agreed that the hospice concept in the United States is a program of care in which an organized interdisciplinary team systematically provides palliative care (relief of pain and other symptoms) and supportive services to patients with terminal illnesses.[1] The team also assists the patient's family in making the necessary adjustments to the patient's illness and death. A hospice's objective is to make the patient's remaining days as comfortable and meaningful as possible and to help the family cope with the stress.

Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) (TEFRA) provided for Medicare coverage of hospice care as of November 1, 1983. The program is to terminate on October 1, 1986, unless the Congress takes action to reauthorize it. The law limits hospice care to beneficiaries having a life expectancy of 6 months or less. A beneficiary can

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[1]See "Hospice Care--A Growing Concept in the United States" (HRD-79-50, Mar. 6, 1979) for a more detailed discussion.

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elect to receive care for two periods of 90 days and one period of 30 days. After election, hospice benefits are provided in lieu of all other Medicare benefits except for payments to the patient's attending physician when the physician is not employed by the hospice.

To receive Medicare reimbursement, hospices must directly provide certain core services--nursing care, medical social services, physician services, and counseling services. In addition, the hospice, directly or through arrangements, must provide physical or occupational therapy or speech-language pathology, home health aide/homemaker services, drugs, medical supplies and appliances, and short-term inpatient care. The law limits inpatient care to no more than 20 percent of the aggregate patient days, with inpatient respite care limited to no more than 5 consecutive days on an intermittent basis. Although the law does not define respite care, it is generally considered to consist of temporary short-time daytime or overnight relief services provided in a facility or the patient's home, so that the primary care giver can have a period of rest from the stress of caring for the patient.[2]

Hospice care must be available on a 24-hour basis and be provided in accordance with a written plan developed and periodically reviewed by the patient's attending physician, the hospice's medical director, and an interdisciplinary team composed of at least one physician, one registered nurse, one social worker employed by the hospice, and one other counselor.

Hospice services are to be paid for on a cost or cost-related basis. Average reimbursement per case, however, is to be limited to 40 percent of the estimated average Medicare expenditures during the last 6 months of life of beneficiaries whose primary cause of death was cancer. Beneficiaries will be required to pay a 5-percent coinsurance on respite care[3] and a copayment of the lesser of $5 or 5 percent per prescription drug.

The law also requires that various reports be submitted to the Congress concerning (1) the effectiveness of the hospice

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[2]From a Congressional Research Service issue brief entitled "Hospice Care Under Medicare" dated June 1, 1983.

[3]Coinsurance paid by the beneficiaries for respite care cannot exceed the inpatient hospital deductible in effect at the time hospice benefits were elected by the beneficiary.

demonstration program which was ongoing at the time of enactment, (2) the equity of the reimbursement method and benefit structure put into effect under the hospice provision, including the feasibility and advisability of a prospective reimbursement system for hospice care, and (3) other aspects of the hospice program.

PAYMENT METHOD INCLUDED IN TEFRA

Regarding the method of hospice reimbursement, the law states that:

> "* * * the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations * * *"

The statute provides the Secretary discretion to fix a payment mechanism in accord with the requirements set forth therein. A prospective reimbursement system is consistent with this grant of authority. Moreover, the Secretary has interpreted similar language used elsewhere in the Social Security Act to authorize prospective reimbursement. For example, an amendment concerning Medicare's End-Stage Renal Disease Program (ESRD), section 226A of Public Law 95-292, has been used to establish a prospective reimbursement system for ESRD patients with the following language.

> "* * * The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end-stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including [reasonable cost]), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals. Such regulations shall provide for the implementation of appropriate incentives for encouraging more efficient and effective delivery of services (consistent with quality care), and shall include, to the extent determined feasible by the Secretary, a system for classifying comparable providers and facilities, and prospectively set rates or target rates

with arrangements for sharing such reductions in costs as may be attributable to more efficient and effective delivery of services."

Furthermore, section 249 of Public Law 92-603, enacted October 30, 1972, required that effective July 1, 1976, Medicaid reimburse nursing homes in all States on a "reasonable cost-related basis." This language has been interpreted through regulation to permit States to reimburse nursing homes prospectively. As of late 1982, at least 36 States had some type of cost-based prospective system in place.

TEFRA (section 122(j)(1)) also requires that:

"* * * The Secretary of Health and Human Services shall conduct a study and, prior to January 1, 1986, report to the Congress on whether or not the reimbursement method and benefit structure (including copayments) for hospice care under title XVIII of the Social Security Act are fair and equitable and promote the most efficient provision of hospice care. Such report shall include the feasibility and advisability of providing for prospective reimbursement for hospice care, an evaluation of the inclusion of payment for outpatient drugs, an evaluation of the need to alter the method of reimbursement for nutritional, dietary, and bereavement counseling as hospice care, and any recommendations for legislative changes in the hospice care reimbursement or benefit structure."

This study requirement suggests that the Congress did not anticipate that HHS would initially pay hospices on a prospective basis, but on a reasonable cost basis up to the cap amount. However, the law does not require the Secretary to report to the Congress before adopting a prospective reimbursement system for hospice care.

Although the current version of the draft regulations for Medicare reimbursement of hospice care were not made available to us because the Secretary had not approved them, earlier drafts of the regulations indicate that HHS was considering adopting a prospective reimbursement system. On June 20, 1983, an HHS official told us that although changes were being made in the draft regulations as the result of the Secretary's review, no changes had yet been made to the structure of the proposed reimbursement system.

Under the law the Secretary of HHS has authority to implement a prospective reimbursement system. Although the inclusion of a provision requiring a study of the feasibility and advisability of prospective reimbursement for hospice care indicates that the Congress did not expect HHS to implement a prospective reimbursement system immediately, the law does not preclude it from doing so. Furthermore, including the study requirement indicates that the Congress was considering moving toward adoption of a prospective reimbursement system.

PAYMENT CAP

In authorizing Medicare reimbursement for hospice service, the Congress, in section 122(c)(2)(B) of TEFRA, chose to impose a cap on the average reimbursement which a hospice program could receive for its Medicare patients. This section states that the cap is to be computed by first calculating the average cost to Medicare during the last 6 months of life for beneficiaries who died of cancer. These data are to be taken from the most recent 12-month period for which data are available. The national average cost is to be adjusted for regional differences in the cost of delivering health care, and the cap amount for a particular hospice would be 40 percent of the regional average cost adjusted by the national medical consumer price index times the beneficiaries served.

The language of this provision of the law is very specific and gives HHS no leeway regarding the formula for computing the cap. HHS does have some discretion in determining how the average cost per Medicare cancer case is determined "using the best available data"; however, even here, the language is sufficiently restrictive so that HHS' discretionary authority is limited.

The legislative history of the hospice provision in TEFRA is very limited. The only document that discusses the cap at any length is a House Committee on Ways and Means print[4] which states that:

> "* * * The intention of the cap is to ensure that payments for hospice care would not exceed the amount that would have been spent by Medicare

[4]Staff of House Committee on Ways and Means, 97th Cong., 2nd Sess., WMCP: 97-35, Explanation of H.R. 6878, The Medicare, Unemployment Compensation, and Public Assistance Amendments of 1982, including Summary, Explanation, and Cost Estimates of the Congressional Budget Office, August 2, 1982, page 18 (Comm. Print 1982).

> if the patient had been treated in a conventional setting. The reimbursement cap has been established on the basis of recent data from the Health Care Financing Administration, used by the Congressional Budget Office in estimating the cost implications of this provision, which indicate that Medicare reimbursement in the last six months of life of a beneficiary dying of cancer would on average exceed $19,000 in 1983. The cap amount would be, based on these assumptions, in excess of $7,000 per beneficiary. * * * "

This indicates that the cap formula was designed to produce a cap in excess of $7,000. However, the Congressional Budget Office data used by the Committee included two errors which resulted in an overstatement of the amount of the cap. When HHS calculated the base amount using Medicare cost data, it came up with a much lower figure, producing a cap figure of about $4,200 per hospice beneficiary in 1984, only about 55 percent of the figure cited in the House Committee on Ways and Means print.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to examine the legislative intent of the law on the method of payment for hospice care and the reimbursement cap and the extent of discretion HHS has in establishing the payment rate for hospice care as a Medicare benefit. We reviewed TEFRA and its related congressional hearings and Committee reports. We also discussed the hospice provision with congressional staff, HHS' Health Care Financing Administration, and National Hospice Organization officials. As requested by your office, we did not obtain comments from HHS on this report.

Except as noted above, our work was done in accordance with generally accepted government audit standards.

Unless you publicly announce its contents earlier, no further distribution of this report will be made for 30 days. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours

Richard L. Fogel
Director