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MEDICARE HOSPICE REGULATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

SEPTEMBER 15, 1983

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THURSDAY, SEPTEMBER 15, 1983

U.S. Senate,
Subcommittee on Health,
Committee on Finance,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:36 p.m. in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Dole, Roth, Heinz, Durenberger, and Mitchell.

Also present: Senator Dodd.

[The press release announcing the hearing and the opening statements of Senators Dole, Roth, and Mitchell, follow:]

[Press Release No. 83-174]

Press Release

For immediate release—August 24, 1983

U.S. Senate, Committee on Finance, Subcommittee on Health, SD-219, Dirksen Senate Office Building

MEDICARE HOSPICE REGULATIONS

The Honorable Dave Durenberger (R., Minnesota), Chairman of the Senate Finance Subcommittee on Health, announced today that the subcommittee has scheduled a hearing on the Administration's regulations to implement the medicare hospice benefit enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The hearing will begin at 2 p.m. on Tuesday, September 13, 1983, in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Durenberger emphasized his wish to hear the views of all parties who are or might be affected by the new hospice law. "This hearing will provide an opportunity for Members to hear the comments of many who have identified certain areas of the regulations or statute that could be improved. It will also allow us to learn the results of the Administration's hospice demonstration projects that are near completion. I would hope the testimony presented to the subcommittee will provide us with a basis for considering changes which may be necessary to provide for appropriate implementation of the new hospice benefit."

[Press Release No. 83-174 (revised)]

PRESS RELEASE

For immediate release—September 8, 1983

U.S. Senate, Committee on Finance, Subcommittee on Health, SD-219, Dirksen Senate Office Building

FINANCE SUBCOMMITTEE ON HEALTH RESCHEDULES DATE AND TIME OF HEARING ON MEDICARE HOSPICE REGULATIONS

The Honorable Dave Durenberger (R., Minnesota), Chairman of the Senate Finance Subcommittee on Health announced today that the subcommittee hearing on the Administration's regulations to implement the medicare hospice benefit enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982 has been rescheduled.

The revised date and time for this hearing is now Thursday, September 15, 1983, at 2:30 p.m. in Room SD-215 of the Dirksen Senate Office Building.

STATEMENT OF SENATOR BOB DOLE—SEPTEMBER 15, 1983

Based on legislation I introduced in 1981 (S. 1958), the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) contained a provision creating a hospice care benefit for medicare beneficiaries. In TEFRA we provided hospice coverage of up to 210 days for terminally ill persons.

Enactment of the hospice provision was possible because many believe, as I do, that it is less costly to care for a patient at home, foregoing expensive hospital treatment. But more importantly, hospice care is more humanitarian. Rather than being in an institution alone much of the time, hospice care will allow an individual to remain at home, surrounded by family and friends.

The purpose of this hearing is to examine the Administration's regulatory efforts to implement the hospice provision. We purposely delayed implementation of the hospice benefit until November of this year. The delay was intended to allow the Administration an opportunity to reflect the results of a number of hospice demonstrations in its proposed regulations. I look forward to hearing from the Administration and our other witnesses as to how well the regulations provide for this very important, humane, and hopefully cost effective care.

STATEMENT OF SENATOR WILLIAM V. ROTH, JR.

Mr. Chairman, I thank you for this opportunity to discuss the hospice regulations. I am particularly pleased to have two Delawareans here today as witnesses. Dr. Amy Hecht is here on behalf of Delaware Hospice, Inc., and Charles Marvil is here from the Wilmington Medical Center.

In early July, when this committee was meeting to discuss the Hospice cap issue, I raised my concern over the issue of contracting for nursing services. A contract with the visiting nurse association for nursing services has been cost effective for Delaware Hospice than hiring their own nurses.

I believe that small hospices and those in rural areas should have the option to continue contracting relationships and still receive medicare reimbursements. Although I understand the rational for the restrictions on nurse contracting, I am sure that some reasonable compromise can be worked out among the various groups interested in this issue.

To: Senator.
From: Ellen.
Date: September 14, 1983.
Re Hospice hearing.

Two Delawareans are coming to the hearing tomorrow in Finance. Enclosed are introductory remarks should you be at the hearing at the start and chose to say something.

The issue with the hospice legislation is that of contracting for nursing services. Most hospices hire nurses outright and that is what the legislation requires. However, with a small number of patients, Delaware Hospice found it cheaper to contract with the Visiting Nurse Association for nursing services. Delaware Hospice will not be able to keep its contractual arrangement if it wants the new Medicare money.

Delaware Hospice, as well as other small and rural hospices, want the flexibility to contract for nurses if necessary. There is a lot of opposition to opening up the law for fear that umbrella type hospices will spring up to take advantage of this new money source.

In July, you wrote to Dole, proposing waiver authority for the Secretary, with some severe restrictions, to take care of Delaware Hospice. Senator Jepsen has introduced a bill which would delete the nursing requirement altogether, and open things completely. The hospitals are supporting Jepson because hospitals may begin hospice programs since the Medicare reimbursement for hospice is higher than the prospective payment will be!!

The waiver approach is a moderate approach and it will be interesting to see how many groups discuss the contracting issue at the hearing.

I talked to Delaware Hospice today and they still want the waiver, but they are moving ahead with plans to hire nursing staff in preparation for Medicare reimbursement.

STATEMENT BY SENATOR GEORGE J. MITCHELL

Mr. Chairman, I am grateful for the opportunity presented by this hearing to receive testimony on regulations recently promulgated by the Health Care Financing Administration to implement the new Medicare benefit for hospice care.

Until recently, the energies of health professionals and health care institutions in this country have been channelled exclusively into making people well. Little effort was given to helping those without hope of a cure to adjust to their impending death and live out their remaining days with a minimum of pain and a maximum of comfort from family and friends. Within the last decade, we have imported the concept of hospice from our European neighbors to offer for the first time an alternative to institutionalized care for the terminally ill.

Hospices are heralded for the continuum of care which they provide for both patients and their families. Services, which are emphasized in the home, but can be made available on an outpatient basis or in an inpatient setting, typically include physical and psychological care for the patient, respite care for the family, and bereavement counseling to help the family cope with loss of a loved one. Hospice care is frequently viewed as a more humane alternative to death in an institution as it seeks to minimize pain and rejects the use of heroic measures which, though futile, may nonetheless be applied in an acute care facility. Most importantly, it assists the patient and his or her family in adjusting to the idea of impending death and in living out those remaining days with dignity.

The proliferation of hospices in this country has seen a variety of provider types. In my own state of Maine, there are approximately 15 hospices which are independent organizations composed mostly of volunteers. A handful of others exist in an inpatient setting.

Also, Maine is fortunate to be one of the states in which Blue Cross/Blue Shield is operating a pilot program to test the bases on which insurance coverage can be provided to the terminally ill. Thus far, it has provided coverage through an existing home health program and has received the support of all of Maine's home health agencies.

I am encouraged by developments in hospice care that have occurred without the benefit of federal involvement. Nonetheless, at present, we are on the threshold of a new Medicare benefit for hospice care that promises to expand upon the growing field of hospice programs. Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 established a three year program of reimbursement, beginning on November 1st, that will provide coverage to Medicare beneficiaries with a life expectancy of six months or less.

The regulations implementing the law have been long awaited by hospices, home health agencies, hospitals and other agencies or institutions which eagerly await participation in the program. I look forward to hearing the comments to be made by today's panelists on the substance of the regulations, the adequacy of the statute, and the results of the demonstration projects sponsored by the Department of Health and Human Services.

While a number of improvements may be necessary in the law or the regulations, I want to voice my concern in particular about one issue which appears quite troublesome to the development of hospice care in the State of Maine under the new reimbursement provision. As I indicated earlier, most of the hospices in my state are volunteer organizations without the benefit of a nursing staff. Yet, the statute precludes such agencies from subcontracting for the delivery of nursing services, services which make up the bulk of hospice care.

Such a restriction may in rural states pose an impediment to the growth of the coalition model of hospice in which two organizations contract with others for a multidisciplinary approach to the delivery of services. Barring subcontracting for nursing care may pose a hardship in areas experiencing a shortage of nurses. Indeed, some believe that failure to allow for such contractual arrangements may leave hospices with financial risks too large to permit their participation in the Medicare program.

I hope this committee will explore more thoroughly the advisibility of allowing for the subcontracting of nursing care, if so, the circumstances under which it can be permitted, and the ramification for providers and the quality of care to both hospice patients and their families.

Senator DURENBERGER. The hearing will come to order.

Today's hearing on the hospice is actually the first on the topic before the Finance Committee, although we are well down the line on implementing regulations that came about as the result of TEFRA legislation in 1982. I want to welcome everyone's interest in the subject and say that we are looking forward to all of the testimony.

This is an issue that we care a great deal about, and we will be keeping close tabs on the hospice legislation over the next several years.

Do you have anything, Mr. Chairman, that you would like to add?

Senator DOLE. Thank you very much, Mr. Chairman.

Based on legislation that I introduced, and others, in 1981, S. 1958, the Tax Equity and Fiscal Responsibility Act of 1982 contained a provision creating a hospice care benefit for medicare beneficiaries. In TEFRA we provided hospice coverage of up to 210 days for terminally ill persons.

Enactment of this provision was possible because many believe, as I do, that it is less costly to care for a patient at home, foregoing expensive hospital treatment. More importantly, hospice care is more humanitarian. Rather than being in an institution alone much of the time, hospice care will allow an individual to remain at home, surrounded by family and friends.

As everybody knows, the purpose of this hearing, as pointed out by Senator Durenberger, is to examine the administration's regulatory efforts to implement the hospice provision. We purposely delayed implementation of the hospice benefit until November of this year. The delay was intended to allow the administration the opportunity to reflect the results of a number of hospice demonstrations in its proposed regulations.

So we are looking forward to hearing the administration. I know there are at least—well, there are probably a number of areas, but I know there are some controversial areas relating to the management of the hospices. I know that Senator Roth and Senator Jepsen have demonstrated particular concern over one aspect of the law and implementing regulations—the prohibition of a hospice contracting with another organization for nursing services.

So there are some areas that I am certain we are going to be focusing on today, and I look forward to hearing the witnesses.

Senator DURENBERGER. Senator Roth?

Senator ROTH. I want to thank the Chairman for having these hearings. Senator Dole has pointed out that it is a matter of considerable concern to me. I was pleased, or am pleased, to have two Delawareans here today as witnesses

Dr. Amy Hecht is the president of the board of trustees for Delaware Hospice, Inc. and Charles Marvil is from the Wilmington Medical Center. I am pleased that they could arrange to come to Washington to share their concerns with the committee.

We have had a problem at home. We are concerned about the issue of contracting for nursing services. For a small hospice, a contract with the Visiting Nurse Association for nursing services has been more cost effective for Delaware hospice than hiring their own nurses. I understand some of the problems created by opening the field up entirely; at the same time I believe that small hospices and those in rural areas should have the option to continue contracting relationships and still receive medicare reimbursements.

As I say, I understand the rationale for the restrictions, but I would hope that some reasonable compromise could be worked out which takes care of these special situations.

Thank you.

Senator DURENBERGER. Thank you.

Senator Mitchell?

Senator MITCHELL. Thank you, Mr. Chairman.

I have a statement which I would ask be placed in the record in its entirety.

Senator DURENBERGER. Without objection, it will be

Senator MITCHELL. In the interests of time I would like to just make a brief comment.

First, I commend you and the Chairman for having this hearing, giving us the opportunity to receive testimony on the regulations.

I would like to say that there are also two witnesses from Maine who I welcome, Beverly Tirrell and Marshall Cohen who will be testifying. I have an unavoidable conflict at 3:30, and they may not get on before then, so I wanted to make certain that was noted.

I also want to commend Senator Roth for the point that he raised, and also to state that it is a problem, perhaps even more so in my own State, which is even more rural. There is a great deal of concern about the reimbursement provision and the possible effect of the failure to subcontract on hospice development in rural areas. I understand that some legislation may be possible to deal with this problem, and I want to express my serious concern for that and say that I hope to participate in that effort with Senator Roth and the other members of the Committee.

Beyond that, I look forward very much, as I know we all do, to hearing from Ms. Davis.

Senator DURENBERGER. Thank you.

I have been informed that Senator Roger Jepsen from Iowa, who has been deeply involved in this issue and cares about it a great deal, wanted to be here today to make a statement but was not able to. His statement will be made part of the record.

[Senator Jepsen's prepared statement follows:]

TESTIMONY OF
SENATOR ROGER W. JEPSEN
ON MEDICARE HOSPICE REGULATIONS

BEFORE SENATE FINANCE COMMITTEE
SEPTEMBER 15, 1983

MR. CHAIRMAN, I APPRECIATE THIS OPPORTUNITY TO PRESENT TESTIMONY TO THE SENATE FINANCE COMMITTEE ON THE RECENTLY ANNOUNCED HOSPICE REGULATIONS.

FIRST OF ALL, I WOULD LIKE TO COMMEND DR. DAVIS AND HER STAFF AT THE HEALTH CARE FINANCING ADMINISTRATION FOR THE FINE WORK THEY HAVE DONE.

ALTHOUGH I DO NOT AGREE WITH ALL OF THE NEW REGULATIONS, I DO BELIEVE THAT THE HEALTH CARE FINANCING ADMINISTRATION HAS DONE AN EXEMPLARY JOB ON A VERY COMPLEX ISSUE. I ONLY WISH THE REGULATIONS WOULD HAVE BEEN AVAILABLE SOONER SO THAT WE WOULD HAVE HAD A LONGER TIME TO CONSIDER THEIR IMPACT.

AS YOU KNOW, MR. CHAIRMAN, I HAVE EXPRESSED A GREAT DEAL OF CONCERN OVER THE INABILITY OF HOSPICES TO CONTRACT OUT THE NURSING SERVICE PORTION OF THE SO-CALLED CORE SERVICES. I HAD HOPED THE REGULATIONS MIGHT PROVIDE THE NEEDED FLEXIBILITY BUT I AM AFRAID THAT JUST IS NOT THE CASE.

I RECOGNIZE THE IMPORTANCE OF NURSING SERVICES AND THAT THEY PLAY AN INTEGRAL PART IN THE OVERALL SUCCESS OF ANY HOSPICE PROGRAM. I AM CONCERNED, HOWEVER, THAT THE FAILURE TO ALLOW ANY CONTRACTING OUT COULD PROVE DISASTROUS FOR MANY EXISTING AND FUTURE HOSPICES.

WHEN CONGRESS WAS DEBATING THE HOSPICE LEGISLATION, A GREAT DEAL OF CONCERN WAS EXPRESSED OVER THE POSSIBILITY THAT "STORE FRONT" HOSPICES WOULD CROP UP OVER NIGHT AS A RESULT OF MEDICARE REIMBURSEMENT BEING MADE AVAILABLE FOR THIS SERVICE.

I SHARE THAT CONCERN.

UNFORTUNATELY, IN OUR ZEAL TO PREVENT THIS TYPE OF SITUATION FROM OCCURRING, WE HAVE EFFECTIVELY ELIMINATED HUNDREDS OF HOSPICES FROM THE PROGRAM. THESE ARE HOSPICES, MR. CHAIRMAN, THAT HAVE BEEN IN EXISTENCE FOR A NUMBER OF YEARS AND FUNCTIONING VERY SUCCESSFULLY IN COMMUNITIES ALL ACROSS AMERICA.

I STRONGLY AGREE WITH THOSE WHO ARGUE THAT WE NEED TO HAVE STANDARDS IN THE NEW HOSPICE PROGRAM. I AM CONCERNED, HOWEVER, THAT THE WAY WE HAVE CHOSEN TO ENSURE A CERTAIN STANDARD IS GOING TO FAIL AT ITS INTENDED PURPOSE AND IN THE PROCESS DENY MANY PEOPLE OF THIS MUCH NEEDED BENEFIT.

IT IS NOT NECESSARY TO ESTABLISH WHAT I BELIEVE IS AN OVERLY RIGID STANDARD IN ORDER TO ASSURE QUALITY OF CARE. THERE IS ROOM FOR

3-3-3-3-3

IT IS THIS DESIRE TO PROVIDE SOME FLEXIBILITY THAT LED ME TO INTRODUCE S. 1511. AS YOU KNOW, MY BILL WOULD ALLOW A HOSPICE TO CONTRACT OUT NURSING SERVICES IN CERTAIN SPECIFIC INSTANCES.

S. 1511 WOULD ALLOW A HOSPICE TO CONTRACT OUT FOR ITS NURSING SERVICES IF IT WAS LISCENSED OR INCORPORATED PRIOR TO ENACTMENT OF THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982.

I WOULD POINT OUT THAT THESE HOSPICES WOULD STILL BE REQUIRED TO MEET THE SAME STANDARDS OF QUALITY OF CARE AND TRAINING THAT THEY WOULD HAVE HAD TO MEET HAD THE NURSES BEEN EMPLOYEES OF THE HOSPICE. MY BILL MERELY GIVES THEM THE OPTION OF HIRING OUTSIDE NURSES FOR THIS SERVICE.

IN ADDITION, MY BILL WOULD ALLOW HOSPICES LOCATED IN RURAL AREAS, OR AREAS EXPERIENCING A MEDICAL MANPOWER SHORTAGE TO CONTRACT OUT FOR NURSING SERVICES. THE PURPOSE OF THIS PROVISION IS TO GIVE THESE AREAS AN OPPORTUNITY TO HAVE A MEDICARE CERTIFIED HOSPICE PROGRAM THAT THEY MIGHT NOT OTHERWISE BE ABLE TO HAVE.

I AM CONVINCED, MR. CHAIRMAN, THAT FLEXIBILITY IS THE KEY TO THE ULTIMATE SUCCESS OF THE HOSPICE PROGRAM. FURTHERMORE, I DO NOT BELIEVE FLEXIBILITY AND QUALITY OF CARE ARE MUTUALLY EXCLUSIVE GOALS.

IT IS CLEAR FROM THE MAIL I HAVE RECEIVED THAT MANY HOSPICES AGREE WITH MY BELIEF THAT FLEXIBILITY IS THE KEY. SOME STATES HAVE GONE AS FAR AS REQUIRING THEIR HEALTH COMMISSIONER TO PUSH FOR THE FLEXIBILITY AT THE NATIONAL LEVEL.

TIME AND AGAIN WE HAVE SEEN TREMENDOUS SOUNDING FEDERAL PROGRAMS COME OUT OF WASHINGTON THAT FAIL TO GET OFF THE GROUND ONCE OUT IN THE STATES. I WOULD HOPE THAT WE MIGHT LEARN A LESSON FROM THOSE PAST MISTAKES.

ONE ARGUMENT THE OPPONENTS OF FLEXIBILITY HAVE PUSHED IS THAT SOMEHOW FLEXIBILITY IS ONLY IN THE INTEREST OF THE AGENCY AND NOT IN THE BEST INTERESTS OF THE PATIENT. I FIND THIS A CURIOUS ARGUMENT AND FRANKLY ILLOGICAL.

IF QUALITY OF CARE IS THE REAL CONCERN THEN WHY NOT WORK TO ESTABLISH STANDARDS INSTEAD OF TRYING TO "DEFINE" A HOSPICE AS A PARTICULAR "THING". HOSPICE, AFTER ALL, IS NOT A THING BUT RATHER A CONCEPT. IT IS A WAY OF CARING FOR AN INDIVIDUAL AND DOES NOT LEND ITSELF TO AN EASY DEFINITION.

UNFORTUNATELY WHAT WE HAVE DONE, IN THE NEW MEDICARE HOSPICE PROGRAM, MR. CHAIRMAN, IS TELL THE PEOPLE OF IOWA OR THE PEOPLE OF NEW YORK OR THE PEOPLE OF KANSAS OR MINNESOTA OR ANY STATE YOU MIGHT CHOOSE JUST HOW THEY MUST SET UP THEIR HOSPICE IN ORDER TO GET MEDICARE REIMBURSEMENTS.

NOW, I HAVE NO PROBLEM WITH SETTING CRITERIA THAT AGENCIES MUST MEET. IF SUCH CRITERIA WERE NOT SET, ONE CAN ONLY IMAGINE THE WASTE, FRAUD AND ABUSE THAT WOULD OCCUR.

5-5-5-5-5

BUT WHAT WE VERY OFTEN FAIL TO PUT IN THE LAWS WE PASS IS RECOGNITION OF THE FACT THAT THE WAY PEOPLE DO BUSINESS IN NEW YORK IS DIFFERENT FROM THE WAY THEY DO BUSINESS IN IOWA.

THE WAY HOSPICES IN IOWA MUST GO ABOUT PROVIDING SERVICES IS NOT NECESSARILY THE SAME AS WHAT THE PEOPLE IN KANSAS MUST DO. JUST BECAUSE SOMETHING HAS WORKED IN CONNECTICUT, DOES NOT MEAN IT WILL WORK IN MINNESOTA.

EACH STATE IS UNIQUE.

THE GEOGRAPHICAL PROBLEMS ARE DIFFERENT.

THE DISTRIBUTION PATTERNS OF THE POPULATION ARE DIFFERENT.

OUR LAWS MUST TAKE THESE FACTORS INTO CONSIDERATION.

IN FACT, MR. CHAIRMAN, WE RECOGNIZE SOME OF THESE DIFFERENCES IN THE NEW PROSPECTIVE REIMBURSEMENT PROGRAM. ARE WE NOT GOING TO HAVE DIFFERENT REIMBURSEMENT RATES FOR DIFFERENT AREAS OF THE COUNTRY? WHY, BECAUSE THE RATES CHARGED IN VARIOUS PARTS OF THE COUNTRY DIFFER SIGNIFICANTLY.

THE PROSPECTIVE REIMBURSEMENT PROGRAM ALSO RECOGNIZES THE DIFFERENCE BETWEEN TEACHING HOSPITALS AND NON-TEACHING HOSPITALS.

BEST AVAILABLE COPY

6-6-6-6-6

WHY? BECAUSE THE PROBLEMS ENCOUNTERED IN TEACHING HOSPITALS SOMETIMES NECESSITATE CHARGING HIGHER RATES.

SO PLACING FLEXIBILITY INTO A LAW IS NOT UNHEARD OF. WE KNOW THE QUALITY OF CARE A PERSON RECEIVES IN A HOSPITAL IN DES MOINES, IOWA, IS COMPARABLE TO THE QUALITY OF CARE THAT PERSON WILL RECEIVE IN NEW YORK, NEW YORK, BUT WE ARE WILLING TO PAY A DIFFERENT RATE FOR THE SAME SERVICE. WE KNOW THAT THE QUALITY OF CARE A PATIENT RECEIVES IN A TEACHING HOSPITAL IS COMPARABLE TO THE QUALITY OF CARE HE OR SHE WILL RECEIVE IN A NON-TEACHING HOSPITAL BUT WE ARE WILLING TO PAY DIFFERENT RATES.

I AM CONFIDENT, MR. CHAIRMAN, THAT WE CAN GET THE SAME QUALITY OF CARE IN THE HOSPICE PROGRAM WHETHER THE NURSING SERVICE IS PROVIDED BY A NURSE WHO IS ON THE DIRECT PAYROLL OF THE HOSPICE OR BY A NURSE WHO IS ON THE PAYROLL OF THE LOCAL PUBLIC HEALTH NURSING SERVICE OR THE LOCAL VISITING NURSE SERVICE.

I WOULD BE MORE THAN HAPPY TO WORK WITH THE COMMITTEE ON GETTING ASSURANCES OF QUALITY OF CARE STANDARDS WRITTEN INTO THE STATUTE.

I WOULD OFFER THE SUGGESTION THAT THE HOSPICE LAW ALREADY HAS MANY OF THE TOOLS TO ACHIEVE THIS.

AS YOU KNOW, MANY OF THE SERVICES A HOSPICE IS REQUIRED TO PROVIDE CAN ALREADY BE CONTRACTED OUT. I WOULD SUGGEST THAT WE USE THOSE QUALITY ASSURANCE MECHANISMS AS A GUIDE TO ASSURING QUALITY IN THE [illegible]

EVEN WITH THE SMALL AMOUNT OF FLEXIBILITY I WISH TO SEE PROVIDED, MANY COMMUNITIES WILL STILL NOT BE ABLE TO SUPPORT A HOSPICE PROGRAM. THIS IS UNFORTUNATE, BUT UNDERSTANDABLE.

I THINK WE HAVE TAKEN A MAJOR STEP FORWARD BY PROVIDING MEDICARE REIMBURSEMENT FOR HOSPICE SERVICES.

AS I MENTIONED EARLIER, IT WOULD BE A TRAGEDY IF WE ALLOWED OVERLY STRINGENT STANDARDS TO PREVENT MANY EXCELLENT AND WORTHWHILE HOSPICE PROGRAMS FROM RECEIVING MEDICARE REIMBURSEMENT.

Senator DURENBERGER. The first witness is Carolyne Davis, Administrator of the Health Care Financing Administration.

Carolyne, we welcome you and look forward to your testimony.

STATEMENT OF CAROLYNE K. DAVIS, Ph.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, D.C.

Dr. DAVIS. Thank you.

I appreciate the opportunity to be here today to discuss the regulation as it relates to hospice care for the terminally ill.

Let me introduce two the people with me: On my left is Mr. Robert Streimer, who is the Director of the Office of Coverage Policy; and on my right is Mr. Steve Pelovitz, the Deputy Director of our Office of Research and Demonstrations.

As you know, following enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA) by Congress, HCFA developed the proposed regulation. We did that utilizing preliminary data from our hospice demonstration program.

As preparation for the writing of the regulation, we met with representatives of most of the national organizations that we felt would be interested in the hospice program. Our regulation in a proposed format was published August 22, with a 30-day comment period.

I would like to point out that the 30-day comment period is in recognition of the fact that we need comments back so that we can have our final regulation out prior to implementation on November 1.

In the regulations we did note a number of issues on which we invited public comment on. I would just like to very briefly comment on some of the major components of the regulation.

Beginning on November 1, beneficiaries can elect hospice care for two 90-day periods and one subsequent 30-day period, as provided in the statute. Of course, the physician and the hospice physician have to certify that the beneficiary has a life expectancy of 6 months or less, and the patient has to sign an election statement which waives his regular medicare benefits for the treatment of the terminal illness and the related conditions.

The patient may revoke this hospice election at any time and assume his own medicare coverage, or he can elect to change to another hospice once during each of the benefit periods.

The law requires that the hospice must be able to provide mandated services on a 24-hour basis, as necessary, with a written plan of care that is developed by the hospice's interdisciplinary team. Regardless of what setting the care is provided in or who provides the care, those services are under the professional management responsibility of the hospice itself.

According to the statute, the hospice must provide virtually all core services—that's nursing care, medical social services, physician services, and counseling services through their own employees.

There are only a couple of exceptions to this in the regulation, and those are for specialized physician services and any additional nursing services that would be necessary to handle an unanticipated workload.

The hospice's medical director must assume an overall responsibility for the patient care. And, as I mentioned, the interdisciplinary team establishes the hospice's care policies and is available to provide or supervise the care given to the patients.

Also, we did stipulate that the hospice must use volunteers and must maintain an effort to recruit volunteers.

In relationship to payment, we propose to pay the hospices for each day that the beneficiary elects hospice care on the basis of predetermined rates for various levels of care. The routine home care is $53.17 a day; continuous home care is variable, from 8 to 16 hours, at $155, and on up to 20 to 24 hours, at $285.

There are two inpatient rates. One is for respite care, which is similar to care in a skilled nursing facility, at $65.15 per day. The law, I would indicate, limits respite care to 5 consecutive days at a time. The second inpatient rate is for general inpatient rate care, and that is at $271 a day. We based that on the cost of our inpatient care that is provided in the hospital-based hospices from the demonstration data that we have.

Also, according to the law, the inpatient care may constitute no more than 20 percent of the total days of elected hospice care.

Thus, the basic payment rates were designed, we think, to reimburse the hospice for the cost of all covered services that are related to the care of the beneficiary's terminal illness. That would include the cost of physician services that are a part of the medical direction and a part of the interdisciplinary group activities, but it does not include the physician services that would be utilized for the hospice patient's attending physician. The physician may continue to bill medicare directly for those types of services that he provides as an attending physician, not the hospice physician.

As I indicated, our payment rates were calculated from the data from the hospice demonstration, except the inpatient respite rate, which was based on a skilled nursing facility cost.

With enactment of Public Law 98-90, the aggregate amount that medicare pays to the hospice is limited by the annual cap of $6,500 per medicare beneficiary. This amount is higher than the one that was originally prescribed by the TEFRA. As you are aware, Public Law was signed into law after the NPRM was issued, so we will reflect the $6,500 cap in the final regulation.

We are designating one intermediary in each State to serve the freestanding hospices. Through the intermediaries we plan to monitor the hospice program and the provision of care to the patients, particularly looking at the election of the hospice care and any subsequent revocations in connection with nonhospice admissions to hospitals by these patients.

We have instructed States to begin surveying hospices that have requested to participate in the medicare program. Instructions are being given to the intermediaries concerning bill processing, and as of November 1 we will be ready for those hospices to participate in the medicare program.

Just a word or two about our demonstration.

We did select 26 hospices to participate in the demonstration. Those demonstrations started October 1, 1980, and they were in a 24-month experimental phase and a 6-month phase-out to allow for the continuation of the coverage of those who had become participants.

The 26 organizations do reflect urban and rural differences and variations in hospice provider types, because they were selected with that in mind. There were 15 hospital-based hospices and 11 home health agency hospices in the demonstrations.

Each hospice must either be certified as a home health agency or have a contractural arrangement with a specified home health agency to provide for the care.

We are embarked on an evaluation of the hospice demonstration in conjunction with the Robert Wood Johnson and the John Hartford Foundations. We have selected Brown University to conduct this independent evaluation and to more clearly look at the effects of hospice care in terms of cost, use, and quality of care. Brown is also gathering information on other groups of terminally ill patients, including a comparison group of patients that are served by hospital and cancer centers that provide conventional medical care.

Presently Brown University, the independent evaluator, has received data on about two-thirds of the sample of hospice patients upon which the evaluation is based. Brown will be using this data to prepare the report which we are scheduled to receive later this month.

The report will discuss in detail the spectrum of cost and quality-of-life issues for both hospice and conventional care patients.

We of course are expected to do a careful analysis of the report for any implications to the current hospice benefit and any possibility of necessary changes that should be considered in the future.

I might point out that these findings from this report will be the basis for the Secretary's report to Congress on the hospice demonstration, as mandated by the TEFRA.

In developing the regulation, we did use data from the preliminary findings on the cost of care, based on the sample of 904 patients for whom we had complete utilization data. This 904 figure compares to the total of approximately 6,000 patients that will be in the final evaluation sample. While the findings may change somewhat when the data is available from the larger sample, we don't expect it will change significantly in the aggregate.

We have, however, calculated that there is an average per-patient cost of about $6,500 for the hospital-based hospice, compared to an average patient cost of about $4000 for the home health agency-based hospice.

So in conclusion, I think that, given the limited data that is available, we believe that we followed a process that allowed us to take advantage of the experience to date to develop a reasonable and an equitable proposal. This NPRM was developed with the most recent information that was available. But in a preparation of the final rule, in order that the program can begin on the statutory date of November 1, we will consider all comments that are received up to September 21.

Of course, it goes without saying that we would like to continue to have comments on implementation of the hospice program so that we can make any necessary regulation changes and incorporate any relevant aspects of the final report into the program as we move forward with entire hospice implementation.

It is important to remember that the medicare hospice benefit is limited to 3 years. We plan to carefully monitor and to study the appropriate structures that should be there to provide the best care to the terminally ill patients and their families in the most cost-effective manner, and to look at whether or not modifications must be made to insure efficiency and effectiveness.

We believe that hospice care does offer an attractive alternative to conventional care, but we also must consider the long-range utility of the program.

I think our primary goal is to assure that beneficiaries continue to receive high quality care during a terminal illness within the context of a financially viable medicare program. And clearly, during these next 3 years, we will be working together to make any changes necessary in hospice care in order to meet this goal.

Thank you.

[The prepared statement of Dr. Carolyne K. Davis follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

CAROLYNE K. DAVIS, PH.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATOR

BEFORE THE

SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

SEPTEMBER 15, 1983

I APPRECIATE THIS OPPORTUNITY TO DISCUSS THE IMPLEMENTATION OF THE PROVISIONS IN PUBLIC LAW 97-248, THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA), WHICH PROVIDE COVERAGE FOR HOSPICE CARE FOR TERMINALLY ILL MEDICARE BENEFICIARIES. WITH ME TODAY ARE MR. ROBERT STREIMER, DIRECTOR OF THE OFFICE OF COVERAGE POLICY, AND MR. STEVEN PELOVITZ, DEPUTY DIRECTOR OF THE OFFICE OF RESEARCH AND DEMONSTRATIONS.

THE ADMINISTRATION CERTAINLY SUPPORTS THE HUMANE AND CARING APPROACH THAT HOSPICES UNIQUELY PROVIDE TO TERMINALLY ILL PATIENTS AND THEIR FAMILIES. THE GROWTH OF THE HOSPICE CONCEPT IN THE UNITED STATES IS A RELATIVELY RECENT PHENOMENON AIMED AT HELPING TERMINALLY ILL PATIENTS CONTINUE TO LIVE IN THEIR HOMES WITH MAXIMUM COMFORT AND MINIMUM DISRUPTION TO ROUTINE ACTIVITIES. SINCE 1979, WHEN THE GENERAL ACCOUNTING OFFICE REPORTED 132 HOSPICES IN VARIOUS STAGES OF OPERATION, THE HOSPICE MOVEMENT HAS GROWN AND ABOUT 1,200 ORGANIZATIONS NOW CONSIDER THEMSELVES HOSPICES.

HOSPICE REGULATIONS

IN RECOGNITION OF THE INCREASING INTEREST IN HOSPICE CARE, CONGRESS ENACTED THE MEDICARE HOSPICE BENEFIT AS PART OF TERFA. TO IMPLEMENT THAT LAW, THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) DEVELOPED PROPOSED REGULATIONS USING PRELIMINARY DATA FROM OUR HOSPICE DEMONSTRATION PROJECT.

WHICH I WILL DESCRIBE LATER. WE ALSO MET WITH REPRESENTATIVES OF MOST OF THE NATIONAL ORGANIZATIONS WHO MIGHT BE INTERESTED IN THE MEDICARE HOSPICE PROGRAM IN PREPARATION FOR WRITING THE REGULATIONS. THESE ORGANIZATIONS INCLUDED THE NATIONAL HOSPICE ORGANIZATION, THE NATIONAL ASSOCIATION FOR HOME CARE, THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION, THE AMERICAN HOSPITAL ASSOCIATION, THE JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS, THE AMERICAN PHARMACEUTICAL ASSOCIATION, THE BLUE CROSS ASSOCIATION, THE AMERICAN HEALTH CARE ASSOCIATION, AND THE AMERICAN ASSOCIATION OF HOMES FOR THE AGED.

AS YOU KNOW, THE REGULATIONS WERE PUBLISHED AS A NOTICE OF PROPOSED RULEMAKING (NPRM) ON AUGUST 22, 1983, WITH A 30-DAY COMMENT PERIOD. THE REGULATIONS NOTE MANY ISSUES ON WHICH WE PARTICULARLY INVITE PUBLIC COMMENT.

LET ME BRIEFLY REVIEW THE MAJOR COMPONENTS OF THE REGULATIONS. BEGINNING ON NOVEMBER 1, MEDICARE BENEFICIARIES CAN ELECT HOSPICE CARE FOR TWO 90-DAY PERIODS AND ONE SUBSEQUENT 30-DAY PERIOD IF, AS PROVIDED IN THE STATUTE, THEIR PHYSICIAN AND A HOSPICE PHYSICIAN CERTIFY THAT THEY HAVE A LIFE EXPECTANCY OF SIX MONTHS OR LESS. THE PATIENT MUST SIGN AN ELECTION STATEMENT WHICH WAIVES REGULAR MEDICARE BENEFITS FOR THE TREATMENT OF THE TERMINAL ILLNESS AND RELATED CONDITIONS.

THE PATIENT MAY REVOKE THE HOSPICE ELECTION AT ANY TIME AND RESUME REGULAR MEDICARE COVERAGE, OR THE PATIENT MAY ELECT TO CHANGE TO ANOTHER HOSPICE ONCE DURING EACH BENEFIT PERIOD.

THE LAW REQUIRES THAT HOSPICES MUST BE ABLE TO PROVIDE THE MANDATED SERVICES ON A 24-HOUR BASIS, AS NECESSARY, ACCORDING TO A WRITTEN PLAN OF CARE DEVELOPED BY THE HOSPICE'S INTERDISCIPLINARY TEAM. THESE SERVICES INCLUDE NURSING CARE, PHYSICAL AND OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY, MEDICAL SOCIAL SERVICES, HOME HEALTH AIDE/HOMEMAKER SERVICES, MEDICAL SUPPLIES INCLUDING PALLIATIVE DRUGS, PHYSICIANS' SERVICES, AND SHORT-TERM INPATIENT CARE INCLUDING RESPITE CARE AND COUNSELING SERVICES. THE HOSPICE MAINTAINS PROFESSIONAL MANAGEMENT RESPONSIBILITY FOR ALL SERVICES PROVIDED TO A PATIENT AND MUST ASSURE THAT THE PLAN OF CARE IS FOLLOWED REGARDLESS OF THE SETTING IN WHICH THE CARE IS PROVIDED OR WHO PROVIDES THE CARE.

ACCORDING TO THE STATUTE, THE HOSPICE MUST PROVIDE VIRTUALLY ALL CORE SERVICES -- NURSING CARE, MEDICAL SOCIAL SERVICES, PHYSICIANS SERVICES, AND COUNSELING SERVICES -- THROUGH EMPLOYEES. THE ONLY EXCEPTIONS TO THIS REQUIREMENT IN THE REGULATIONS ARE FOR SPECIALIZED PHYSICIAN SERVICES AND ADDITIONAL NURSING SERVICES TO HANDLE UNANTICIPATED WORKLOADS. OTHER SERVICES NOT PROVIDED DIRECTLY BY EMPLOYEES

MUST BE PROVIDED UNDER A LEGALLY BINDING AGREEMENT WHICH SPECIFIES THAT THE OTHER PROVIDER WILL EXECUTE THE HOSPICE'S PLAN OF CARE AND MAINTAIN THE HOSPICE'S MEDICAL RECORDS. AGREEMENTS FOR INPATIENT CARE MUST FURTHER SPECIFY THE SERVICES TO BE PROVIDED, DOCUMENTATION REQUIREMENTS, PERSONNEL QUALIFICATIONS, AND OTHER ITEMS NECESSARY TO ASSURE THE CONTINUUM OF QUALITY HOSPICE CARE.

THE HOSPICE'S MEDICAL DIRECTOR MUST ASSUME OVERALL RESPONSIBILITY FOR PATIENT CARE. AN INTERDISCIPLINARY TEAM COMPOSED OF AT LEAST ONE REGISTERED PROFESSIONAL NURSE, A PHYSICIAN, A SOCIAL WORKER, AND A COUNSELOR MUST ESTABLISH THE HOSPICE'S CARE POLICIES AND PROVIDE OR SUPERVISE THE CARE GIVEN TO PATIENTS. THE HOSPICE MUST USE VOLUNTEERS AND MUST MAINTAIN AN EFFORT TO RECRUIT VOLUNTEERS.

WE PROPOSE TO PAY HOSPICES FOR EACH DAY A BENEFICIARY ELECTS HOSPICE CARE ON THE BASIS OF PREDETERMINED RATES FOR VARIOUS LEVELS OF CARE. THE BASIC PAYMENT RATE FOR ROUTINE HOME CARE WILL BE $53.17 PER DAY. CONTINUOUS HOME CARE, REQUIRING PREDOMINANTLY SKILLED NURSING CARE FOR AT LEAST 8 HOURS DURING CRISIS PERIODS, WILL BE PAID IN THREE PORTIONS. FOR 8 TO 16 HOURS OF CARE, THE HOSPICE WILL RECEIVE $155.98. FOR 16 TO 20 HOURS OF CONTINUOUS CARE, THE HOSPICE WILL BE PAID $233.97. FOR 20 THROUGH 24 HOURS, THE PAYMENT WILL BE $285.96.

THERE ARE TWO INPATIENT RATES: ONE FOR RESPITE CARE AND ONE FOR GENERAL INPATIENT CARE. THE INPATIENT RESPITE RATE OF $61.65 IS BASED ON THE COST OF CARE IN A SKILLED NURSING FACILITY AND REFLECTS OUR BELIEF THAT APPROPRIATE RESPITE CARE, PROVIDED PRIMARILY TO RELIEVE A PATIENT'S FAMILY, CAN BE PURCHASED BY A HOSPICE AT THIS LESS EXPENSIVE LEVEL. THE LAW LIMITS RESPITE CARE TO FIVE CONSECUTIVE DAYS AT A TIME. IF INPATIENT RESPITE CARE CONTINUES BEYOND THE FIFTH DAY, PAYMENT WILL BE MADE AT THE ROUTINE HOME CARE RATE. THE GENERAL INPATIENT RATE IS $271 A DAY AND IS BASED ON THE COST OF INPATIENT CARE PROVIDED BY HOSPITAL-BASED HOSPICES IN THE DEMONSTRATION. ACCORDING TO THE LAW, INPATIENT CARE MAY CONSTITUTE NO MORE THAN 20 PERCENT OF THE TOTAL DAYS OF ELECTED HOSPICE CARE.

THE BASIC PAYMENT RATES FOR HOSPICE SERVICES ARE DESIGNED TO REIMBURSE THE HOSPICE FOR THE COST OF ALL COVERED SERVICES RELATED TO THE CARE OF THE BENEFICIARY'S TERMINAL ILLNESS, INCLUDING THE COSTS OF PHYSICIANS' SERVICES ASSOCIATED WITH MEDICAL DIRECTION AND INTERDISCIPLINARY GROUP ACTIVITY. OTHER PHYSICIANS' SERVICES ARE NOT INCLUDED BECAUSE THESE SERVICES DO NOT OCCUR FREQUENTLY OR UNIFORMLY IN THE CARE OF A TYPICAL HOSPICE PATIENT. INSTEAD, WE HAVE PROVIDED FOR THE HOSPICE TO BILL THE MEDICARE CARRIER SEPARATELY FOR THESE SERVICES. AS THE LAW PROVIDES, THE HOSPICE PATIENT'S ATTENDING PHYSICIAN WILL CONTINUE TO BILL MEDICARE DIRECTLY FOR THOSE SERVICES HE PROVIDES.

THE PAYMENT RATES WERE CALCULATED TO INCLUDE OVERHEAD COSTS AND TO ALLOW FOR LOCAL ADJUSTMENTS FOR DIFFERENCES IN AREA WAGE LEVELS. DATA FROM THE HOSPICE DEMONSTRATION WERE USED AS THE BASIS FOR CALCULATING ALL RATES EXCEPT THE INPATIENT RESPITE RATE WHICH, AS I MENTIONED, IS BASED ON SKILLED NURSING FACILITY COSTS. THE HOME CARE RATES WERE NOT ADJUSTED FOR INFLATION, BECAUSE THEY INCLUDED DEMONSTRATION COSTS FOR DATA COLLECTION AND REPORTING NOT INCLUDED UNDER THESE REGULATIONS, AND SO OFFSET THE INFLATION INCREASE. ALSO, SINCE THE DEMONSTRATION HOSPICES WERE REIMBURSED FOR COSTS AND THERE WERE NO TESTS OF "REASONABLENESS" APPLIED, THERE WERE NO INCENTIVES FOR EFFICIENCY. IN ADDITION, SOME DEMONSTRATION HOSPICES HAD A LOW VOLUME OF SERVICES WITH RESULTING HIGHER COSTS PER VISIT. FINALLY, AS REQUIRED BY LAW, THE RATES EXCLUDE ANY PAYMENT FOR BEREAVEMENT COUNSELING.

THE AGGREGATE AMOUNT MEDICARE PAYS TO A HOSPICE WILL BE LIMITED BY AN ANNUAL CAP OF $6,500 PER MEDICARE BENEFICIARY. THIS CAP AMOUNT IS HIGHER THAN THE ONE ORIGINALLY PRESCRIBED IN THE LAW. AS YOU ARE AWARE, THE $6,500 CAP WAS SPECIFIED IN LEGISLATION WHICH WAS SIGNED INTO LAW (AS PUBLIC LAW 98-90) AFTER WE PUBLISHED THE NPRM AND WILL BE REFLECTED IN THE FINAL REGULATIONS. TO ADMINISTER THE HOSPICE BENEFIT, ONE INTERMEDIARY WILL BE DESIGNATED IN EACH STATE TO SERVE FREESTANDING HOSPICES. HOSPICES THAT ARE SUBDIVISIONS

OF OTHER PROVIDERS WILL USE THE SAME INTERMEDIARY AS THE PARENT PROVIDER. THROUGH THE INTERMEDIARIES, WE WILL CLOSELY MONITOR THE MEDICARE HOSPICE PROGRAM AND THE PROVISION OF SERVICES TO PATIENTS, PARTICULARLY THE ELECTION OF HOSPICE CARE AND SUBSEQUENT REVOCATIONS IN CONNECTION WITH NON-HOSPICE ADMISSIONS TO HOSPITALS.

BASED ON OUR PROPOSED REGULATIONS, WE HAVE INSTRUCTED STATES TO BEGIN SURVEYING HOSPICES THAT HAVE REQUESTED TO PARTICIPATE IN THE MEDICARE PROGRAM. INSTRUCTIONS ARE ALSO BEING READIED FOR DISTRIBUTION TO INTERMEDIARIES CONCERNING BILL PROCESSING AND RELATED FUNCTIONS. ON NOVEMBER 1, WE WILL BE READY FOR HOSPICES TO PARTICIPATE IN THE MEDICARE PROGRAM.

HOSPICE DEMONSTRATION

CONGRESS ADDED THE NEW MEDICARE HOSPICE BENEFIT LAST YEAR WHILE HCFA WAS IN THE MIDST OF A MAJOR DEMONSTRATION TO GATHER DATA ON THE COST, USE, AND QUALITY OF CARE PROVIDED BY HOSPICE ORGANIZATIONS. THIS PROJECT WAS INITIALLY DESIGNED, OF COURSE, TO HELP US IN DEFINING THE APPROPRIATE SCOPE OF FEDERAL INVOLVEMENT IN THE GROWING HOSPICE MOVEMENT.

THE 26 HOSPICES SELECTED TO PARTICIPATE IN THE DEMONSTRATION WERE REIMBURSED STARTING ON OCTOBER 1, 1980, UNDER WAIVERS OF THE MEDICARE AND MEDICAID STATUTE AND REGULATIONS WHICH

LIMIT REIMBURSEMENT FOR CERTAIN HOSPICE SERVICES. THESE WAIVERS HAVE PERMITTED EXPANDED COVERAGE OF HOSPICE SERVICES FOR MEDICARE AND MEDICAID PATIENTS WHO HAVE AGREED TO TAKE PART IN THE DEMONSTRATION. ORIGINALLY, THE PROJECT WAS SCHEDULED FOR A 24-MONTH EXPERIMENTAL PHASE, WITH A SIX-MONTH PHASEOUT PERIOD TO ALLOW FOR THE CONTINUATION OF THE SPECIAL HOSPICE COVERAGE FOR THOSE PATIENTS WHO BECAME PARTICIPANTS AT THE END OF THE ACTIVE ENROLLMENT SEGMENT OF THE DEMONSTRATION. THE MEDICARE PORTION OF THE DEMONSTRATION HAS SINCE BEEN EXTENDED UNDER THE PROVISIONS OF TEFRA, AND WILL CONTINUE UNTIL IMPLEMENTATION OF THE HOSPICE BENEFIT CONTAINED IN THAT ACT.

THE DECISION TO CHOOSE 26 ORGANIZATIONS WAS BASED ON THE NEED FOR EVALUATION DATA WHICH WOULD REFLECT URBAN AND RURAL DIFFERENCES AND VARIATIONS IN HOSPICE PROVIDER TYPES. THERE ARE CURRENTLY 15 HOSPITAL-BASED HOSPICES AND 11 HOME HEALTH AGENCY-BASED HOSPICES PARTICIPATING IN THE DEMONSTRATION. EACH HOSPICE MUST EITHER BE CERTIFIED AS A HOME HEALTH AGENCY OR HAVE A CONTRACTUAL ARRANGEMENT WITH A SPECIFIED HOME HEALTH AGENCY TO PROVIDE HOME CARE SERVICES. FOR 24 OF THESE HOSPICES, MEDICAID STATE AGENCIES ALSO PARTICIPATED IN THE FIRST TWO YEARS OF THE PROJECT AND REIMBURSED FOR SERVICES TO MEDICAID PATIENTS. ALTHOUGH THE HOSPICE LEGISLATION DID NOT EXTEND THE MEDICAID PORTION OF THE DEMONSTRATION, STATES MAY PROVIDE HOSPICE SERVICES AS AN OPTIONAL SERVICE

OR UNDER A WAIVER PERMITTING HOME AND COMMUNITY-BASED SERVICES FOR MEDICAID PATIENTS WHO WOULD OTHERWISE REQUIRE INSTITUTIONAL CARE.

PARTICIPATING HOSPICES ARE BEING REIMBURSED UNDER THE DEMONSTRATION FOR A NUMBER OF SERVICES AND ITEMS NOT COVERED UNDER THE NEW HOSPICE BENEFIT. FOR EXAMPLE, THE DEMONSTRATION HOSPICES PROVIDE OUTPATIENT PRESCRIPTION DRUGS AND INPATIENT RESPITE CARE WITHOUT COST-SHARING REQUIREMENTS. ALSO, THE DEMONSTRATION PLACES NO LIMIT ON INPATIENT DAYS OR TOTAL DAYS OF HOSPICE CARE AVAILABLE TO A MEDICARE HOSPICE PATIENT. THE DEMONSTRATION ALSO REIMBURSES FOR BEREAVEMENT COUNSELING AND PERMITS THE CONTINUED UTILIZATION OF REGULAR MEDICARE BENEFITS, WHICH ARE NOT PERMITTED UNDER TEFRA.

DEMONSTRATION EVALUATON

IN SEPTEMBER 1980, JUST PRIOR TO THE IMPLEMENTATION OF THE HOSPICE DEMONSTRATION, HCFA, IN CONJUNCTION WITH THE ROBERT WOOD JOHNSON FOUNDATION AND THE JOHN A. HARTFORD FOUNDATION, SELECTED BROWN UNIVERSITY TO CONDUCT AN IN-DEPTH, INDEPENDENT EVALUATION OF THE HOSPICE DEMONSTRATION. TO MORE CLEARLY UNDERSTAND THE EFFECTS OF HOSPICE CARE IN TERMS OF COST, USE, AND QUALITY OF CARE, BROWN IS ALSO GATHERING INFORMATION ON OTHER GROUPS OF TERMINALLY ILL PATIENTS, INCLUDING A SELECTED COMPARISON GROUP OF PATIENTS

SERVED BY HOSPITAL AND CANCER CENTERS WHICH PROVIDE CONVENTIONAL MEDICAL CARE.

THE EVALUATION IS FOCUSING ON:

- WHAT ARE THE COST AND UTILIZATION PATTERNS OF HOSPICE CARE AND DO THEY VARY BY HOSPICE TYPE?
- WHAT IS THE COST OF CARING FOR THE TERMINALLY ILL IN THE LAST MONTHS OF LIFE IN A HOSPICE SETTING VERSUS A CONVENTIONAL CARE SETTING?
- WHAT IS THE DIFFERENTIAL IMPACT OF HOSPICE ON THE QUALITY OF LIFE OF TERMINALLY ILL PATIENTS AND THEIR FAMILIES AS COMPARED TO CONVENTIONAL CARE?
- ARE THERE DIFFERENCES IN THE MEDICAL AND SOCIAL INTERVENTIONS THAT HOSPICE AND NONHOSPICE PATIENTS RECEIVE?
- WHAT IS THE LIKELY IMPACT OF MEDICARE REIMBURSEMENT ON THE ORGANIZATION, STRUCTURE, STAFFING PATTERNS, AND COST OF HOSPICE?
- WHAT IS THE ROLE OF VOLUNTEERS IN HOSPICE?

UNFORTUNATELY, THE EVALUATION RESULTS WERE NOT AVAILABLE PRIOR TO CONGRESS' DELIBERATIONS ON THE HOSPICE PROGRAM, NOR WERE FINAL RESULTS AVAILABLE TO US IN HCFA AS WE DEVELOPED OUR PROPOSED RULE IMPLEMENTING THE NEW PROGRAM. PRESENTLY, BROWN UNIVERSITY, THE INDEPENDENT EVALUATOR OF THE HOSPICE DEMONSTRATION, HAS RECEIVED DATA ON ABOUT TWO-THIRDS OF THE SAMPLE OF HOSPICE PATIENTS UPON WHICH THE EVALUATION IS BASED. BROWN WILL USE THESE DATA TO PREPARE A REPORT WHICH WE ARE SCHEDULED TO RECEIVE LATER THIS MONTH. THIS REPORT WILL DISCUSS IN DETAIL THE SPECTRUM OF COST AND QUALITY OF LIFE ISSUES FOR BOTH HOSPICE AND CONVENTIONAL CARE PATIENTS. OF COURSE, HCFA AND THE INDEPENDENT FOUNDATIONS SUPPORTING THE HOSPICE EVALUATION WILL CAREFULLY ANALYZE THE REPORT FOR ANY IMPLICATIONS TO THE CURRENT HOSPICE BENEFIT AND NECESSARY CHANGES THAT SHOULD BE CONSIDERED FOR THE FUTURE. THESE FINDINGS WILL BECOME THE BASIS FOR THE SECRETARY'S REPORT TO CONGRESS ON THE HOSPICE DEMONSTRATION, AS MANDATED BY TEFRA.

IN DEVELOPING THE REGULATION, WE DID USE DATA FROM THE PRELIMINARY FINDINGS ON THE COST OF CARE PROVIDED UNDER THE DEMONSTRATION. THESE FIGURES ARE BASED ON A SAMPLE OF 904 PATIENTS FOR WHOM COMPLETE UTILIZATION DATA WAS AVAILABLE. THIS 904 FIGURE COMPARES TO A TOTAL OF APPROXIMATELY 6,000 PATIENTS WHO WILL BE IN THE FINAL EVALUATION SAMPLE OF PATIENTS. THUS, THE FINDINGS MAY CHANGE SOMEWHAT WHEN DATA ARE AVAILABLE FROM THE LARGER SAMPLE.

OUR PRELIMINARY FINDINGS SHOW ONLY A SMALL DIFFERENCE IN THE OVERALL AVERAGE LENGTH OF STAY IN HOME HEALTH AGENCY (HHA)-BASED HOSPICES COMPARED TO HOSPITAL-BASED HOSPICES, 54 AND 51 DAYS, RESPECTIVELY. HOWEVER, THE PERCENTAGE OF HOME-VERSUS-INPATIENT DAYS COMPRISING THESE STAYS VARIES SIGNIFICANTLY, WITH HOSPITAL-BASED HOSPICES PROVIDING 37 PERCENT OF THEIR CARE ON AN INPATIENT BASIS AS OPPOSED TO 14 PERCENT FOR HHA-BASED HOSPICES. THIS DIFFERENTIAL RESULTS IN HIGHER TOTAL COSTS FOR EACH PATIENT IN A HOSPITAL-BASED HOSPICE. WE HAVE CALCULATED AN AVERAGE PER PATIENT COST OF ABOUT $6,500 FOR HOSPITAL-BASED HOSPICES, COMPARED TO AN AVERAGE PATIENT COST OF ABOUT $4,000 IN HHA-BASED HOSPICES.

CONCLUSION

GIVEN THE LIMITED DATA AVAILABLE, WE BELIEVE WE FOLLOWED A PROCESS THAT ALLOWED US TO TAKE ADVANTAGE OF THE EXPERIENCES OF MANY TO DEVELOP A REASONABLE AND EQUITABLE PROPOSAL. THE NPRM WAS DEVELOPED WITH THE MOST RECENT INFORMATION AVAILABLE ON THE HOSPICE PROGRAM IN THIS COUNTRY AND WITH THE ADVICE OF INDIVIDUALS WHO ARE MOST KNOWLEDGEABLE ON HOSPICE AND RELATED HEALTH CARE ISSUES. FOR OUR PREPARATION OF THE FINAL RULE, SO THAT THE PROGRAM CAN BEGIN BY ITS STATUTORY EFFECTIVE DATE OF NOVEMBER 1, WE WILL CONSIDER ALL COMMENTS WE RECEIVE BY SEPTEMBER 21. FOR THE LONGER

TERM, OF COURSE, WE NEED TO HEAR COMMENTS ON THE IMPLEMENTATION OF THE HOSPICE PROGRAM SO THAT WE MAY MAKE NECESSARY REGULATORY CHANGES AND INCORPORATE ANY RELEVANT ASPECTS OF THE FINAL REPORT OF THE DEMONSTRATION EVALUATION, AS APPROPRIATE.

IT IS IMPORTANT TO REMEMBER THAT THE MEDICARE HOSPICE BENEFIT IS LIMITED TO THREE YEARS. ACCORDINGLY, WE MUST CAREFULLY MONITOR AND STUDY THE MEDICARE HOSPICE PROGRAM TO DETERMINE IF IT IS APPROPRIATELY STRUCTURED TO PROVIDE THE BEST CARE TO TERMINALLY ILL PATIENTS AND THEIR FAMILIES IN A COST-EFFECTIVE MANNER, OR WHETHER MODIFICATIONS MUST BE MADE TO ASSURE IMPROVED EFFICIENCY AND EFFECTIVENESS. CERTAINLY, WE HAVE MUCH MORE TO LEARN. AFTER A DECADE OF STUDY, WE HAVE JUST BEGUN TO IMPLEMENT A MAJOR REIMBURSEMENT REFORM, PROSPECTIVE PAYMENT, FOR HOSPITALS, AND EVEN IN THIS INSTANCE WE STILL HAVE IMPORTANT QUESTIONS TO RESOLVE. GIVEN HOW MUCH LESS WE KNOW ABOUT HOW TO REIMBURSE BEST FOR THE HOSPICE BENEFIT, WE EXPECT TO EXAMINE A NUMBER OF WAYS TO IMPROVE ON OUR PRESENT APPROACH. WE WILL ALSO BE REVIEWING WHETHER ANY CHANGES ARE NEEDED IN THE BENEFIT OR COVERAGE ASPECTS OF THE PROGRAM. IN THIS PROCESS, WE EXPECT TO CONTINUE TO DISCUSS THESE MATTERS WITH INTERESTED INDIVIDUALS, ORGANIZATIONS, AND CONGRESSIONAL COMMITTEES.

WHILE HOSPICE CARE OFFERS AN ATTRACTIVE ALTERNATIVE TO THE CONVENTIONAL CARE OF THE TERMINALLY ILL, WE MUST CONSIDER

THE LONG TERM UTILITY OF THE PROGRAM. OUR PRIMARY GOAL MUST BE TO ASSURE THAT MEDICARE BENEFICIARIES CONTINUE TO RECEIVE HIGH QUALITY CARE DURING THEIR TERMINAL ILLNESSES WITHIN THE CONTEXT OF A FINANCIALLY VIABLE MEDICARE PROGRAM. DURING THE NEXT THREE YEARS WE MUST WORK TOGETHER TO MAKE ANY CHANGES NECESSARY TO MEET THIS GOAL.

MY COLLEAGUES AND I WILL BE PLEASED TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

Senator DURENBERGER. Thank you very much.

I might defer my questions and see if any of my colleagues have questions.

George, do you have any questions?

Senator MITCHELL. I do have some questions.

Senator DURENBERGER. Why don't you proceed, then.

Senator MITCHELL. Oh, all right.

Thank you, Dr. Davis. You heard both Senator Roth and I refer to this question involving the problem of subcontracts. Would you please, for our benefit, describe the problem and what you see as a possible solution for it, if any?

Dr. DAVIS. Yes.

I think it's very clear that the statute does provide for core services and identifies that nursing and physician services, medical social work and counseling are the core services that are to be provided in the context of the employee relationship.

I think that it's important to recognize that the concept of hospice is embraced by an interdisciplinary team, working to develop a plan of care for the hospice patient. Clearly, I think that's what the Congress had in mind and why it designated core services in the statute.

It's apparent that some individual institutions feel that they are not able to meet the requirement.

Senator MITCHELL. Is it not true that those are more likely to be found in rural or sparsely populated areas?

Dr. DAVIS. I think that that is possible, although it's also possible it could be in more urbanized areas, too. It seems to me, however, that one way to solve this would be for them to go into a coalition model of activity.

I am rather concerned at the idea of allowing indiscriminate rent-a-nurse phenomenon to happen as part of forming an interdisciplinary core team, because I think you have got to have a true team relating to each other in planning the care. My concern would be to not move away from that, which I think is the true spirit of the hospice concept. So it seems to me if there is a way that can be worked out to allow for a coalition to be formed to make up the hospice, that that would perhaps be the best way of resolving this problem, Senator.

Senator MITCHELL. Since the patient electing hospice care is going to be required to give up other benefits, should the consent form specify exactly what the person is being asked to give up, make clear that there is a right of revocation to insure that you get a truly informed consent?

Dr. DAVIS. Well, we do clearly believe that it is important that the beneficiary recognize and know exactly what they are giving up. As part of the overall plan we did indicate that each agency would have to have a form signed by the beneficiary. That form should clearly indicate that the beneficiary recognizes that he is in a sense revoking the regular medicare program and substituting in its place the hospice benefit.

Senator MITCHELL. As I understand it, the regulations require that a preponderance of nursing care be given to hospice patients. Is that correct? As opposed to home health aid care?

Mr. STREIMER. No, Senator, that is not correct. The design of the regulation is such that the interdisciplinary team of the hospice will spell out in great detail precisely the kinds of care that an individual patient would receive. If that patient happened to need a heavier load of aid services or homemaker services, that would be reflected in that plan.

Senator MITCHELL. So there is no requirement in the regulations that there be a certain level of nursing care?

Mr. STREIMER. That is correct.

Senator MITCHELL. All right. Thank you.

Those are all of the questions I have for Dr. Davis, Mr. Chairman.

Senator DURENBERGER. Thank you very much.

Relating to the question that Senator Mitchell asked you, the regulations acknowledge that it will be necessary to closely monitor the incidence of hospice elections and revocations, especially in connection with non-hospice covered medicare admissions to hospitals, so that we don't see manipulation and coercion taking place.

Can you give us some idea of the monitoring procedures that you are going to require? The auditing procedures, or whatever?

Dr. DAVIS. Yes. I think there will be several approaches that will be taken. Actually, it will probably be a three-pronged approach.

First of all, of course, the State survey agency will be surveying conditions of participation on a yearly basis. The State survey agency, as well as the fiscal intermediaries, will be looking for any pattern of revocation that would be consistent within any particular hospice agency.

For example, if an agency appears to have a large number of individuals who, just at the point of reaching their cap limit, are suddenly revoking their benefits, it would certainly make us look more seriously at that.

In addition to the State agency's survey of this condition of participation, the fiscal intermediaries will be doing the medical review, and onsite interviews will be taking place with either the beneficiary and/or a family member to verify or to check as to whether or not there has been coercion in terms of revocation. So I think that between those three aspects, and looking at patterns, we can track this. We intend to aggressively pursue all three.

Senator DURENBERGER. My next question relates to respite care. As I understand the regulations, they define "respite care" as "short-term inpatient care provided to an individual only when necessary to relieve family members or other persons caring for the individual."

I am not sure that we intended that respite care be defined only in terms of inpatient care. I think we thought that it might also apply at home. Under what circumstances might the regulations permit respite care reimbursement at home?

Dr. DAVIS. Well, I think our feeling, too, is that it would be provided at home. We didn't make any mention of that because the statute requires that there be a copayment for respite care in the inpatient setting. That's why we addressed that particular component.

It becomes evident when we did the data collection and analysis for our home-based rate that the hospice patient may or may not need care every day. The rate that has been calculated does include any necessity for respite care. It would be perfectly permissible for an agency to provide respite as a component of its home care. We didn't disallow it, we simply didn't address to it because there wasn't any necessity to.

Senator DURENBERGER. Can you tell me how many hospices currently provide nursing care services exclusively through arrangements with other providers and therefore would appear to be excluded from participation in medicare because they don't meet the core-service requirement?

Dr. DAVIS. I really can't, Mr. Chairman. We really don't have data. Our only data comes from other sources: either through data that was collected by the JCAH or some best assumption that the National Hospice Organization has. We don't as yet have an accurate accounting for even who is a hospice. We know there are about 1,200 providers that call themselves a hospice in one format or another.

Senator DURENBERGER. Most of the rest of my questions deal in one way or another with clarifying the issues that are raised in the back of this blue book—the prospects of prospective reimbursement, the problems with the cap, and so forth. So to the degree that those questions haven't been responded to in your statement, I am going to pose some more specific questions to you.

One question that hasn't been mentioned concerns what you see when you look down the road in terms of the development of hospice care and the future of consumer choice in this whole process of selecting a provider.

It strikes me generally as I look over the regulations that there isn't a lot of room for price competition, there isn't a lot of room for service competition, because you have been fairly tight on what is reimbursable and what isn't. Cost-sharing obviously is a factor.

I wonder if you wouldn't be able to share with us briefly what you see happening in the future to the role of the consumer in choosing the provider, as opposed to having the payment system making the choice, or some other provider making the choice.

Dr. DAVIS. Well, I think we very clearly recognize that this first 3 years is, in a sense, our demonstration continued on a nationwide basis. We felt that the statute is fairly prescriptively written in the interests of collecting the data and analyzing it and moving forward into other areas.

It is quite clear from our data base that we can begin to look longer range at the possibility of constructing, say, a DRG system. We might entertain that at some future point.

I think that if we move on and get more knowledge of how a hospice actually works, we will then be able to respond to some elements of how one can actually instill more competition into the system. I think when any program is new, it merits very careful monitoring and a very systematic review before we begin to expand to a point where we have major elements with a great deal of flexibility. But I'm quite certain that competition will come down the road, as more providers come on board and become hospices.

Senator DOLE. Let me announce to all of the witnesses: We are in the process of a series of eight record votes back-to-back; so if you see us sort of rotating you'll know. Senator Durenberger has gone to vote; when he gets back I'll go vote. You may be answering his question while he's gone and my question while I'm gone, but don't worry about it. It will all work out all right, I think. And I know Senator Mitchell has a 3:30 commitment.

Do you have other questions of Dr. Davis, Senator?

Senator MITCHELL. No.

Senator DOLE. I just want to ask a couple of questions, then I will submit questions in writing so we may get on to the other members of the panel.

You know, one thing that we are concerned about, at least I am as one of the original sponsors of this effort, we've told our colleagues it's going to save money, and I'm wondering what your latest estimates of the savings or costs of medicare's hospice benefit are. Do you have any late estimates?

Dr. DAVIS. Yes, Senator, we do. Our estimates were published in the NPRM. They have not changed since then. We estimate that it will be a net cost in 1984 of $80 million and in 1985, $110 million; and then in 1986, $160 million.

Senator DOLE. Well, that's going to be a matter of some concern to those of us who would like to impress upon our colleagues this was a cost-savings amendment, not an addition. So we will continue to work in that area.

Let me see if there is any other thing I want to ask right not. If not, I can submit my questions.

[Pause.]

Senator DOLE. Can you develop a DRG for general inpatient hospice care?

Dr. DAVIS. Yes, we certainly can. It would take us a little bit of time to do that because we would need to collect the data.

As you recognize, the diagnosis-related grouping system depends upon looking at what the elements of the resource allocations are. That is predicated upon a length of time.

We need to collect the data from hospices as it relates to the hospice care with an interdisciplinary team, since we assume that the team is a variable that might be different than general inpatient care. Once we have collected that data for a year or so, we could certainly develop a DRG system.

Senator DOLE. How are you going to insure that hospices will continue to provide hospice service after a beneficiary exhausts his or her hospice benefits under medicare, and when the individual can no longer afford such care?

Dr. DAVIS. We speak to that in the regulation. We do require that they continue to provide that care once a patient has elected a hospice, even if his benefits run out. And we clearly plan on monitoring that.

Again, as I said earlier, that's a three-pronged approach, using our State survey agencies which will be looking into conditions of participation as to whether or not hospices have fulfilled their obligation to do so.

Second, we would be watching through the fiscal intermediaries which will be keeping a running tab on expenditures per patient so that we can track how many have run over the cap. And if we find a tendency where an agency has no patients that they are caring for past the cap, and yet the patients are still alive, we would probably be looking for any patterns in terms of patient revocation. We would go out and site-visit to find out if there had been coercion, and if necessary take administrative action.

Senator DOLE. I will submit maybe a dozen questions in writing.

[Senator Doles' questions and the answers from Dr. Davis follows:]

1. Q. How many hospices do you expect to be certified during the first year Medicare's hospice benefit is in effect? How many persons will elect the hospice benefit annually?

A. We estimate that only 300-400 of the approximately 1,500 organizations that identify themselves as hospice will apply for Medicare certification during the first year. All that apply will be surveyed and those that meet the standards will be certified.

We estimate that approximately 31,000 beneficiaries will elect the Medicare hospice benefit in FY 84. Comparable figures for FY 85 and FY 86 are 40,000 and 49,000 respectively.

2. Q. What are your latest estimates of the savings or costs of Medicare's hospice benefit?

A. The latest estimates are that the hospice program will have a net cost of $80 million in FY 1984, $110 million in FY 1985 and $170 million in FY 1986 for a three-year total cost of $360 million.

3. Q. Preliminary estimates which you furnished the Committee earlier this year from the Medicare National Hospice Demonstration Project indicated that the total cost for patients receiving hospice care through home health agency-based hospices was $4,026 for 1981 and $6,311 for hospital-based hospices. Could you please discuss your recent findings on the average utilization and total costs of hospice care per patient, by type of hospice.

A. The most current demonstration cost information indicates that the total cost (in 1982 dollars) for patients receiving hospice care through home health agency-based hospices was $4,750 and $5,890 for hospital-based hospices. The two attached tables summarize the major cost and utilization data.

TABLE 1

Cost of Hospice [a]

Unadjusted for Patient Mix

	Home Care Hospices (N=2746 patients in 14 hospices)	Hospital-Based Hospices (N=1143 patients in 11 hospices)
Average Cost Per Hospice Day [b]	$ 66	$ 95
Average Hospice Days [b]	72.5 days	62.3 days
Average Cost Per Patient [b]	$4758	$5890

Source: Year 1 Medicare Demonstration Hospice Cost Sample merged HCFA/ODR data base.

[a] Calculated in 1982 dollars for services provided to patients from date of hospice enrollment to hospice discharge using the National Hospice Study cost methodology.

[b] Average cost per hospice day multiplied by number of hospice days does not yield average cost per patient due to rounding errors.

TABLE 2

Composition of Hospice Stays: Inpatient Days Versus Days at Home

Unadjusted for Patient Mix

Days in Setting:	Home Care (HC) Hospices (N=2746 patients in 14 hospices)	Hospital-Based (HB) Hospices (N=1143 patients in 11 hospices)
Inpatient (Hospice and Hospital)[a]		
Mean	5.2 days	18.2 days[b]
Median	0.4	9.0[b]
At Home		
Mean	66.7	43.8
Median	32.3	12.6
Total Hospice Stay		
Mean[c]	72.5	62.3
Median	37.1	33.3

Source: Year 1 Medicare Demonstration Hospice Cost Sample merged HCFA/ODR data base.

[a] Excludes days of stay in miscellaneous inpatient (e.g. Skilled Nursing Facility) settings.

[b] Includes both general hospital care and HB hospice inpatient unit care received by HB patients.

[c] Includes days of stay in miscellaneous inpatient (e.g. Skilled Nursing Facility) settings. Mean miscellaneous inpatient days for HC patients was 0.6 days; for HB patients, 0.3 days.

4. Q. How representative do you think data obtained from the 26 hospices involved in the Medicare hospice demonstration project will be for the 1,200 hospices which are estimated to exist in the country?

A. Unfortunately, there is very little information available which describes and categorizes the different types of existing hospices nationwide. However, the scope of services provided by hospices under the demonstration is generally consistent with those that must be provided under the Medicare hospice benefit. Where differences exist between the demonstration and the hospice benefit, the rates have been adjusted to reflect them.

5. Q. How different will the final prospective payment rates for hospice care be as a result of more complete analysis of demonstration project data?

A. The final rates have been calculated based on more recent and extensive cost and utilization data described in a previous answer from the hospice demonstration and differ from the proposed regulations as follows:

Day of Care	Proposed Rates	Final Rates
Routine Home Care	$ 53.17	$ 46.25
Continuous Home Care	311.96	358.67
Inpatient Respite Care	61.65	55.33
General Inpatient Care	271.00	271.00 *

* The calculation based on more recent data results in a per diem rate of $255.00. However, the proposed rate has been retained because of the concern that nonhospital-based hospices may have to arrange for inpatient care with hospitals at a higher rate than the cost actually incurred by the hospitals.

The lower rates reflect longer average lengths of stay with a decreased frequency of visits for demonstration patients. Final data on the demonstration evaluation will be available by the summer of 1984 and will be analyzed to determine any rate updates.

6. Q. How many hospices will be able to provide care within the $6500 cap specified in the law? Please describe how you plan to implement and monitor the cap.

A. HCFA believes that most if not all hospices which are efficiently operated will be able to provide care under the cap. We would note that the cost experience of the demonstration project hospices (updated to 1984 dollars) shows that 15 of the 25 had costs that averaged below $6500 a patient. Eleven out of the 14 home health agency-based hospices were in this group, as were 4 of the 11 hospital-based hospices. This performance was for a period during which there was no need to consider limiting costs or the use of inpatient days, as the current statute requires. Also, there was no prohibition against payment for curative care.

The experience of the home health agency-based hospices shows that the use of inpatient care is more moderate when the emphasis is on home care, and we believe that the statutory requirements that no more than 20 percent of aggregate Medicare days of care be on an inpatient basis will cause the hospital-based hospices to shift to a pattern of providing care that will enable them to function under the cap.

Under the implementation plan we currently envision, all payments to the hospice will be made through the intermediary assigned to service it. Intermediaries will maintain a running track of payments to a hospice and will notify the hospice when payments approach the aggregate cap amount. Because all the payments flow through one source to a provider identified by a unique number, we anticipate no difficulty in monitoring payments.

7. Q. Do you think that adjustments should be made in the $6500 hospice cap to reflect the varying cost of delivering health care in different regions of the country?

A. No. It is true that an unadjusted cap is not completely consistent with a payment mechanism that embodies regional wage adjustments; however, we do not see an immediate problem of equity for providers in high cost areas. As noted in a previous answer, most of the hospices in the demonstration projects which are generally located in metropolitan areas appear able to provide care within the $6500 cap. Thus, at the present time, the main problem may be that the cap is over generous to the provider in a low cost area.

8. Q. The regulations indicate that you adjusted base year data used for the general inpatient care payment rate by increases in the medical care component of the Consumer Price Index. Why didn't you adjust the data using increases in the hospital room component of the Consumer Price Index?

A. The general inpatient rate is designed to reimburse for hospice care that may be provided in a variety of institutional settings and that may be comprised of a variety of services in addition to routine costs. For example, the rates include payments for drugs, supplies, ancillary services and general hospice overhead in connection with its interdisciplinary group activities, etc. We believe that the hospital room component of the Consumer Price Index (CPI) is too narrow a measure to apply to these rates. We also believe that the range of services encompassed in the rates is best inflated by the broader measure provided by the Medical Care Component of the CPI.

9. Q. Can you develop a Diagnosis Related Group (DRG) for general inpatient hospice?

A. Yes, we could develop hospice care DRGs for use in paying for inpatient care. We do not believe that such DRGs could be developed at the present time, however, because the key to developing them is historical data on the consumption of resources by various groups of patients. When sufficient data has been accumulated on hospice inpatient care, the development of one or more DRGs for this care would be technically possible.

10. Q. The prospective home care rates reflect only the 1981 cost experience of demonstration hospices. You indicate in the regulations that the home care rates reflecting demonstration experience have built into them certain overhead costs, such as data collection. Does this apply to the nursing, home health, therapy, and drug components of home care hospice services? Why shouldn't these components be adjusted for inflation?

A. The final home care rates, including the components that comprise the rates, have been adjusted for inflation through 1984.

11. Q. You indicate in the regulations that you are not proposing a specific mechanism to adjust the prospective hospice rates after reimbursement has begun. Instead, you will monitor the cost and utilization experience of selected hospices and adjust the rates as an examination of selected cost reports dictates. How will you assure that these selected hospice cost reports are representative of all participating hospices? Will these cost reports be as detailed as those required for other Medicare providers?

A. As we have noted, HCFA prefers to retain the flexibility to respond to the impact of the prospective rates as the need dictates. We had said that we would examine a sample of hospice cost reports and had anticipated that this would be a scientifically valid sample which, by definition, would be representative of the hospice population. However, we received so many comments on the proposed regulation which suggest that the sample should, during the initial stages of the program, be a complete one that the final regulations provide for cost reporting data from all hospices. The cost reports for hospices will be designed with the objective of avoiding unnecessary detail while recognizing the need to capture the full costs of hospice operations.

12. Q. The hospice law requires, as a condition of participation, that hospices provide assurances that inpatient care not exceed 20 percent of the total number of days of hospice care provided by a particular hospice to Medicare beneficiaries during a 12-month period. The regulations require hospices to refund reimbursements made for inpatient care in excess of this limit. Why didn't you draft regulations that would require hospices first to undertake a plan for correction before having their reimbursement reduced?

A. We rejected this alternative because the nature of the survey and certification process, with its plan of correction, resurveys, and appeals of termination is not a process geared to fiscal accountability. Under that process, a hospice could repeatedly exceed the ratio so long as it periodically corrected its behavior in time for the resurvey called for under its plan of correction. Thus, if left as only a condition of participation, this statutory requirement could remain imperfectly implemented by many providers for the entire three-year life of the benefit. Under the final regulations, hospices have a financial incentive to correct inappropriate patterns of utilization. Hospices will be paid the routine home care rate for each day of inpatient care in excess of the 20 percent statutory limit. We believe this measure will soften the impact of the payment limit without blunting the incentive it provides for more appropriate utilization.

13. Q. The regulations define respite care as short term inpatient care provided to an individual only when necessary to relieve family members or other persons caring for the individual. The Congress certainly didn't intend that respite care be defined only in terms of inpatient care. Respite care can be surely be provided in the home. Please describe how the proposed regulations would allow respite care to be provided in the home.

A. Institutional respite is the only type of respite care mentioned in the proposed regulation because it is the only type of respite care mentioned in the statute and the only type of respite care that in the context of HCFA's payment system requires the development of a separate payment rate. However, there is nothing in the statute or regulations that precludes a hospice from providing respite care in a patient's home. We did not develop a separate rate for this level of care because the demonstration data indicate that the costs of home respite closely approximate the routine home care costs. However, through analysis of home respite care costs, we have developed a component for inclusion in the final rate for routine home care which explicitly compensates the hospice for this care.

14. Q. What kinds of special provisions and safeguards would regulations have to contain for a legal guardian or some other person to elect hospice care for terminally ill beneficiary?

A. Many comments were received on this issue in response to the request in the proposed regulation. On the basis of the comments, we are satisfied that some provision is necessary to enable a patient who is in need of hospice care to receive it even though he or she may not be able, at the time of election, to execute the election statement. At the same time, we continue to be concerned that the patient's access to the full range of curative (rather than palliative) care covered under Medicare not be foreclosed by an election executed by an individual who may not be exercising an appropriate choice. We considered several alternatives and have included in the final regulations a provision to permit an election (or revocation) to be made by another individual when authorized in accordance with State law.

15. Q. As you know, the hospice law provides that a beneficiary who elects hospice care must waive all rights to Medicare payments for any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected. The law also authorizes the Secretary of Health and Human (HHS) to establish guidelines to stipulate what services are waived that are related to the treatment of the beneficiary's terminal condition or are equivalent to hospice. The proposed regulations do not enumerate specific services that might be considered related to hospice care. Supplementary information published with the regulations offers one example of an illness--pneumonia--which would be considered related to the underlying terminal condition and therefore covered as hospice care. Would you provide for the committee other examples of conditions and services that would be considered related to hospice care?

A. To place this question in context, we would note that the main issue is not what services would be considered as hospice care, since the hospice is primarily able to make that determination itself. The issue is what services would Medicare recognize for payment outside the hospice benefit for a terminally ill patient. Since such payments would be outside the "cap," it may well be in a hospice's interest to attempt to assert that a related condition is unrelated.

We believe, for example, that the repeated bone fractures, with the accompanying need for reduction of the fractures, that may accompany bone cancer are related to a terminal condition. Similarly, we regard surgical procedures necessary to alleviate pain resulting from the terminal illness as treatment of a related condition. We believe that these treatments are appropriately provided through the hospice and fall under the statutory cap.

16. Q. The regulations acknowledge that it will be necessary to closely monitor the incidence of hospice elections and revocations, especially in connection with non-hospice covered Medicare admissions to hospitals, to assure that manipulation and coercion do not take place. Please describe the monitoring procedures you will have in place for these purposes. What kinds of audits will you be doing to assure that billed-for-services have been furnished and that other requirements for participation and payment are met? Will there be common audits of providers who participate in Medicare as a home health agency, a skilled nursing facility, or hospital and as a hospice?

A. We will publish shortly instructions for our intermediaries to monitor hospice elections and revocations, especially in conjunction with hospital admissions, as part of the claims review process. State survey and certification agencies will also monitor elections and revocations through onsite reviews of hospice records and through interviews with patients and their families in their homes.

Medicare intermediaries will be performing financial audits of hospices which will be coordinated with the parent institution if the hospice is hospital,-skilled nursing facility-or home health agency-based. A specific audit protocol will be released with the final cost report and will be governed by Medicare principles of reimbursement and reasonable cost.

17. Q. How will you ensure that hospices will continue to provide hospice services after a beneficiary exhausts his or her hospice benefits under Medicare and when the individual can no longer afford such care?

A. As a condition of participation, a hospice may not discontinue or diminish care provided to a beneficiary because the individual is unable to pay for care after Medicare hospice benefits are exhausted. State surveyors will review patient care plans and medical records and will observe patient care to determine whether services have been diminished in any way.

In addition, medical review will be conducted by fiscal intermediaries on hospice claims where the beneficiary has been discharged or has revoked hospice benefits. This review, which may include home visits to interview the patient and family, will be to assure that beneficiaries are not being discharged or forced to revoke their hospice benefits because it is no longer profitable to care for them. Where problems are identified by the intermediary, the proper agencies will be informed so that corrective action can be initiated.

18. Q. What measures do you think will be most effective in assuring that the proportion of volunteer participation in a hospice is not diminished after Medicare reimbursement has begun?

A. The final regulations set a numerical standard of 5 percent of total direct patient care hours as the minimum volunteer effort necessary to permit Medicare participation. Hospices also must document a continuing level of volunteer activity and report on expansion of care and services accomplished through the use of volunteers. If, upon a survey, a hospice is found to have failed to maintain the required level of volunteer effort, it would have to develop and implement a plan of correction and Medicare would resurvey to assure compliance. Because volunteer services is a condition of participation, failure to meet its requirements could ultimately result in termination as a Medicare provider.

Senator DOLE. We are going to hear testimony later on from the National Association of Home Care and from others who raised concerns about the designation of volunteers as employees. Apparently this is a particular problem for physicians who have designated as employees, will be unable to bill for their services under part B.

Why do you require such a designation? I guess that's the question.

Mr. STREIMER. Senator, we actually got a great many comments soon after the legislation was passed that this was clearly the direction we should be moving toward because of the care service requirements and the requirement in the statute that nursing care, physician service, medical social services, and counseling had to be given by employees of the hospice.

We were told by the various organizations that very often volunteers were performing those tasks and that the easiest way that hospices would find to fit into the mold of the statute was that if, indeed, we considered all volunteers to be employees.

On the issue of physicians, the statute clearly sets out a situation where the only physician outside the hospice that can be paid is the person's attending physician, who they designate, whom is paid under part B with the coinsurance as they are now.

Any other physician services that are required by the beneficiary will be paid by the medicare program to the hospice. It will then be up to the hospice to have a financial arrangement with the physician whether he is salaried or whether he has some other arrangement with the hospice. But I don't think there are going to be situations where physician care is needed that payment will not be made. I think the issue is we will be paying the hospice, and the financial arrangement for the physician will be between the physician and the hospice itself.

Senator DOLE. All right.

I understand you have been working very closely with all of the various groups who have an interest in this, as you try to promulgate the regulations.

I would also indicate some interest in the matter raised by Senators Mitchell, Roth, and Jepsen. Coming from a rural State, as I understand we haven't had any contact. But it probably is an area that we are going to have to focus on.

I think in the interests of time, if it is satisfactory to you, I will submit my questions.

Dr. DAVIS. Fine.

Senator DOLE. I will call the next panel so they will be prepared by about the time Senator Durenberger returns.

Ms. Hurzeler, Mr. Gaetz, Ms. Amy Hecht, and Florence Wald.

We have about 4 minutes remaining on the rollcall. I think Senator Mitchell and I will head for the floor. Senator Durenberger is walking in, and Senator Dodd is on his way to introduce a member of the panel. So lots of luck, and we will be right back. [Laughter.]

Senator DURENBERGER. All right. Thank you very much for your patience. We can start with Rosemary and your statement. You will get your introduction, apparently, after you make your statement. Thank you for being here.

Rosemary?—Oh, here he is.

STATEMENT OF SENATOR CHRISTOPHER J. DODD OF CONNECTICUT

Senator **Dodd**. Hello, Mr. Chairman.

Senator **Durenberger**. Senator. You may proceed.

Senator **Dodd**. Well, let me be very, very brief, Mr. Chairman. First of all, I appreciate very much your holding up for a minute or so here. I have a prepared introduction which I will ask be included as part of the record.

Senator **Durenberger**. Without objection, it will be made part of the record.

[The prepared statement of Senator Dodd follows:]

Statement of Senator Christopher J. Dodd

Mr. **Dodd**. Mr. Chairman, it is a great honor indeed to introduce, Rosemary Johnson-Hurzeler from the Connecticut Hospice to the Finance Committee today.

Experts around the country agree that if you want to learn about delivering the absolutely highest quality of Hospice care, then Connecticut Hospice in Branford, Connecticut is the very first place you should visit.

The great State of Connecticut has many exemplary institutions. Even so, Connecticut Hospice has to be one of the most exemplary. As the oldest and first teaching Hospice in the country, Connecticut Hospice was a true pioneer: What sets it apart is that it has continued to be a pioneer over the past decade, ever striving to find the best way to deliver quality care to hospice patients and their families.

Therefore, it is with a great deal of pride that I introduce Rosemary Johnson-Hurzeler. I thank her for coming to enlighten us here today.

I would also like to acknowledge two other witnesses from Connecticut who will testify today. Florence Wald from the Yale School of Nursing and Margaret Cushman from the National Association for Home Care will be speaking later on. I know that my colleagues on the Finance Committee look forward to hearing their remarks.

Senator **Dodd**. I am delighted to introduce to the Committee Rosemary Johnson-Hurzeler and two of our other witnesses who are with her, Florence Wald and Margaret Cushman.

If anyone wants to know about hospice, the first place you go is Connecticut. We have the oldest hospice program in the country. It's a statewide program; it's a teaching program; it's really been the pioneer in the country in delivering services in what has now become one of the most highly respected forms of delivery this country has to offer.

This committee will hear testimony from people who have dealt firsthand with the issues that hospice is involved in, and I'm delighted, as one member of our Senate delegation, to be with them here this afternoon to introduce them to this committee, and my hope is, of course, that the committee will take their advice and recommendations to heart. These are fine, fine representatives, and I'm delighted to be able to represent them here this afternoon.

Senator **Durenberger**. Thank you very much.

Senator **Dodd**. I thank you for allowing me to come by.

Senator **Durenberger**. Now, you had all better be about half as good as Chris says you are, and you'd better do it in one minute each. [Laughter.]

All right, if we may start with Rosemary Johnson-Hurzeler.

STATEMENT OF ROSEMARY JOHNSON-HURZELER, R.N., M.P.H., H.A., CHIEF EXECUTIVE OFFICER, CONNECTICUT HOSPICE, BRANFORD, CONN.

Ms. JOHNSON-HURZELER. The first American hospice, serving 5,000 patients over the last 8 years, blesses you for your recognition of the worth of human technology in an increasing sophisticated technological environment.

We have four concerns that we share with the committee around the proposed regulations.

First and foremost is the issue of quality. We do not believe that there are sufficient standards representing the inpatient hospice component, and we feel this lack of standards jeopardizes the quality of life of the hospice patient.

We would only point out that the national average for hospice inpatient nursing is 8 hours in a 24-hour day, and the ICF rules which are proposed are no more than one-half hour a day in a 24-hour period, that the physician's presence with the hospice inpatient is the standard, but then, in the ICF there is no requirement except on admission.

And it should be pointed out that the hospice case mix is in the 90th percentile of the severity of illness, as recorded in the Federal Register on September 1, 1983.

The second point that we have is that we feel the standards do not call for sufficient cost and utilization reporting, which, bottom line, would mean by 1986 we don't feel there would be sufficient data on which to evaluate and advance the hospice movement.

We point out that the hospital, which is a known provider, has very stringent requirements——

[Bell ringing.]

Senator DURENBERGER. I knew this would be a problem, starting right from the first witness. [Laughter.]

You know we've got a problem this afternoon, as you can all see. And about all I can say to everyone here is that we have asked you to prepare written statements, and they will be made a part of the record.

One of the unfortunate parts about this process is that Senators aren't going to have time to ask questions, which was the whole idea to limiting you to 1 minute.

So I will let you go through the rest of the cards, if you can do that quickly.

Ms. JOHNSON-HURZELER. Thirty seconds—15 seconds.

Senator DURENBERGER. And I just suggest to everybody else we try to keep it as close to 1 minute as possible.

Ms. JOHNSON-HURZELER. We do feel that the cap amount is sufficient. We do point out that hospice is cost effective in the inpatient, in that it is 50 percent of hospital cost on a per diem basis, but that the inpatient as well as the home care per diems appear to be too low by a factor of about 10 to 15 percent. However, if the quality standards are not addressed, then we do feel that the rates are too high.

The fourth is simply the issue of certification and recertification. In recert, it excludes the community physician, who is a vital part and link for the patient and family in the election, the delicacy involved in the patient's right to know versus the patient's right to privacy, and the revocation, which excludes the legal guardian perhaps as the patient's condition progresses and he cannot make that decision for him or herself.

Thank you, Mr. Chairman.

Senator DURENBERGER. That was very well done. Thank you very much.

Don, you're next.

[Ms. Johnson-Hurzeler's prepared statement follows:]

TESTIMONY BY THE CONNECTICUT HOSPICE INC.
REGULATIONS IMPLEMENTING SECTION 122 OF PUB.L.97-248
September 15, 1983

In January of 1983 the U.S. Congress bestowed a gift on the people of the United States with the introduction of Hospice legislation. This gift was a remarkable recognition of the worth of human technology in an increasingly sophisticated technical environment. Consumers treasure this gift, and Providers of Hospice care are privileged to be a part of this newly recognized system of care.

By 1986, depending on the use or abuse of this marvelous gift, Congress will renew or rescind the Hospice legislation. We offer the following remarks in hopes that the attendant regulations implementing Hospice legislation will strengthen the Hospice system between now and 1986, and will enable a favorable response from Congress at that time.

The Hospice reimbursement legislation must provide an incentive to health care organizations to provide Hospice care as an alternative. To do so, it must allow providers to recover the costs of providing appropriate care, and it must require the appropriate reporting of costs and utilization statistics so that adequate evaluation of the hospice program of care is possible when the legislation sunsets.

The Connecticut Hospice (see Exhibit A) has analyzed the elements of the Conditions of Participation and shares the following concerns:

1. QUALITY STANDARDS: The omission of quality of care standards jeopardizes quality of life and opens the door to potential fraud and abuse of the Hospice program.

2. COST AND UTILIZATION REPORTING: Because requirements for reporting of costs and utilization are virtually nonexistent, evaluation of the program in 1986 will be difficult or impossible.

3. PER-DIEM PAYMENTS AND CAP: Although the per-patient cap of $6500 is reasonable, the per-diem reimbursement levels for both home-based and inpatient care are insufficient, provided that care is provided at an appropriate level to adequately support the complex mix of patients that qualify for Hospice care.

4. RECERTIFICATION, ELECTION and REVOCATION - The physician certification process excludes the community physician; rules for election confuse the issues of patient right to know vs. patient privacy; and the revocation procedures exclude the legal guardian as the illness progresses.

I. QUALITY STANDARDS

The standard of care as performed by The Connecticut Hospice conforms to the requirements published under Sec. 19-13-D4b., short-term hospitals, special, hospice, of the Public Health Code for Connecticut. The Connecticut Hospice inpatient service requiring intensity of nursing and medical components is delivered at the level of an intensive care unit. The requirements for staffing levels and physician availability in the Hospice, SNF, and ICF settings are presented in Exhibit B of this testimony. In summary,

	HOSPICE	ICF-LEVEL
Nursing	8 hrs. in 24	1/2 hrs in 24
Physician	every day	maybe never
Casemix	90th percentile	not rated

The Federal Register, September 1, 1983, Table 3A, lists the Connecticut Hospice as having a case mix which is more complex than 90% of all acute-care inpatient facilities in the country. This exceedingly complex mix of patients, which we believe to be representative of that mix of patients receiving Hospice inpatient care nationwide, cannot adequately be cared for in a setting providing care at the level of an intermediate care facility (ICF), as suggested by the legislation. The Hospice inpatient provider, whether free-standing hospice, hospital, or nursing home, must be required to provide a level of care which is appropriate to support the quality of life for as long as life lasts. This can not be assured at the level of minimum staffing required by the Conditions of Participation. Furthermore, if quality standards are not drawn, the per-diem money offered will net large profits for those entrepreneurs not fully versed in the Hospice philosophy and program.

Recommendation: Increase the general inpatient medical and nursing staff ratios, and the levels of other core services, up to those levels required in the inpatient acute setting.

II. COST AND UTILIZATION REPORTING

Existing data on the costs of providing Hospice care are inadequate, as evidenced by the wide variation in estimates of net savings or increased expense resulting from the passage of this legislation. Given this lack of adequate data, it is imperative that the next three years provide Congress with sufficient information to evaluate the worth of the Hospice program, as measured by the resources consumed and benefits provided. Unfortunately, the Hospice Conditions for Participation require only minimum reporting on costs and utilization.

Under the new PPS per-case DRG reimbursement methodology to be employed for hospitals, hospitals will be required to perform detailed cost analyses and cost reporting over the next three years, and to meet additional requirements promulgated by Professional Review Organizations. However, the Hospice Conditions of Participation require only selected providers to produce cost reports, and those reports will be less sophisticated than those required under traditional cost-based reimbursement. Furthermore, requirements for utilization or peer review are virtually non-existent (See Exhibit C).

Given these minimal reporting and review requirements, combined with a reimbursement system not requiring itemized listings of services provided, Congress will not have sufficient information available in 1986 to accurately evaluate the services provided and benefits received under the Hospice program, and make a positive determination that the Hospice system of care is an appropriate and cost-effective element in the overall health delivery system.

Recommendation: Continue full cost reporting requirements for all participating Hospice providers during the three years of the program, including comprehensive reporting of utilization service volumes in the inpatient and the home care setting.

III. PER-DIEM PAYMENT LEVELS AND OVERALL CAP

The cost basis upon which the TEFRA Hospice prospective payment per-diem rates were calculated was derived from data compiled by the HCFA Hospice Demonstration project on 6,000 patients over three years. Approximately 1,780, or 30%, of these patients were served by The Connecticut Hospice. Based on our own analysis, the per diem costs of care are higher than those in the Conditions of Participation. Our investigations, using our computerized patient database, support the following conclusions:

Complex Casemix, Cost-effective Care:

The mix of patients requiring Hospice inpatient care is quite complex. Our casemix (as measured by the DRG casemix index as published in the 9/1/83 Federal Register) is more complex than that of 90% of all inpatient acute-care facilities. Hospice inpatient care for these very ill patients is cost-effective. Although the average length of stay of Hospice patients is more than double that of non-Hospice inpatients, the per-diem costs of care for Hospice patients are lower than those for hospital patients (see Exhibit D).

Adequate Per-Patient Cap:

Given this complex mix of patients, plus staffing levels at the acute-care ICU level, plus an overall ratio of inpatient to home care days of 40:60 for patients in our home care area, we are budgeting for 1984 an average cost per patient of $5,500. Hence, we believe that the published per-patient cap of $6,500 is adequate, particularly since most participating hospices will have a lower ratio of inpatient to home care days.

Inadequate Per-diem Reimbursement Rates:

While providing care to our complex patient mix, with staffing levels conforming to the published standards of care as required by the Connecticut Public Health Code, we find our costs per day in both the inpatient and home care settings to be approximately 10-15% greater than the per-diem reimbursement rates specified by the Conditions for Participation. We therefore conclude that, if appropriate standards of care are included in the Conditions for Participation, the participating hospices will experience a reimbursement shortfall which will not cover the per-diem costs of care. If, on the other hand, appropriate standards of care are not included, the per-diem rates will be an open invitation for potential fraud and abuse of the Hospice program, by allowing those organizations providing less than adequate care to receive per-diem reimbursement designed to cover more comprehensive services.

DRG Payments Higher - Hospitals Won't Participate:

When we compare the average total reimbursement, per case, for inpatient care under both the Hospice legislation and the new Medicare PPS/DRG reimbursement for hospitals, we find that, on the average, a hospital may receive greater reimbursement under the DRG per-case methodology than it would under the Hospice legislation. This difference is due to the significantly greater average per-diem reimbursement provided by the DRG payment formula (see Exhibit D), combined with appropriate additional payments for "outlier" patients whose length of stay is significantly greater than average (20% of the inpatients at the Connecticut Hospice qualify as outliers under the PPS/DRG regulations).

Hence, the financially prudent Hospital would not elect to participate in the Hospice program, particularly since such participation would require duplicate administrative and financial systems for billing and reporting. This in turn would mean that Hospice providers not operating inpatient units who contract with area hospitals may pay the DRG rates to the hospitals for each Hospice patient admission, while receiving a lower sum of money on the average from the Hospice program.

An increase in the per-diem reimbursement amount for inpatient care, up to the level required to adequately compensate providers for the costs of providing quality care, would lessen the difference between the two forms of reimbursement, would encourage hospitals with home care programs to participate in the hospice program, and would allow home-based hospices to send their patients to the hospital without serious financial loss.

Insufficient Coverage of Drugs and Biologicals:

The per-diem reimbursement rates for both inpatients and home care patients include a calculated average per-diem cost for those drugs deemed by the regulators to be necessary for the palliative care of terminal cancer patients. Based on our three years of experience and data at the Connecticut Hospice, we suspect that the extent to which specific drugs and biologicals are deemed palliative and terminal-disease related may not meet the tru needs of our patients. Included as Exhibit E is the Connecticut Hospice Formulary, a drug compendia which has met the needs of over 1500 patients. Exhibit F is an analysis of our drug useage for the past two fiscal years by therapeutic category, as designated by the American Hospital Formulary Service.

Unspecified Billing and Payment Mechanisms:

The Hospice Conditions of Participation are silent with respect to the billing and payment mechanisms to be implemented by the various intermediaries. Critical to the cash-flow position of all Hospices is the inclusion of a periodic interim payment option which insures a steady cash flow. PIP payment level could be based on 1984 budgeted materials which reflect an assumption of compliance with the 20:80 inpatient to home care days ratio and the per-patient cap amount.

Recommendation: If qualified standards of care are drawn and implemented, and comprehensive costs and utilization reporting required, the per-diem reimbursement for both home care and inpatient care should be increased by approximately 10-15%. This can be accomplished within the overall existing confines of the per-patient cap of $6,500. In addition, the legislation should include some assurance of the availability of periodic interim payments to allow each provider to maintain a viable cash flow position.

IV. RECERTIFICATION, ELECTION AND REVOCATION

A. PHYSICIAN RECERTIFICATION

Physicians have never before been required in any program of care to offer an opinion in writing as to the patient's length of life prior to the implementation of a treatment plan for that patient. We do not anticipate that this will be problematic for the physician, but we do think it would be wise to include them as co-authors in subsequent recertification, for two reasons: (1) it broadens the physician's involvement in Hospice care, which is in general healthy for the patient and family; and (2) it encourages a continued commitment by the physician who has essentially provided long-term treatment and support to the patient and his family, and enables that physician to continue that commitment until the patient dies.

Recommendation: Include physicians as co-authors in subsequent recertification. Enhanced quality of life for the patient and family is made possible by the community physician playing a major role in the medical evaluation and treatment plan.

B. ELECTION

The requirement that a person sign an election form to enter a hospice system of care is particularly delicate. It balances the patient's right to know with the patient's right to privacy. (See Exhibit E for a true example of the situation some patients find themselves in when hospice (palliative) care is to become their next therapy modality).

Recommendation: The document which contains the election statement and a statement of informed consent should be worded in such a way that it gives the patient maximum flexibility as to his right to know his current condition, and his right to maintain his privacy and dignity.

C. REVOCATION

The conditions call for the patient to revoke his election if he wishes to return to the traditional Medicare payment system. It appears from the Conditions of Participation that only the patient can revoke his election. However, it may happen that, at the point that revocation becomes desirable from the patient family's point of view, the patient is at a point in his illness where he is mentally and physically incapacitated, so that a legal guardian is handling his affairs.

Recommendation: If the family becomes concerned that palliative care is not appropriate for that patient, there should be a mechanism available for the legal guardian to revoke the election, similar to the mechanism for the guardian to invoke a second or third election.

EXHIBIT A

PROFILE

THE CONNECTICUT HOSPICE, INC.
Incorporated 1971
Non-Profit 501 (c) (3)

PROGRAMS:	Home Care - Serves 13 cities and towns in Health Service Area II: Population: 550,000 Inpatient - 44 beds - Serves the State of Connecticut Bereavement - Serves the State of Connecticut
AVERAGE DAILY CENSUS:	Home Care - 50 patients Inpatient - 42 patients Bereavement - 180 active families
LICENSE:	Short-Term Hospital, Special, Hospice State of Connecticut Public Health Code 19-13-D4b State Department of Health Services
MEDICARE CERTIFICATION:	Home Health Agency, Hospital
HOSPICE CLASSIFICATION:	Free-Standing Facility Charter and voting member, National Hospice Organization
PAID STAFF:	195 persons, 165 full-time equivalents
NON-PAID STAFF - VOLUNTEERS:	325 persons (250 donating 4 hours per week)
ORGANIZED MEDICAL STAFF:	8 physicians which includes Medical Director.
PROSPECTIVE BUDGET APPROVAL:	Commission on Hospitals and Health Care (CHHC)
REIMBURSEMENT:	All major third party payors; Office of Direct Reimbursement (ODR) for HCFA Demonstration
POPULATION SERVED:	55% market penetration in Home Care Service Area 780 individual physicians each year select hospice as the appropriate mode of care of these patients
ANNUAL CASELOAD:	1,012 individual patients; 1,268 different admissions
UNDUPLICATED PATIENTS:	To date 4,776 patients served

DRG STATUS: Minor teaching hospital
Case-mix index - 90th percentile of all hospitals

CERTIFIED PUBLIC ACCOUNTANT: Arthur Andersen & Co.

LEGAL COUNSEL: Wiggin & Dana - John Q. Tilson, Esq., Partner

CREDENTIALS:

Licensed by the State of Connecticut, Department of Health Services as a Short-Term Hospital, Special, Hospice
Licensed by the State of Connecticut, Department of Health Services, Child Day Care Center (The Charlie Mills Preschool Program)
Certified by Medicare as a Hospital with a Hospital-Based Home Care Program
Institutional Member: Connecticut Hospital Association
Institutional Member: Association of Connecticut Home Health Agencies
Hospital Member: Commission on Hospitals and Health Care

Accredited for Continuing Medical Education By:

The American Medical Association
The American Hospital Association
The American Board of Medical Specialties
The Association for Hospital Medical Education
The Council of Medical Specialty Societies
The Association of American Medical Colleges
The Federation of State Medical Boards
American College of Nursing Home Administrators
American Medical Records Association
Academy of Professional Funeral Service Practice
Hospital Institution & Educational Dietetic Food Services
Connecticut Nurses' Association
Connecticut Pharmaceutical Association

EXHIBIT B

STAFFING LEVELS AND PHYSICIAN AVAILABILITIES - HOSPICE, ICF AND SNF

Hospice	___	___
NURSING -	NURSING -	NURSING -
The ratio of patients to registered nurses in the hospice shall not be less than one nurse to six patients per 8 hour shift.	There shall be at least 1 registered nurse on duty 24 hours per day, 7 days per week. There shall be at least 1 nurse on duty on each patient-occupied floor at all times.	There shall be at least 1 nurse's aide on duty on each patient-occupied floor at all times and intercom communication shall be available with a licensed nurse.
The ratio of patients to all nursing staff and nurse aide to patient shall not be less than 1 nurse or nurse aide to 3 patients.	Staff shall not fall below the following: 1. Licensed nursing personnel: 7 a.m. to 9 p.m.: .47 hrs. per patient	Staff shall not fall below the following: 1. Licensed nursing personnel: 7 a.m. to 9 p.m.: .23 hrs. per patient
These ratios allow for 8 hours of care per patient per day.	9 p.m. to 7 a.m.: .17 hrs. per patient	9 p.m. to 7 a.m.: .08 hrs. per patient
	2. Total nursing and nurse's aide personnel: 7 a.m. to 9 p.m.: 1.40 hrs. per patient 9 p.m. to 7 a.m.: .50 hrs. per patient	2. Total nursing and nurse's aide personnel: 7 a.m. to 9 p.m.: .70 hrs. per patient 9 p.m. to 7 a.m.: .17 hrs. per patient
MEDICINE -	MEDICINE -	MEDICINE -
A framework to ensure 24 hours, 7 day a week, on-call availability, including physician home visits and 8-hour-a-day on-site medical staff coverage.	Is available by phone 24 hours per day; is available to respond promptly to an emergency; and is able to provide an alternate physician for coverage whenever necessary.	Is available by phone 24 hours per day; is available to respond promptly to an emergency; and is able to provide an alternate physician for coverage whenever necessary.

EXHIBIT C

MINIMAL COST & UTILIZATION REPORTING

	Hospice	Hospital
System	New	Old
Provider	Unknown	Known
Cost Estimates	Non-existent	Accurate
Experience with RM	No/pps per diem	Yes/pps/case
National Standards	No	Yes
Dollars	Increase	Decrease
Cost Reporting	No	Yes
Utilization Reporting	No	Yes
1986	Stop	Go

Solution: Every provider submit cost reports and utilization.

EXHIBIT D:

PER-DIEM COSTS AND AVERAGE LENGTH OF STAY HOSPICE INPATIENT SETTING (1) and ACUTE-CARE HOSPITALS (2)

DIAGNOSIS RELATED GROUPS NON-SURGICAL CASES ONLY SELECTED MALIGNANCIES (3)	---HOSPITAL----- AVG. LOS	---HOSPITAL----- 1982 COST PER DIEM (4)	-----HOSPICE---- AVG. LOS	-----HOSPICE---- 1982 COST PER DIEM (5)
10 Nervous System, AGE70CC	9.6	$646	20.9	$280
64 Ear, Nose, Throat Malig.	5.7	899	12.0	280
82 Respiratory	7.4	730	21.0	280
172 Digestive Syst. AGE70CC	8.2	709	18.6	280
203 Hepatobiliary, Pancreas	8.0	648	20.6	280
274 Breast Malign. AGE70CC	7.5	639	19.2	280
318 Kidney, Urinary AGE70CC	5.5	702	12.4	280
346 Male Reproductv AGE70CC	6.9	645	24.1	280
366 Female Reprod. AGE70CC	5.2	769	16.9	280
403 Lymphoma, Leukemia	7.1	782	18.9	280
413 Myeloproliferative Dis	7.3	712	11.7	280

NOTES:

(1) Hospice average costs and length of stay from all inpatient discharges, 10/1/82 through 7/31/83.

(2) Hospital average costs and length of stay from Tables I-V, Federal Register, September 1, 1983, for Northeast Urban Hospital with Connecticut New Haven area wage adjustment. No outlier adjustments are included in the average costs.

(3) Non-surgical malignancies with highest patient volume in the Hospice setting.

5 ([illegible]) Hospice per-diem inpatient costs in Fiscal Year 1982 dollars (for comparability with Federal costs)

4 ([illegible]) Hospital per-diem costs from Fiscal Year 1982 cost reports.

EXHIBIT E

THE CONNECTICUT HOSPICE, INC.
FORMULARY
THERAPEUTIC CATEGORY LISTING

4:00 ANTIHISTAMINE DRUGS

Brompheniramine
Chlorpheniramine Maleate
Cyproheptadine HCl
Diphenhydramine HCl

8:00 ANTI-INFECTIVE AGENTS

8.12 Antibiotics
8.12.06 Cephlosporins
Cefamandole Nafate
Cephalothin
Cephradine

8.12.08 Chloramphenicol
Chloramphenicol

8.12.12 Erythromycin
Erythromycin

8.12.16 Penicillins
Ampicillin
Carbenicillin
Cloxacillin
Dicloxacillin
Oxacillin
Penicillin G, Potassium
Penicillin VK

8.12.24 Tetracyclines
Doxycycline
Tetracycline HCl

8.12.28 Other Antibiotics
Amikacin Sulfate
Clindamycin
Gentamicin Sulfate
Tobramycin
Vancomycin HCl

8.16 Antitubercular
Ethambutol
Isoniazid

8.24 Sulfonamides
Sulfamethoxazole-Trimethoprim
Sulfasoxazole

8.32 Trichomonacides
Metronidazole

8.36 Urinary Germicides
Methenamine Hippurate
Methenamine Mandelate

10:00 ANTINEOPLASTIC AGENTS

Megestrol Acetate
Mithramycin
Tamoxifen

Policy Statement: The pharmacy department will procure any other antineoplastic agent for any individual patient that is deemed appropriate for palliative care by the primary Hospice physician.

12:00 AUTONOMIC DRUGS

12.04 Parasympathomimetic
(Cholinergic Agents)
Bethanechol
Physostigmine

12.08 Parasympatholytic
(Cholinergic Blocking Agents)
Atropine Sulfate
Belladonna
Benztropine Mesylate
Scopolamine Hydrobromide

12.12 Sympathomimetic
(Adrenergic Agents)
Albuterol
Dopamine Hydrocholoride
Ephedrine Hydrochloride
Epinephrine Hydrochloride
Isoetharine Hydrochloride
Isoproterenol Hydrochloride
Levaterenol Bitartrate
Metaproterenol
Phenylpropanolamine
Terbutaline

12.16 Sympatholytic
(Adrenergic Blocking Agents)
Ergotamine Tartrate
Phenoxybenzamine
Propranolol

12.20 Skeletal Muscle Relaxants
Baclofen
Methocarbamol

20:00 BLOOD FORMATION AND COAGULATION

20.04.04 Iron Preparations
Ferrous Gluconate

20.12.04 Anticoagulants
Heparin Sodium
Warfarin Sodium

20.12.08 Antiheparin Agents
Phytonadione
Protamine Sulfate

20.12.16 Hemostatics
Gelatin, Absorbable

24:00 CARDIOVASCULAR DRUGS

24.04 Cardiac Drugs
Digoxin
Lidocaine
Nifedipine
Procainamide HCl
Propranolol
Quinidine Sulfate
Verapamil

24.06 Antilipemic Drugs
Chlorestyramine Resin

24.08 Hypotensive Agents
Clonidine
Diazoxide
Hydralazine HCl
Methyldopa
Metoprolol
Nadolol
Prazocin

24.12 Vasolidating Agents
Glyceryl Trinitrate
Isosorbide Dinitrate

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28.08 Analgesics and Antipyretics
Acetaminophen
Aspirin
Choline Salicylate
Codeine
Hydromorphone
Ibuprofen
Indomethacin
Levorphanol Tartrate
Meperidine Hydrochloride
Methadone Hydrochloride
Morphine sulfate
Naproxen
Oxycodone
Oxymorphone Hydrochloride
Phenylbutazone
Propoxyphene Hydrochloride

28.10 Narcotic Antagonists
Naloxone Hydrochloride

28.12 Anticonvulsants
arbamazepine
Phenobarbital
Phenytoin

28.16 Psychotherapeutic Agents

28.16.04 Antidepressants
Amitriptyline Hydrochloride
Doxepin
Imipramine HCl

28.16.08 Tranquilizers
Chlorpromazine
Diazepam
Haloperidol
Hydroxyzine
Oxazepam
Perphenazine
Prochlorperazine
Thioridazine Hydrochloride

28.16.12 Other Psychotherapeutic

28.20 Respiratory and Cerebral Stimulants
Ammonia, Aromatic spirit
Dextroamphetamine Sulfate
Methylphenidate Hydrochloride

28.24 Sedatives and Hypnotics
Chloral Hydrate
Phenobarbital

36:00 DIAGNOSTIC AGENTS

36.10 Blood, Occult Diagnostic
Guaiac

36.88 Urine Contents
For Glucose - Copper Sulfate Reagent
- Glucose Oxidase Reagent

For Bilirubin
Blood
Ketones
pH
Protein

40:00 ELECTROLYTE CALORIC AND WATER BALANCE

40.04 Acidifying
Ascorbic Acid

40.08 Alkalinizing Agents
Sodium Bicarbonate

40.10 Ammonia Detoxicants
Lactulose

40.12 Replacement Solutions
Phosphorous
Potassium Chloride
Sodium Chloride

40.18 Potassium-Removing Resins
Sodium Polystyrene Sulfonate

40:20 Caloric Agents
Dextrose

40.24 Salt and Sugar Substitutes
Sodium Free Salt

40.28 Diuretics
Acetazolamide
Aminophylline
Chlorthalidone
Ethacrynic Acid
Furosemide
Hydrochlorothiazide
Mannitol
Spironolactone
Triamterene/Hydrochlorothiazide

40.36 Irrigating Solutions
Acetic Acid
Sodium Chloride
Water, Purified USP

48:00 EXPECTORANTS AND COUGH PREPARATION

Acetylcysteine
Codeine
Dextromethorphan
Dihydrocodeinone Bitartrate
Guaifenesin
Potassium Iodide
Terpin Hydrate

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52.04 Antibiotics
Chloramphenicol
Polymyxin

52.04.08 Sulfonamides
Sulfacetamide Sodium

52.08 Anti-inflammatory Agents
Dexamethasone

52.28 Mouth Washes and Gargles
Cetylpyridinium Chloride
Hydrogen Peroxide

52.32 Vasoconstrictors
Naphazoline

56.12 Cathartics
Bisacodyl
Casanthranol
Cascara Sagrada
Dioctyl Sodium Sulfosuccinate
Glycerin
Magnesium Citrate
Magnesium Hydroxide
Petrolatum, Liquid
Psyllium Hydrophilic Mucilloid
Senna

56.16 Digestants
Whiskey
Wine

Dimenhydrinateand Anti-Emetics

Oxymetazoline

52.04 Antacids and Adsorbents
Aluminum Hydroxide
Charcoal, Activated
Magnesium Hydroxide

56.08 Anti-Diarrhea Agents
Diphenoxylate Hydrochloride
Kaolin and Pectin Mixture
Opium, Camphorated

56.10 Antiflatulents
Simethicone

Ipecac
Meclizine Hydrochloride
Prochloroperazine
Trimethobenzamide

56.40 Miscellaneous GI Drugs
Cimetidine
Metoclopramide

68.00 HORMONES AND SYNTHETIC SUBSTITUTES

68.04 Andrenals
Cortisone Acetate
Dexamethasone
Hydrocortisone
Methylprednisolone
Prednisone
Triamcinolone

68.16 Estrogens
Diethylstibestrol

68.20 Insulins and Anti-Diabetic Agents
Chlorpropamide Tolazamide
Acetohexamide
Insulin, Isophane
Insulin, Regular
Tolbutamide

68.24 Parathyroid
Levothyroxine

72:00 LOCAL ANESTHETICS

Lidocaine

84.08 Antipruritics and Local Anesthetics
Lidocaine
Phenazopyridine Hycrochloride

84.12 Astringents
Bismuth

84.20 Detergents
Chlorhexidene Gluconate
Soap, Superfatted

84.24 Emollients, Demulcents, and Protectants
Acid Mantle
Benzoin Compound
Calamine Lotion
Methyl Salicylate
Petrolatum, Jelly
Petrolatum, Liquid

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84.04.04 Antibiotics
Bacitracin

84.04.08 Fungicides
Clotrimazole
Nystatin

84.04.16 Miscellaneous Local Anti-Infectives
Benzoyl Peroxide
Hexachlorophene
Iodine
Isoprophyl Alcohol

Talc
Wool Fat, Hydrous
Zinc Oxide

84.28 Keratolytics
Silver Nitrate

86:00 SPASMOLYTICS

Aminophylline
Flavoxate
Theophylline

88:00 VITAMINE

Folic Acid
Vitamin C
Vitamin B, Complex
Multivitamin Preparations
Maintenance, Therapeutic

Pyridoxine Riboflavin
Thiamine

92:00 UNCLASSIFIED

Allopurinol
Artificial Saliva
Carbamazepine
Cholestyramine
Levo-Dopa
Oxygen
Water for Injection, Sterile

EXHIBIT F

TO: Pharmacy and Therapeutics Committee DATE: November, 1982

FROM: Lynne Cote, Director of Pharmacy, Chairman

SUBJECT: Annual Drug Usage Report

The following analysis is a descriptor of drug usage at The Connecticut Hospice Inpatient as approved by this committee.

Drug Usage by Therapeutic Categories

A. Analysis of drug usage by broad therapeutic categories as distinquished in the American Hospital Formulary Service.

B. The percentages represent a relationship of the number of dosage units of a particular drug category to the total of the dosage units administered for all drug modalities.

	% of Dosage Units Administered	
	'81-82'	'80-81'
Category		
Antibiotics	1.2	1.9
Antineoplastics	0.27	0.19
Cardiovascular	1.7	3.1
Central Nervous System	65.76	60.4
Narcotics	43.3	
Major/Minor Tranquilizers	5.9	
Non-Narcotic Analgesics	12.1	
Anticonvulsants	3.2	
Antidepressants	1.2	
Antihistamine	0.35	0.78
Autonomic drugs	1.0	0.8
Electrolyte/Water Balance	2.2	3.9
Expectorants/Cough	1.9	0.9
Eye, Ear, Nose, and Throat	0.05	0.3
Gastrointestinal	16.2	16.5
Hormones and Synthetic substitutes	4.5	5.1
Vitamins	0.5	1.4
Spasmolytics	0.7	1.0
Unclassified	0.8	0.2

EXHIBIT G

A HOSPICE PATIENT'S STORY

Katherine* had grown accustomed to acting as head of the household in the ten years since her husband died in a car accident. She had not remarried. Her family had helped her raise her two daughters, now 14 and 16 years old.

Then tragedy struck again--her family doctor discovered she had cancer. Trips to specialists, treatments at the nearby hospital had been to no avail; the disease had spread and worsened. After thorough discussion of available alternatives with her doctor, Katherine asked for hospice care.

Katherine's physician referred her to The Connecticut Hospice home care program in July. She was able to be cared for at home until November except for a two-week admission to the inpatient facility when circumstances in the home became overly difficult for her and her family because of increased symptoms. By November she needed around the clock care provided in the inpatient building.

Katherine needed the best that Hospice could give: medically-directed, multi-faceted care, support and treatment from all its caregiving disiciplines. Katherine had every reason for distress: a young woman, a single parent with young children, a malignant disease. She knew the nature of her illness, had seen little improvement from treatment, and observed the inevitable deterioration of her body, her strength, her self image, her control over her life and the future of her children. This loss of identity was at the core of her suffering.

In time, with all the support given, Katherine grew in her understanding of the preciousness of life even as she accepted its certain end. She gave all she had to life. Hospice helped her to do this by easing not just her physical pain, but the grief inherent in losing her temporal self.

Our hope is that Hospice can always bring comfort.

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*The patient's name and some details of her life have been changed to protect the privacy of her family.

The National Hospice Reimbursement Act

How a Hospice and a Home Health Agency Can Structure Their Relationship to Meet the Core Service Requirement for Nursing Care

Technical Assistance
from the National Hospice Organization

By Sue A. Kaplan and Ann Morgan Vickery

The National Hospice Reimbursement Act ("the Hospice Act"),[1] scheduled to go into effect on November 1, 1983, requires that a Medicare-certified hospice routinely provide directly substantially all of each of the four basic "core services" of hospice care: nursing care, medical social services, physician services,[2] and counseling.[3] Other home care services such as home health aide care, homemaker services, and physical, occupational and speech therapy, need not be provided directly by a hospice with its employees but may be contracted for with another agency.[4] In addition, during periods of unusually high patient case load or under extraordinary circumstances, a hospice will be permitted to contract for nursing and other core services if necessary to supplement hospice employees.[5]

The requirement that the core services be "routinely provided directly" means that professional personnel and volunteers[6] providing these services must be employed directly by a hospice. The purpose of this provision is twofold: (1) to ensure that the hospice has adequate control over personnel providing the "basic and coordinated range of services,"[7] that are central to the integrity of hospice care; and (2) to reduce the cost of these services by requiring that the core hospice staff be employees of the hospice itself, thereby eliminating for core services the "double overhead" attributable to contract personnel who, in effect, serve two masters.

This article discusses the requirement in the Hospice Act concerning the provision of nursing care—one of the four core services. Many hospices currently supply nursing care to their patients through contractual arrangements with home health agencies ("HHA's"); thus, the "core services" provision of the Hospice Act will require these hospices to restructure this relationship. In most cases, compliance with the requirement that nursing care be provided directly by hospice

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[1] The National Hospice Reimbursement Act is contained in Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324 (1982).

[2] The patient's own physician will continue to be paid separately for the services rendered to the patient as attending physician, if he or she is not an employee of the hospice.

The authors are associated with the Washington, D.C. law firm of Hogan and Hartson. Ms. Kaplan is a graduate of the Harvard Law School. Ms. Vickery, a graduate of the Georgetown University Law Center, is general counsel to the National Hospice Organization.

employees can be readily achieved. Discussed below are various ways in which a hospice may restructure its relationship with its nurses in order to comply with the Hospice Act. As can be seen, the options are quite straightforward and should not present a barrier to certification as a Medicare provider.

I. Directly Employing the Nurses of the HHA.

Under all of the options presented in this article, the key requirement is that the hospice must have an employment relationship with the nurses that serve its patients. This can be accomplished most directly by the hospice arranging for the nurses now employed on a full-time basis by an HHA to work part-time for the hospice. In this way, a nurse would be a part-time employee of both the HHA and the hospice.

In hiring such a nurse on a part-time basis, the hospice should follow all the steps that would be necessary if the nurse were employed on a full-time basis. Thus, for example, as the employer, the hospice would be required to comply with Federal Income Tax Withholding provisions,[8] the Federal Insurance Contributions Act ("FICA"),[9] and the Federal Unemployment Tax Act ("FUTA").[10]

The employment agreement itself need not be a formal document, but its provisions should be clearly understood by both the hospice administrator and the nurse. For example, provisions should be included stating the rate and method of determining the nurse's salary (per hour, per visit, annual rate based on fixed number of hours per week, etc.); the hospice's policy regarding reimbursement for travel expenses; requirements for availability to provide services; verification of the nurse's qualifications and licensure; and procedures for record-keeping, among others. Whether embodied in a written contract[11] or in a statement of personnel policies, such provisions should either be drafted by or reviewed by an attorney for the hospice, in order to make sure that the hospice is fully protected and will receive the services it requests.

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[3] 42 U.S.C. § 1395x(dd) (1983).

[4] *Id.*

[5] Hospice Care Proposed Rule, 48 Fed. Reg. 38146, 38169 (1983) (to be codified at 42 C.F.R. § 418.80); *see also* Staff of House Comm. on Ways and Means, 97th Cong., 2d Sess., Explanation of H.R. 6878 at 20 (Comm. Print 1982).

[6] The proposed Hospice Care regulations provide that a volunteer under the jurisdiction of a hospice will be considered an employee of the hospice. 48 Fed. Reg. 38146, 38166 (1983) (to be codified at 42 C.F.R. § 418.3).

[7] Staff of House Comm. on Ways and Means, 97th Cong., 2d Sess., Explanation of H.R. 6878 at 20 (Comm. Print 1982).

[8] 26 U.S.C. §§ 3401-3404 (1979).

Since the hospice will be the employer of the nurses providing care to its patients, and thus responsible for any accident that may be caused by a nurse, the hospice should also consult with its insurance carrier to make certain that its liability policy covers part-time employees. Some HHA's have expressed concern that their own insurance premiums will rise if their nurses work part-time in the employ of a hospice. This fear is based on a misunderstanding of the HHA's potential liability. When a nurse who is employed on a part-time basis by a hospice is in the home of a hospice patient, that nurse will be acting in her capacity as an employee of the hospice. Thus, while the hospice will be potentially liable for any accident that may occur, the HHA should have no potential liability for any such occurrence.[12]

Finally, an aspect of the employment arrangement which will be of particular concern to the nurse-employees is the provision of fringe benefits such as health and disability insurance. As part-time employees of two separate entities, the nurses run the risk that neither employer will pay for the fringe benefits they now receive as full-time employees of a single employer. Unless the hospice provides for or arranges with the HHA for the provision of such fringe benefits, it may be quite difficult for the hospice to find qualified nurses willing to work on such a part-time basis.

Fringe benefits may be provided in several ways. For example, the hospice could provide one-half of the benefits and the HHA provide the other half, or the HHA could provide the full amount of fringe benefits (as if the nurses were full-time employees of the HHA) and then pay a proportionally reduced share of the nurses' salaries. The second option may be illustrated by the following example. If a nurse works 50 percent of her time for each organization, at a salary of $20,000 per year with fringe benefits worth $4,000 per year, each entity would pay a total of $12,000 per year (*i.e.*, one-half of $24,000) for the nurse's services. However, the amount paid by HHA would be comprised of $4,000 of fringe benefits and $8,000 of salary, whereas the hospice would pay $12,000 in wages.

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[9] 26 U.S.C. §§ 3101-3125 (1979).

[10] 26 U.S.C. §§ 3301-3308 (1979).

[11] Copies of contract forms used by various hospice programs are available from the National Hospice Organization.

[12] There may nevertheless be gray areas that could cause problems. For example, if a nurse is traveling from the home of a hospice patient to the central office or to the home of an HHA patient and is involved in an accident, liability for the accident may be unclear. For this reason, both the hospice and the HHA should discuss the part-time arrangement with their insurance carriers to make sure that both are fully protected.

This latter option, in which the HHA would continue to pay for the full amount of fringe benefits, would appear to be more efficient and might well be financially attractive to an HHA. Under Federal tax law, the calculation for employee withholding and the required employer's contribution under FICA and FUTA is based on wages and not on fringe benefits.[13] The hospice would, therefore, end up paying a greater share of the withholding and the taxes that are due since it would be paying a higher percentage of the nurses' salaries. This savings to the HHA might provide an incentive for allowing its nurses to enter into separate employment agreements with a hospice.

Despite the apparent ease with which a part-time employment arrangement could be structured, and despite the benefits that might accrue to the HHA as well as to the hospice, it is nevertheless possible that some HHA's will be unwilling to allow their nurses to be employed directly by a hospice on a part-time basis. The following sections discuss what can be done in this event to maintain the relationship with the HHA, and at the same time comply with the core services requirement of the Hospice Act.

II. Operating as a Subunit of the HHA.

An HHA may prove to be unwilling to allow its nurses to enter into separate part-time employment relations with another entity but may nevertheless be interested in continuing its relationship with a hospice. If this is the case, the HHA and the hospice could restructure their relationship in a way that would allow the hospice to continue to use the nurses of the HHA in supplying care to its patients, while at the same time complying with the requirement that nursing care be provided directly. One way to do this would be for the hospice to become a subunit of the HHA. As a subunit, the hospice would be part of the HHA's corporation; the nurses employed by the HHA and assigned to work for the hospice unit would, therefore, also be employees of the hospice.[14] Thus, for purposes of the Hospice Act, the nursing services formerly contracted for would now be provided directly by the HHA/hospice corporation.

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[13] 26 U.S.C. §§ 3121(a) (2), 3306(b) (2), 3401(a) 1979.

[14] Hospice Care Proposed Rule, 48 Fed. Reg. 38146, 38166 (1983) (to be codified at 42 C.F.R. § 418.3). The proposed regulations require that, when a hospice is a separate unit of another organization, to be an "employee" of the hospice an individual must work "substantially full-time" for the hospice unit. This requirement is intended to ensure that the core services are provided by employees "'dedicated'" to the hospice. It does not preclude such employees from providing services outside the hospice unit. *Id.* at 38149. While there is some question as to what the "substantially full-time" requirement will entail, clearly the HHA and the hospice subunit will be able to share personnel, and nurses will be able to work for the hospice on a less than full-time basis.

If the intent in structuring the relationship between the hospice and the HHA is to comply with the core services requirement of the Hospice Act, the hospice should not be established as a separate subsidiary corporation of the HHA. While the employees of the subsidiary-hospice might be considered employees of the parent-HHA, employees of the parent would not be considered employees of the subsidiary. Thus, as a subsidiary corporation, the hospice would have no direct employment relationship with the nurses employed by the HHA. This is not to say that a hospice cannot be a subsidiary of an HHA; but rather that if the corporate relationship between the two entities is structured in this way, the hospice would have to enter into separate employment agreements with the HHA's nurses in order to be in compliance with the core services requirement.

III. Creating a Third Agency.

A third alternative would be for the hospice and the HHA to set up jointly a third agency which would operate as a hospice under the control of the boards of directors of the existing hospice and the HHA. Such an entity could be structured and controlled in a variety of ways depending upon the wishes of the parties and the law of the State in which the hospice would operate.

This alternative combines elements of the options suggested in Parts I and II of this article. While creating a jointly controlled third entity would bring the corporate structures of the newly founded hospice and the HHA closer together, the hospice would not be an integral part of the HHA's corporation. Therefore, employees of the HHA would not be deemed to be employees of the hospice and the hospice would be required to have separate employment agreements directly with the nurses of the HHA.

The main advantage of establishing such a jointly controlled hospice would be that an HHA, which might otherwise refuse to allow its nurses to work on a part-time basis for an independent hospice, might well be willing to permit such an arrangement with a hospice over which it had some measure of control.

As is apparent from the options set forth above, the core services requirement of the Hospice Act will by no means present an insurmountable obstacle to certification as a Medicare provider. The simplest solution for most hospices that are unable or unwilling to hire their own full-time nurses, will be to directly employ, on a part-time basis, those nurses currently working for the hospice under a contractual arrangement with an HHA. For other hospices, a restructuring of their relationship with the HHA may be the preferable solution. The key requirement—that the hospice have an employment relationship with the nurses that serve its patients—can be readily met by pursuing any one of the options outlined in this article.

STATEMENT OF DONALD J. GAETZ, ADMINISTRATOR, HOSPICE, INC., FORT LAUDERDALE, FLA. PRESIDENT, NATIONAL HOSPICE ORGANIZATION, ARLINGTON, VA.

Mr. **Gaetz**. Thank you, Senator.

Senator **Durenberger**. Are those your charts?

Mr. **Gaetz**. No, sir. As a matter of fact, one of the most honorable things I've done in the hospice movement is hold Rosemary Johnson-Hurzeler's charts. So I don't need any of my own. [Laughter.]

Mr. Chairman, there is a national wellspring of gratitude within the hospice movement to you, sir, for all that you have done to support hospice in Minnesota and in the Nation, and to each member of this committee and to your professional staff for the work that they have done.

What you passed is not a relief act for providers but a benefit for patients and families, and we believe it is a good law, well supported and well accepted.

As you know, the entire benefit will come before you in 1986 for review. We will be the first, then, to recommend from the standpoint of the National Hospice Organization any changes which solid experience might determine to be needed then.

The NPRM represents a long stride in the right direction in implementing the law, but there are some important areas that we think need to be improved.

First and foremost, the rules should more equitably, as has been pointed out by members of the committee, recognize hospices that are volunteer-intensive and which are found in rural or underserved areas.

Now the regs require that an agency with a hospice submit dedicate staff to the hospice "substantially full time." NHO submits that's impractical, inefficient, and inequitable, to require providers such as a rural VNA with a hospice subdivision to dedicate staff to that subdivision on a full-time basis. Small rural programs would be adversely affected by this provision, and it should be changed.

The law as it exists provides sufficient flexibility for a part-time staff, for a hospice to be able to share staff with other providers, and to utilize volunteers in lieu of staff. We think the regulations should reflect the flexibility that's in the law, and that flexibility can take care of—without any need for a congressional amendment—many of the problems that have been pointed out by Senators today. This can be done within the regs. It doesn't require a change in the law.

With respect to physician billing, we don't believe that volunteer hospice medical directors should be prevented from separately billing under medicare part B. Again, this adversely affects rural areas, and if the physician is a volunteer, there would be no double-dipping involved.

In conclusion, Mr. Chairman, we want to thank you for your help. We believe this law is a good law the way it stands, and we need time to implement it and implement it properly.

Senator **Durenberger**. So do we all. Thank you very much.

[Mr. Gaetz's prepared statement, position paper, and letter to Senator Durenberger follow:]

National Hospice Organization
1901 N. Fort Myer Drive, Suite 402
Arlington, Virginia 22209
(703) 243-5900

STATEMENT BY DONALD J. GAETZ

PRESIDENT, NATIONAL HOSPICE ORGANIZATION

HEARING

SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE

U. S. SENATE

SEPTEMBER 15, 1983

Mr. Chairman, my name is Donald J. Gaetz, and I am President of the National Hospice Organization. I serve as an unpaid volunteer. NHO represents more than 2,000 community organizations, all volunteer groups, institutions, agencies, and others who are developing and delivering care to the terminally ill and their families in all 50 states. NHO's only mission is to advocate for those who serve and are served by America's hospices.

Nearly two years ago, when Members of this Committee and your professional staff began working with us to develop hospice legislation, a mutual understanding guided our efforts: that our objective would not be a relief act for providers but rather would be a benefit for dying patients. The legislation which you passed and which will be effective on November 1 has successfully kept faith with that early objective.

It is a measure of that success that throughout the nation today providers who desire to receive hospice reimbursement are changing their traditional methods of operation, in order to provide the comprehensive services that will meet the comprehensive needs of the dying -- instead of requiring the terminally ill and their families to conform to the conventions and preset patterns of providers.

If business as usual with the hospital, nursing home and home health industries were sufficient to meet the unique, complex, and intensive needs of hospice patients, there would have been no need for you to enact a Medicare hospice benefit in the first place. Indeed, there would have been no need for hospice.

I can report to you that hospices throughout the country are rising positively and creatively to the challenge of broadening their services and improving their operations in order to qualify to provide the care Congress intends for terminally ill patients and their families. More than two-thirds of NHO's provider hospices intend to qualify and are working hard and in good faith to qualify as Medicare providers under the law as it exists.

There is a national wellspring of gratitude within the mainstream of the hospice movement to you and to each Member of this Committee and to your professional staff for the commitment and care that have gone into designing the hospice statute. We believe it is a good law, thoughtfully developed, well supported in the Congress, and well accepted by the hospice movement.

Your decisiveness and your vigilance in remedying a technical flaw and thus restoring the aggregate hospice cap to $6,500 solved what we believe to be the only matter requiring congressional amendment. As you know, the entire benefit will come before you for thorough reexamination in 1986. NHO will be the first to recommend any legislative changes which solid experience may determine to be necessary at that time.

The hospice movement earnestly requests that this Committee continue careful vigilance over the implementation and administration of the hospice benefit. We are thankfully aware that it has been because of your interest, Mr. Chairman, and that of other Members of the Senate and House, that the proposed regulations implementing this law have been vastly improved between the draft sent forward by HCFA in the spring and the proposed rule which was published in August. We are confirmed in our belief that Secretary Heckler is a strong friend of hospice by her responsiveness to you and her cooperation with us.

The Notice of Proposed Rulemaking represents a long stride in the right direction in faithfully implementing the law and in keeping faith with the expectations of those who provide and receive hospice care. There are, however, some important areas where the rules can and should be improved.

NHO has asked each of our hospice programs to carefully evaluate the NPRM. Our standing committees and our Board of Directors have done likewise. With your permission, we wish to submit for the record of this hearing our detailed comments on the proposed rules, and we respectfully request your help in persuading the Administration to consider the changes we are suggesting.

We seek your support in three most critical areas. First, the rules should more equitably recognize hospices which are volunteer-intensive and which often are found in rural or underserved areas. Now the regulations require that the members of the hospice team be substantially full-time employees. NHO submits that it is impractical, inefficient, and inequitable to require a provider such as a Visiting Nurses' Association with a hospice subdivision to designate staff to that subdivision on a full-time basis. Small rural programs and medically underserved areas would be especially adversely affected by this provision.

The law as it exists provides the Department with sufficient flexibility to allow hospices to employ part-time staff, to share staff with other providers, and to utilize volunteers to carry out any hospice function. The rules should reflect this flexibility.

The current proposed rules prohibit volunteer hospice medical directors from billing Medicare Part B when they also are the primary attending physician to hospice patients. Clearly,if the medical director is paid by the hospice, separate billing by the physician under Part B would be double-billing by the physician and should be prohibited. However, if physicians are volunteering their time to the hospice, they should not be penalized financially with respect to Part B for serving their own terminal patients. In many rural communities, the same physician is a primary admitter to the hospice and the volunteer hospice medical director. That arrangement should be preserved and encouraged.

The Department has asked for comment on how to enforce the intent of Congress that the voluntary component of hospice not be diminished by the availability of Medicare payment. In our judgment, there is no magic number or percentage that will ensure that this intent is carried out. Instead, NHO recommends what we believe is a far stronger and more enforceable requirement: that a hospice must have a volunteer program extensive enough for every single patient to be offered the use of volunteer services in the home and inpatient setting.

Our second major concern relates to payment rates. While they are a vast improvement over the rates suggested in the spring, the four proposed prospective payment rates in the NPRM are flawed by miscalculation. HCFA has based these rates on 1981 cost data, failing to adjust the rates to account for the rise in the medical care component of the CPI from 1981 until now. We find nothing in the law or the legislative history to suggest that it was your intention to pay hospices for care rendered in 1984 at 1981 levels with no adjustment for inflation.

If HCFA's data were properly adjusted to reflect current prices, the routine home care rate should be $66.75. The inpatient rate should be $314.58, and the continuous home care rate should be $360.48. By making these adjustments, the rates would more accurately reflect the experience of HCFA's own Hospice Demonstration Project as well as what we believe to be the level of care required by terminally ill patients.

Third, we believe the intent of Congress that hospice remain home-based has been extra-legally inverted into an inflexible payment denial mechanism. The statute requires, as a condition of participation in Medicare, that a hospice provide no more than 20 percent of its days of care in inpatient settings. Elsewhere in the Medicare program, if a provider varies temporarily from a condition of participation, there is provision for a plan of correction which the Department carefully monitors to assure compliance in a timely fashion. Payments are not denied or reduced. The published rule, however, singles out hospices for unequal treatment. The rule allows HCFA to financially penalize a hospice which has achieved and can maintain the 80/20 ratio on a current basis but which, during a specific reporting period, has aggregate statistics which vary even slightly from the standard. No allowance is made for a plan of correction.

This restriction is severely unfair to hospital-based hospices which in good faith are now working to improve and expand their home care programs to comply with the 80/20 requirement.

Mr. Chairman, the NHO is aware of proposals which would allow subcontracting for nursing services and opposes such a change in the law. We believe that "brokering" for core services would severely undermine the quality of hospice care and increase the cost of hospice service, reducing the proportion of the payment that goes toward direct patient care. Moreover, we believe that hospice providers who currently perceive the core services requirement as a barrier to Medicare certification have not fully explored alternatives to their current structures — structures which have been dictated by the restrictive reimbursement system which existed in the past. When Medicare coverage has been extended to new services in the past, existing provider groups have nearly always had to adjust their operations somewhat. That is true in this case, and hospice programs all over the country are in the process of making necessary organizational changes to comply with this requirement.

The National Hospice Organization is on record in support of the law as enacted. It is a good law, and it should be given an opportunity to work. We will look forward to working with you to examine the need for refinements in 1986, when the current benefit will be subject to renewal.

In the meantime, we believe that any changes in the law would cause substantial disruption in view of the rapidly approaching implementation date of November 1.

The concerns we express with respect to the proposed rule can be addressed satisfactorily within the framework of the current law, and we hope that we may continue to look to you, Mr. Chairman, and to the Committee to assist in bringing about the adjustments which are necessary to ensure the faithful implementation of the law.

# # #

National Hospice Organization
1901 N. Fort Myer Drive, Suite 402
Arlington, Virginia 22209
(703) 243-5900

Position Paper

SUBCONTRACTING FOR NURSING SERVICES UNDER THE MEDICARE HOSPICE BENEFIT

Those who serve and are served by America's hospices are deeply gratified by the interest and support which Congress has shown toward the needs of the terminally ill and their families. The National Hospice Reimbursement Act, scheduled to go into effect on November 1, 1983, earned the bipartisan cosponsorship of more than two-thirds of the Senate and House.

The National Hospice Organization has embodied and represented the hospice movement in the United States since its inception and represents the vast majority of hospices which were in existence prior to the availability of Medicare reimbursement.

The NHO opposes legislation which would amend the law to allow hospices to subcontract for nursing services. Should you be asked to consider such legislation, we urge that you consider the following points and preserve the law in its current form without change.

We believe that subcontracting or "brokering" for nursing services will severely undermine the quality of hospice care provided to terminally ill patients and increase the cost of hospice services, reducing the proportion of the payment that goes toward direct patient care. Moreover, we strongly believe that hospice providers who currently perceive the core services nursing requirement as a barrier to Medicare certification have not explored alternatives to their current structures, structures which have been dictated by existing reimbursement requirements. The NHO now is engaged in a program of technical assistance, education, and training to aid hospices in qualifying for Medicare certification this fall and over the next few years.

Quality considerations

Nursing represents 75% of hospice care provided in the home. To allow contracting for this service would jeopardize the ability of hospices to maintain administrative control over the majority of care provided to dying patients. It would allow hospices to be paid for critically important care that they did not themselves provide. It would make large Medicare payments available to groups which have not met Medicare standards for hospices.

These serious concerns led Congress to thoughtfully and, we believe, appropriately, require that a hospice directly provide those services which are central to the integrity of hospice care: nursing care, social services, counseling, and physician care (with the exception that the patient's own physician will, of course, continue to be paid for services rendered to the patient). These "core" services may be provided by hospice staff and volunteers who are truly employed — on a paid or unpaid, full-time or part-time basis — by a hospice which is certified to participate in Medicare.

Hospices are permitted to contract for inpatient care and a substantial portion of home care services, including home health aides, homemakers, physical therapy, and other components of care. And, during periods of unusually high patient caseload, they may temporarily contract for nursing or other "core" services. There is substantial flexibility in the law.

The Joint Commission on Accreditation of Hospitals undertook, with the support of the Kellogg Foundation and cooperatively with the National Hospice Organization, the American Medical Association, the American Hospital Association and others, a two-year study of hospice practice in the U. S. in order to develop a hospice accreditation program. In written testimony submitted this spring to a committee of the Massachusetts legislature, the JCAH commented extensively on the "core" services issue.* We respectfully suggest that you review that testimony. In part, it observed:

> When contracted services were involved, we typically found more than one care plan, the care plan at the primary hospice organization and the care plan used by the contracted organization. The problems resulting were many. Some services were excluded, not on either care plan. The goals of the intervention and frequency were not the same for the same patient. There was often duplication of services as one team member may perform more than one function. The family was often unsure which team members were responsible for what services or who to call in case of an emergency. The attending physician received calls from all contracted services, sometimes for the duplication of orders, sometimes for contradictory treatment. Often, since the physician would only sign one care plan, contracted services excluded were providing care in the total absence of physician orders and without physician knowledge . . . .

Cost considerations

Hospices in the HCFA Hospice Demonstration Project report that contracting for nursing increased the administrative overhead on a nursing visit by 30-60%.

If contracting were permitted, Congress would have created a class of health providers able to purchase 75% of their primary services from others. Yet these hospices would be required to absorb the overhead costs of a full-service hospice.

The purchasing of nursing services from a Medicare-certified agency, while giving the appearance of maintaining quality would, in fact, increase costs both to the hospice program and to Medicare. On top of the actual costs of nursing care, two administrative overheads would be added: that of the hospice and that of the contract agency. This double overhead would be reflected in the costs ultimately passed back to Medicare, and more importantly, would diminish the funds available to provide care at the bedside of dying patients.

The contract agency clearly would reap a windfall, however, as it could bill the hospice on a "charges" basis and receive a higher payment than it ordinarily would receive from Medicare, which pays for home care at the lower of costs or charges. The law, as written, prevents this skimming off of excess payments which should be used for direct patient care.

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Structural issues

NHO hospice members are those which arose out of volunteer organizations and existing health providers who committed themselves to the hospice concept and built the hospice movement in the virtual absence of formal reimbursement. In the development of NHO's own standards and principles, in the support of development of an accreditation system, and in the support of licensing and reimbursement legislation at the state and federal levels, the history of the hospice movement has been not to urge approval of the lowest common denominator but to set standards which meet patient/family needs and then work to raise provider capability to meet those standards.

Because in the past there has been no reimbursment for hospice care as a distinct service, hospices have had to contract with other agencies in order for their patients to receive Medicare-covered services. Consequently, hospices have not, in most cases, been organized in precisely the manner prescribed in the law. The reimbursement hospices will receive as certified Medicare providers will allow them to operate for the first time as comprehensive programs, and hospices all over America now are in the process of making necessary organizational changes. The NHO is currently engaged in providing technical assistance. The attached monograph, for example, suggests various alternative mechanisms for complying with the core nursing service requirement.

Some have suggested that rural areas exist where the nursing shortage is so severe that nursing services can be obtained only by contracting with other providers, such as county health providers. We are currently investigating, through NHO's membership, whether such exceptional circumstances exist. If so, we believe that NHO would support an exceptions process under which the Secretary of Health and Human Services could allow waiver of the core services requirement on a case-by-case basis. Indeed, we would be the first to recommend such a process.

* * * *

When members of Congress of both parties agreed to work with hospice leaders to draft and enact a hospice benefit, it was with the understanding that the legislation not be a relief act for providers, but a benefit for patients and families. At that time, one fear shared by members of Congress and hospices alike was that the availability of reimbursement would attract a sudden onrush of interest by some whose concern for hospice care resulted primarily from the establishment of a new source of revenue. There was a similarly strong concern that hospice programs be bona fide, that they utilize a legitimate hospice team, and that Medicare beneficiaries truly receive hospice services as opposed to a re-packaging of services which were already available. These are the concerns which led to the core services requirement. Regrettably, some of those who tried unsuccessfully to abolish the core services minimum requirements a year ago are taking this opportunity to revisit the issue and attempt to get reimbursement for a kind of hospice "brokerage."

The National Hospice Organization is on record in support of the law as enacted. It is a good law, and it should be given an opportunity to work. If it is found to cause substantial disruptions in true hospice care, we will be the first to recommend legislative solutions in 1986, when the current benefit will be subject to review and renewal, or before, if necessary.

In the meantime, we believe that a hospice provider should have a direct employment relationship with its nurses and that legislation to remove that statutory requirement would be a retreat from the goal of providing comprehensive, well-managed, quality hospice care to the terminally ill, elderly, and disabled who are Medicare beneficiaries.

JCAH

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611
312/642-6061

John E. Affeldt, MD
President

October 5, 1983

The Honorable David Durenberger
Chairman
Subcommittee on Health
Committee on Finance
United States Senate
Dirksen Senate Office Building (SD-219)
Washington, D.C. 20510

Dear Mr. Chairman:

The purpose of this letter is to seek your assistance in clarifying the record of the hearings you conducted on September 15, 1983 dealing with the subject of the Department of Health and Human Service proposed rules for implementing the Medicare Hospice benefit.

During the course of the above referenced hearings testimony was presented by Mr. Donald J. Gaetz, President, National Hospice Organization. This testimony included the following:

> "In written testimony submitted this spring to a committee of the Massachusetts legislature, the JCAH commented extensively on the 'core' services issue. We respectfully suggest that you review that testimony."

We contacted the staff of the Committee on Health Care, House of Representatives, Commonwealth of Massachusetts seeking a copy of this "written testimony" we allegedly submitted. To our amazement we received a copy of this "written testimony" on October 3, 1983. We not only received a copy of this testimony but also a copy of testimony before that committee presented by Mr. Donald J. Gaetz. Mr. Gaetz's testimony included the following:

> "The Joint Commission on Accreditation of Hospitals whose written testimony I have appended to mine and ask that it become part of the Record of this hearing, has found in its national survey process that the quality and effectiveness of care suffers greatly when the essential services that make hospice hospice are contracted out back into the traditional health care system."

Member Organizations
American College of Physicians
American College of Surgeons
American Dental Association
American Hospital Association
American Medical Association

Chairman Durenberger
Washington, D.C.
October 5, 1983
Page Two

The difficulty we have before us is that Mr. Gaetz's testimony is in error in two important respects. First the JCAH has neither prepared written testimony for hearings before the Massachusetts legislature nor authorized any individual or organization to submit testimony on our behalf. Second, the JCAH has made no finding that the quality and effectiveness of care suffers greatly when the essential services that make hospice hospice are contracted out back into the traditional health care system.

The facts are that the JCAH, in its study of the hospice field found that:

- hospice care is an evolving concept;
- it would be a grave error to freeze development of hospices by institutionalizing such care in a rigid mold through legislation and regulation;
- services furnished by a hospice provider under arrangement may be of high quality; and
- services furnished directly by a hospice provider are not necessarily of consistently high quality.

The JCAH standards for hospice care, adopted by our Board of Commissioners, in August of this year, recognize these concepts and the probability that a great variety of organizational models will emerge to manage the provision of such care. The objective of our hospice accreditation program will be to assess the quality of hospice care being provided by a hospice without regard to organizational structure involved.

We have written the Chairman of the Committee on Health Care, House of Representatives, Commonwealth of Massachusetts stating our disavowal of the testimony submitted by Mr. Gaetz in our name. We have asked that our letter on this subject be included in the record of that committee's hearings.

Similarly we ask you, Mr. Chairman, to include this letter in the record of your September 15, 1983 hearings on Hospice proposed regulations.

Thank you for your kind attention to this matter.

Sincerely,

John B. Affeldt

John B. Affeldt, M.D.
President

:amf

NHO National Hospice Organization
1901 N. Fort Myer Drive, Suite 402
Arlington, Virginia 22209
(703) 243-5900

September 21, 1983

Health Care Financing Administration
U.S. Department of Health & Human Services
Room 132, East High Rise
Attention: B.P.P.-241-P.
6325 Security Boulevard
Baltimore, Maryland 21207

COMMENTS: MEDICARE PROGRAM; HOSPICE CARE; PROPOSED RULE

On behalf of the National Hospice Organization, we wish to express appreciation to the Secretary of Health and Human Services and to the Health Care Financing Administration for the cooperative and consultative manner in which this proposed rule has been developed.

Having examined in detail the proposed rule published in the Federal Register of August 22, 1983, the NHO considers it to be, on the whole, a well-reasoned and thorough document. Nevertheless, we find a number of areas in which improvements need to be made and respectfully submit for consideration the following comments by section. In general, the concerns of the NHO go to the following issues. We believe that:

o the rules should be modified in certain respects to more clearly address the needs of hospices which are volunteer-intensive and which often are found in rural or underserved areas;

o the proposed prospective rates of payment should be recalculated to reflect current costs; and

o the condition of participation relating to the ratio of home care to inpatient care should not be converted to an extra-statutory payment denial mechanism.

We would, however, like to emphasize that several sections of the proposed rule should not be altered or diluted. These have been the subject of extensive debate and we believe that HCFA has carefully considered all positions and taken an appropriate stance.

* Contracting for Core Services. The rule, at 418.80, fulfills the intent of the statute that substantially all of the core services of physician care, nursing, counseling and social work, be provided directly by hospice employees.

We consider this essential to achieve the dual objectives of cost efficiency and program integrity.

Permitting the delivery of core services, particularly nursing, under arrangements would have the effect of allowing a hospice to broker out a very substantial portion of its patient care services. This would add to the cost of hospice care because the caregiver retained under arrangements must carry an allocation of administrative cost of both the hospice and the outside agency. It would endanger program integrity because a significant share of hospice services would be delivered by an agency which is not a qualified hospice and because a hospice cannot hope to have as much control over the quality and priorities of contract staff as its own employees.

* Professional Management Responsibility - Inpatient Care. We believe that the rule, at 418.56(e), is equitable and does not impose an unreasonable burden on hospices or potential vendors of inpatient services. The contractual elements are appropriate and consistent with the delivery of quality hospice services. This portion of the rule will help to ensure that inpatient services reflect the priorities of the hospice in meeting the needs of its patients.

* Staffing Requirements - Inpatient Care. The upgrading of the ICF level standards to require the presence and care of a registered nurse (418.100(a)) is a welcome addition and

should be retained. This section does not impose restrictive staffing patterns but accomplishes the goal of ensuring a level of care above that of mere custodial services.

* * *

In response to the publication in the Federal Register for August 22, 1983 of the Proposed Rule for Hospice Care under the Medicare Program, the following comments, indexed by Section, are submitted by the National Hospice Organization.

Section	Comment
418.3	The phrase "substantially full time" should be deleted from the definition of the term "employee". It is inefficient, impractical and inequitable to require a provider with a hospice subdivision to designate staff to that subdivision on a full time basis. Small and rural providers would be especially adversely affected by this provision which would prevent the flexibility necessary to accomplish cost-effective patient care coverage.
418.24(e)(2)	Ambulance service should be designated as a covered service not waived by a hospice election. This is appropriately characterized as an "exceptional and unusual circumstance". Such special transportation, required at times to transport the patient to and from the hospice inpatient facility, has not been included in the calculation of hospice service rates and is not a service which should be operated or compensated by a hospice.

418.26(e) The signature of an individual authorized to sign on behalf of a beneficiary should be accepted on the election statement when the beneficiary is unable to sign or otherwise indicate the intention to elect hospice care due to physical condition or mental confusion. Hospice care encompasses both the patient and the family. Services to the patient/family unit should not be thwarted by the inability of the patient to physically sign or mentally comprehend the hospice election statement.

418.50 The requirement for 24 hour availability of services should be clarified and strengthened to indicate that, at a minimum, nursing services, physician services and pharmacy access for prescription drugs and biologicals be specifically available as needed by the patient. It is also essential that the hospice maintain patient visiting and assessment capability on a 24-hour availability basis.

418.52 The governing body should be required to designate an individual who will be responsible for the day-to-day management of the hospice program. Administrative authority must be clearly defined; programmatic as well as fiscal accountability are both protected and controlled when an administrator is designated.

418.54 The phrase "the medical portion of" should be inserted prior to "the hospice's patient care program". The medical director should not have administrative authority for the overall program function of the hospice but should retain responsibility for the medical care rendered by the hospice to patients and their families.

418.56(c) Language should be added to indicate that the hospice must ensure that care rendered under arrangement be in accordance with the hospice plan of care.

418.56(e) Clarification is required to indicate that the provision of certain limited inpatient ancillary services which cannot be provided at the hospice inpatient facility not require the same contractual complexity as general hospice inpatient care. Such services are usually brief in duration and technical in nature. Examples might include surgery, radiation or specialized chemotherapy when these are indicated for palliation.

418.58(a)&(b) Either the medical director or a qualified designee should be permitted to establish and/or review the hospice plan of care. It is impractical to require the medical director to sign all plans of care and plan of care reviews when a hospice-employed physician member of an interdisciplinary group may be available for this purpose.

418.66(a) The phrase "through the hospice medical director" should be deleted. Each hospice should determine how quality assurance activity should be conducted. Regulations should mandate outcome rather than form.

418.66(b) The phrase "and evaluate the care they provide" should be changed to "and evaluate the hospice program". This is a clarification to indicate that general program evaluation is required, as opposed to individuals evaluating the care they themselves provide.

418.68(a) Add "or groups" after "an interdisciplinary group". Hospices may have more than one interdisciplinary group which provides patient care.

418.68(b) It must be understood that the interdisciplinary group is not purely an administrative or supervisory body, but rather is composed of those individuals the majority of whom participate directly in the care of patient/family.

418.70 The provisions related to volunteers should be further strengthened by requiring (1) that a Volunteer Services Coordinator be designated whose responsibilities are stated in writing, (2) that volunteers must (rather than "may") be used in direct patient service roles, (3) that volunteer services be recorded on a monthly basis and monthly activity records be maintained for all volunteers, and (4) that every patient must have access to a patient care volunteer with documentation of any refusal by a patient or family.

A numerical standard for volunteer participation does not seem necessary or desirable if the above requirements are added. However if the department decides to include one, the following standard should be used: Direct patient care volunteers will provide the equivalent of 5% of the total patient care hours of all paid direct and contracted employees.

418.94(a) The requirement for supervisory visits by the nurse every two weeks should be deleted. Current proposed language reflects home health agency regulatory requirements. The registered nurse in the hospice program, working within the interdisciplinary group concept, is able to provide adequate home health aide supervision without a biweekly supervisory home visit.

418.96(b)(3) It should be added that the primary care giver or other family members may be trained to administer medication if such is approved by the attending physician. This is in keeping with general hospice and home health care practice.

418.96(d) The section should be clarified so as to relate only to drug storage at sites other than the patient's home.

418.100(e) This waiver may be too liberal in light of the kind of patients who will be cared for in hospice inpatient units. The vast majority of patients will be nonambulatory and will be acutely ill. This provision needs careful review by fire safety experts to assure that the section is appropriately constructed, given this patient population.

418.100(f) Patient care areas should be required to include safe, sanitary and adequately equipped facilities for food preparation by patients and families. Such food preparation may provide an important physical and/or psychosocial component to the care of the patient and its availability is an essential part of hospice inpatient services.

418.100(j) The hospice should be required to maintain an infection control procedure. This reflects necessary requirements in hospitals and skilled nursing facilities.

418.100(q) This requires clarification to indicate that such supervision is required for hospice <u>inpatient</u> health services, as opposed to home services.

418.100 Because there is either no hospice licensure law or there is a lack of uniformity of such laws in the various states, certain items must be addressed for freestanding hospices since they will not be subject to existing hospital, SNF or ICF licensure laws. This applies specifically to those items not covered by the generic requirement of compliance with The Life Safety Code. Examples might include emergency generators, oxygen systems, patient care equipment, safety measures and devices, security and emergency water supply.

418.202(e) There is concern about patients who become part of a hospice program and then need long term inpatient care, not short term. These patients typically are those who could be cared for at home but they have no primary caregiver able to give care or have an inappropriate home environment. Many hospice programs will want to continue to care for these patients at home as long as that is possible, and in the inpatient unit for short periods of time to manage symptoms. They cannot, however, provide long term non-acute care and will occasionally need to transfer these patients to the appropriate facility in the community. The department and fiscal intermediaries need to understand that in these few instances a discharge may take place and the hospice program would not be held financially responsible for this care which is not a covered service. Naturally, the hospice program should have written policies and criteria to cover such instances and should have to demonstrate fair application of these policies to all patients regardless of their financial condition.

418.202(g) Clarification of the distinction between the duties of the aide and the homemaker is required. If personal care is to be provided, adequate training is as essential for homemakers as it is for aides. All personal care, whether by aides or homemakers, should be under the general supervision of an R.N.

418.204 Continuous care should not be defined as consisting primarily of nursing services. Often patients can be maintained in the home during a period of crisis with continuous coverage by an aide with supplementary visits by a nurse. Occasionally a nurse is required to be in continuous attendance. Hospices should have the flexibility within these regulations to meet the appropriate staffing requirements necessary to implement continuous care at home.

418.302(f) This section should be deleted. The statute provides that the 80/20 ratio be utilized as a condition of participation. There is no authorization to convert this requirement to a payment denial mechanism. It would be inequitable to financially penalize a hospice which has achieved and can maintain this ratio on a current basis but which, during a specific year, has aggregate statistics below the standard.

418.304(c) The word "paid" should be inserted prior to "employee of the hospice". Those physicians who are volunteer medical directors should retain the right to bill medicare part B for professional services to their patients.

418.306 The procedures used in the establishment of the routine home care rate, the continuous home care rate, the inpatient respite rate and the general inpatient rate are flawed.

The routine home care rate should be adjusted from 1981 to 1984 dollars by the application of the medical care component of the CPI as an inflation adjustment. While the demonstrations, from which the rate data was drawn, were reimbursed on a cost basis, there is no evidence to indicate that inefficiency resulted in an artificial inflation of costs. Further, efficiency incentives supposedly inherent in prospective reimbursement are not sufficient to preclude all inflation related increases in the cost of delivering care in the last three years. It is also clear that the necessity for a hospice to be prepared for selective cost reporting will impose data collection costs and that some hospices will continue to experience smaller service volumes.

It is inequitable to use the medical care component of the CPI as the basis for inflating the general inpatient rate. The factor used should be the same as that used to establish the Medicare schedule of limits on hospital inpatient operating costs (as published in the Federal Register for September 30, 1982). This would be consistent with the methodology used to calculate the general inpatient rate which relied on hospital based experience and also consistent with the assumption that hospice inpatient costs are similar enough to hospital costs to warrant a reduction of the hospice rate based on the relative routine costs of those hospitals in which a demonstration site was based.

Further, the interdisciplinary group must manage the care in the general inpatient setting as well as the other three settings. Therefore a cost component for the group should also be included in the general inpatient care rate.

The assumptions which underlie the inpatient respite care rate will present hospices with a difficult choice. Given the fact that the volume of inpatient respite days is not large enough to justify the establishment of a less costly "step-down" respite unit within the hospice's inpatient facility, the hospice must either accept the financial loss of caring for the respite patient in its general inpatient setting or place the patient in a contracted SNF or ICF facility.

If these regulations, as stated in the Supplementary Information section, contemplate that the per diem costs associated with the hospice's general inpatient unit (whether free-standing or under arrangements) exceed those costs which are necessary to provide inpatient respite care, then the prospective rate must take into account the costs which will be incurred by a hospice in arranging for less costly care. The mean routine cost per day for SNF's has no established identity with the market price which hospices will have to pay for SNF or ICF services to hospice respite care patients.

Neither does the SNF mean routine cost per day include a component for an equitable allocation of the hospice's own administrative costs. Apparently the established rate assumes that all hospice administrative costs will be absorbed by other categories of days. This is unrealistic and inequitable.

The inpatient respite rate should be based on the following components: the mean charge per day for SNF's; the daily cost of supplies, drugs, other necessary ancillary services, and the interdisciplinary group; a factor for hospice general and administrative costs; and the appropriate inflation adjustment.

The necessity of a factor for hospice general and administrative costs is also the reason the continuous home care rate is inadequate if nursing is to be the primary service component. The hourly direct costs alone for nurses, including salary, fringe benefits and travel expense, exceed $12.12. This rate, when indexed for inflation, would be adequate to provide primarily non-nursing services and would also be adequate to include a general and administrative cost factor. The continuous care rate should be indexed for inflation just as should be the routine home care rate.

In our experience, and according to information we have seen on the demonstration project, the cost proposed for home care drugs is inadequate. We believe this cost should be $5.50 in 1981 dollars.

In summary, the prospective rates should be recalculated as follows:

Routine Home Care

Service Component	Cost per Day
Drugs (reduced 5% to reflect coinsurance)	5.23
----------	$57.45
Inflation adjustment (medical care component of the Consumer Price Index from 1981-1984)	X 1.256
Routine Home Care Rate	$72.16

General Inpatient Care

National inpatient care rate from 1981 demonstration data	$216.00
Interdisciplinary group	6.32
Inflation adjustment (estimated actual rate of increase	

in Medicare inpatient operating costs 1981-1983 plus estimated market basket rate of increase plus one percentage point 1983-1984)	X 1.415
General Inpatient Care Rate	$314.58

Inpatient Respite Care

1982 mean routine charge per day for SNF	xxx
Daily cost of supplies, drugs, ancillary services and interdisciplinary group	xxx
Hospice general and administrative cost per day	xxx
Inflation factor	xxx
Inpatient Respite Care Rate	xxx

Continuous Home Care

Service Component	Avg Cost per Visit (hrs)	Avg Visits per Day(hrs)	Cost Per Day
Continuous care (includes general			

Service Component	Avg Cost per Visit (hrs)	Avg Visits per Day(hrs)	Cost Per Day
& administrative costs	12.12	24 hours	290.88
Social Services/ Therapy	57.00	.08 hours	4.56
Daily cost of drugs (reduced 5% to reflect coinsurance)			5.23
Daily cost of supplies			2.83
Daily cost of equipment			6.51
Interdisciplinary group			6.32
Total			316.33
Inflation adjustment (medical care component of the Consumer Price Index from			
			15.

1981-1984)	x 1.256
Continuous Home Care	
Rate per Day	397.31
8 up to 16 hours interval (1/2)	198.66
16 up to 20 hours interval (3/4)	297.98
20 through 24 hours interval (11/12)	364.20

* * *

The National Hospice Organization appreciates this opportunity to comment on the proposed rule and urges that the views represented here receive the same careful attention that has characterized the development by your Agency of this important document.

Sincerely,

Louise Bracknell

Donald J. Gaetz
President

Louise Bracknell
Executive Director

Michael Rosen

Michael Rosen, Chairperson
Licensure and Reimbursement
Subcommittee

STATEMENT OF AMY B. HECHT, R.N., ED.D, PRESIDENT, BOARD OF TRUSTEES, DELAWARE HOSPICE, WILMINGTON, DEL.

Senator DURENBERGER. Amy Hecht, welcome.

Ms. HECHT. Thank you, Mr. Chairman. I am really very pleased to have this opportunity to meet with you this afternoon.

I am President of Delaware Hospice, which is one of about 800 home-care hospices in the country. We are very pleased that hospice care will soon be reimbursable under the medicare program.

However, I wish to make two points regarding the proposed regulations:

First, the average daily rate of $53.17 for routine home care is too low. Quality hospice care cannot be provided for this amount. Many of our patients require $12 a day or more for medications alone. Oxygen for one patient cost $400 a week.

Our average cost per patient day is $66.74, as outlined in the material that you have. If the rate remains as it is, patients are going to be forced into more costly inpatient care, which will negate the cost effectiveness as well as the philosophy of hospice.

My second point concerns the regulation's prohibition of contracting for core services. Our hospice is small; we can serve only about 20 patients at a time. Our patient family load varies. Last month, for example, when we had a census of 15, we had five deaths within 8 days.

Under the proposed regulations we will need to maintain a nursing staff in excess of our needs a lot of the time. Small hospices need the flexibility of contracting for nursing services in order to be cost effective. It can be done with strict monitoring of quality.

I do not think the law itself needs to be changed. This is what our hospice does, and we do it well.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Amy B. Hecht follows:]

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STATEMENT OF AMY B. HECHT, Ed.D., R.N.,
President, Delaware Hospice, Inc.,
Wilmington, DE, at the
SENATE COMMITTEE ON FINANCE,
Thursday, September 15, 1983, 2:30 p.m.,
Dirkson Senate Office Building.

Suite 109, Talley Building/3509 Silverside Road, Concord Plaza/Wilmington, Delaware 19810/(302) 478-5707

I am Amy Hecht, a nurse, the former Assistant Dean of the College of Nursing at the University of Delaware, and for several years now the President of Delaware Hospice, Inc.

After five years in the planning stage, Delaware Hospice began patient care in mid-October, 1982. We presently serve the northernmost of Delaware's three counties and are negotiating to extend our services to the other two counties. We project serving 180 patients and their families per year.

Like many other hospices, we rejoiced in the possibility of Medicare coverage for hospice services. But we have grave reservations over two aspects of the proposed regulations.

(1) <u>Prohibition of contracting for nursing services</u>:

We contract for nursing services with two non-profit agencies, the Visiting Nurse Association of Delaware and Professional Home Health Care Agency. We believe that this arrangement has enabled us to provide a high level of quality care with a high level of monitoring and control by Delaware Hospice, and we believe that this arrangement is cost effective.

Like most hospices we are small and probably always will be small. Our projections indicate that we will serve approximately 23 patients at any one time.

With such small numbers our patient census can vary widely and rapidly. For example, recently with a patient census of 15 we had 5 deaths in 8 days, followed shortly by 2 more. In a situation like this we need the staffing flexibility that contracting would provide.

If the proposed regulations on this are not changed we will be forced to maintain a nursing staff in excess of our needs or hope that the required numbers of "as needed" nurses are available when we need them.

We recognize the validity of the "double overhead" criticism of contracting. But we believe that such criticism overlooks the offsetting factors such as (in our case) the lowered nursing fees because of United Way subsidization of one of our contractual agencies and the highly efficient use of staff time made possible by contracting.

Furthermore, we note that the ways being suggested as ways around prohibition of contracting would involve as least as much "double overhead" and would be administratively awkward.

We do not believe that the legislation need be changed. We believe that the regulations interpreting the legislation need to be changed and can be changed.

BEST AVAILABLE COPY

(2) Impossibly low per diem rate for "Routine Home Care":

We believe that the per diem rate for "Routine Home Care" (the level at which most of our services will be reimbursed) will not cover our costs for providing these services.

Several of our patients have required $12 per day for common medications. One of our patients required $400 per week in oxygen. Many need a hospital bed and a standard commode, and these cost $3.73 per day. The proposed $53.17 reimbursement per day is not adequate.

We project a cost of $66.77 per patient per day for this level of care, and that figure includes no special therapies and no palliative radiation or chemotherpay.

At this rate, if we had 25 Medicare patients on "Routine Home Care" we would lose almost $124,000 per year, and we cannot afford to do that. (See attached projection sheet.)

We believe that hospices have much to contribute to the terminally ill and their families, and we know that many of our patients and their surviors feel the same way from their personal experience with hospice care.

The following is an excerpt from an article from the September 6th editions of The News-Journal papers of Wilmington. The article was written by Suzanne Loewenstein Bush, whose father was one of our patients.

"The article said simply that my father died at home. To most readers that statement may have had little significance. But to our family, several close friends, Delaware Hospice - and especially to my father - that sentence was the culmination of a three-month commitment to make the best of a tragic situation.

"The tragedy was the cancer that killed my father. The triumph for us - and for an increasing number of families involved in such situations - is that there were people willing and able to help our family and my father lived these last three months the most fruitful way possible under the circumstances.

"The Wilmington Medical Center had exhausted all treatment possibilities in May. Officials informed my mother that my father would have to be moved.

"This left her to contend with two personal crises.

"First, she was reluctant to send her husband to a nursing home. She missed him and wanted him home. And, although he wanted to come home, she knew there was no way she could care for him alone.

"Second, the realization that my father's condition was indeed terminal was at last inescapable.

"Help for both crises came from Delaware Hospice, Inc. After interviewing family members, physicians' records and explaining the Hospice program to my father, Gretchen Jones of Hospice invited us to participate in what was truly a remarkable project.

On paper Hospice agreed to provide regular visits by a registered nurse, a nurses' aide and various support personnel. Our family agreed to provide a primary care giver - my mother - who would be responsible for around the clock routine care of my father.

"In reality, Hospice provided people who truly cared for the whole family. People who came at three in the morning or four in the afternoon if there was a crisis or even the hint of one. People who held our hands - and frequently held us together when our strength failed.

"During these last three months, my father was able to enjoy visits with his grandchildren. He was able to see his family cope with his situation and mature. Through all this he was not a patient in a hospital. He was a part of the family, a participant in our lives. He settled arguments, laughed with us, played his traditional role in the household.

"This incredible gift was ours because of Delaware Hospice, an organization that started last October. There have been 42 patients in the program. Like my father's case, each of these patients represents a family, friends and people whose lives were dramatically changed because they were able to choose an alternative to traditional care for the terminally ill." (See attached complete article.)

We are Delaware Hospice believe that hospice has much to offer our country. It should not be shackled by unnecessarily limiting regulations or inadequate reimbursement.

We respectfully request that you reconsider these two points of special concern to Delaware Hospice and other hospices like ours.

MEDICARE HOSPICE REIMBURSEMENT COMPARISONS ("Routine Home Care" level)

If DH had 25 patients, all Medicare reimburseable, all on "Routine Home Care" level:

25 patients x 53.17/patient/day reimbursement = 1,329.25 reimbursement/day

DH cost to provide services

Staff and overhead	18.36 (1)	Medicare totals	10.88
Nursing			
.43 RN visits/day (3/week)	14.62 (2)	Medicare uses .34/day =	20.74
.43 HHA visits/day (3/week)	13.76 (2)	Medicare uses .46/day =	16.10
Drugs, supplies, equipment	20.00 (3)	Medicare totals	5.45
	66.74 (4)		53.17

25 patients x 66.74/patient/day cost = 1,668.50 cost/day

Shortfall (Cost less reimbursement) = 339.25/day or 123,826.25/year

(1) Is our figure for "Staff and overhead" really so out of line? No!

- The DH Certificate of Need projected a staff (not including nurses) of 4.8 employees for 23 patients; the NHO projects a staff (not including nurses) of 5.6 employees for 25 patients; DH presently has 4.0 included in its budget.

- The DH 1983-84 budget (not including nurses) is 167,568; NHO projects an annual budget (not including nurses) for a model hospice with 25 patients at 228,958. DH salary structure is in line with the figures for the NHO model hospice; other DH expenses total way below NHO figures.

(2) Are the "Nursing" figures out of line? No!

- The visits/week (RN's & HHA's) total 6.0, compared with Medicare's 5.6. The rates are those of one of the two non-profit nursing agencies with which we contract for nursing.

(3) Is this figure adequate? Probably not!

- NHO uses 5.00/patient/day for supplies, equipment and medications. But an electric bed and standard commode cost 3.73/day; supplies cost something; and one common prescription for one of our patients costs 12/day.

(4) - This does not include: special therapies or out-patient services (physical, occupational, speech therapies; palliative radiation or chemotherapy)

THE PER DIEM RATE FOR "ROUTINE HOME CARE" IS IMPOSSIBLY LOW FOR DELAWARE HOSPICE!

5-26-83

Hospice: how to make the best of a tragic situation

Thinking out loud

by Suzanne Loewenstein Bush

THE OBITUARY said simply that my father died at home. To most readers that statement may have had little significance. But to our family, several close friends, Delaware Hospice — and especially to my father — that sentence was the culmination of a three-month commitment to make the best of a tragic situation.

The tragedy was the cancer that killed my father. The triumph for us — and for an increasing number of families involved in such situations — is that there were people willing and able to help our family and my father live these past three months the most fruitful way possible under the circumstances.

The Wilmington Medical Center had exhausted all treatment possibilities in May. Officials informed my mother that my father would have to be moved.

This left her to contend with two personal crises.

First, she was reluctant to send her husband to a nursing home. She missed him and wanted him home. And, although he wanted to come home, she knew there was no way she could care for him alone.

Second, the realization that my father's condition was indeed terminal was at last inescapable.

Help for both crises came from Delaware Hospice, Inc. After interviewing family members, reviewing physicians' records and explaining the Hospice program to my father, Gretchen Jones of Hospice invited us to participate in what was truly a remarkable project.

On paper Hospice agreed to provide regular visits by a registered nurse, a nurses' aide and various support personnel. Our family agreed to provide a primary care giver — my mother — who would be responsible for around the clock routine care of my father.

In reality, Hospice provided people who truly cared for the whole family. People who came at three in the morning or four in the afternoon if there was a crisis or even the hint of one. People who held our hands — and frequently held us together when our strength failed.

During these last three months, my father was able to enjoy visits with his grandchildren. He was able to see his family cope with his situation and mature. Through all this he was not a patient in a hospital. He was a part of the family, a participant in our lives. He settled arguments, laughed with us, played his traditional role in the household.

This incredible gift was ours because of Delaware Hospice, an organization that started last October. There have been 42 patients in the program. Like my father's case, each of those patients represents a family, friends and people whose lives were dramatically changed because they were able to choose an alternative to traditional care for the terminally ill.

Next month, new federal reimbursement legislation will go into effect that will alter the way hospitals approach health care. As a result of the Tax Equity and Fiscal Responsibility Act of 1982 the Department of Health and Human Services proposed certain incentives to the health care industry to control costs. These proposals, the Prospective Payment System, have been approved by Congress and go into effect on Oct. 1. According to the May issue of the magazine Medical Laboratory Observer, "the legislators directed a radical change in the way hospitals are paid for treating Medicare patients."

These changes will undoubtedly affect the way hospitals treat cases where the patients have no reasonable hope of recovery. The article continues, "Since hospitals will be paid a fixed amount per case, whether the patient stays two days or 20, each facility's incentive will be to maximize its number of admissions, keep its stays as short as possible, and use services most efficiently."

As more and more patients arrive at that threshold where hospital

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care is no longer a mitigating factor to their conditions or economically feasible, the need for an alternative care system like hospice will increase.

According to Murray Goodwin, executive director of Delaware Hospice, the federal government has outlined four levels of hospice care. Each level has a maximum allowable reimbursement associated with it. Goodwin says the reimbursements will be awarded to hospice facilities that meet a complex set of guidelines developed by the government. Hearings on the reimbursement schedules and the guidelines will be held in Washington this month, and the outcome of these hearings will determine how effective an alternative to traditional hospital care hospice can be.

Goodwin points out that hospice care ultimately can cost everyone — the government and the patients — less than hospital care. Yet current proposals will compel hospice to adopt guidelines that will only drive costs up. Under those proposals, hospice organizations would have to put nurses on their payrolls instead of contracting for nursing services. So nursing care couldn't be purchased according to the patient load. Additionally, hospice would have to employ its own physicians instead of relying on the patient's continued relationship with his or her own physician.

If the government's aim is truly to become a "prudent buyer" of health care services, legislation that forces hospice to operate without regard to sound economic principles does not make sense. Everyone agrees that health care costs must be controlled. But the measures that control those costs must provide reasonable alternatives for patients and their families. Regulating those alternatives into prohibitively expensive operating modes is unfair and counterproductive.

Delawareans are fortunate that a coalition of religious and community groups had the foresight and compassion to create a formula that can bring families and loved ones to a better understanding of death — and a greater appreciation of life. That formula represents sound medical care, economical custodial care and recognizes the emotional needs of the patient and his or her family.

Delaware Hospice is offering a volunteer training course, beginning next week. For details, contact the hospice office at 478-5707.

Suzanne Loewenstein Bush of Elkton, Md., is manager of promotional programs for Gannett Co. Until the end of August, she was market research and public service director for The News-Journal Co.

(302) 478-5707

DELAWARE HOSPICE

Suite 109, Talley Building
3509 Silverside Road
Concord Plaza
Wilmington, DE 19810

Senator DURENBERGER. Florence, I guess you are the acknowledged founding mother of hospice, so if you want to take more than 1 minute, we will all agree you are entitled to it.

Ms. WALD. That's very kind. I'm going to try not to, though.

STATEMENT OF FLORENCE S. WALD, R.M., M.N., M.S., ASSOCIATE CLINICAL PROFESSOR, YALE SCHOOL OF NURSING, NEW HAVEN, CONN.

Ms. WALD. My focus is on the principles of hospice care and the problems that patients who are terminally ill and their families have.

The issues all relate to the election statement as well as the revocation of the election statement.

In illnesses such as cancer there is a delicate balance with risks and uncertainty, decisions are rarely black or white. Patients need an open system of care throughout their illness. Curative treatment and palliative treatment; are complimentary. The election statement locks the patient into one system.

Linking the skills of these two systems should be done so that a patient should not have to ask: "Do I have to be dying to be made comfortable?" or, "Couldn't I have a shot of radiation to reduce this pressure," only to be told it's against the rules. To what purpose is the section of this legislation? It seems so contrived and complex.

Was the election statement written to keep costs down?

My clinical experience tells me that it will cost society more. Put yourself in the position of the patient or family. Putting one kind of treatment aside is one of great consequence. Most would put it off and continue in curative treatment, which we all know is more costly.

And also, the later palliative care begins the harder it is to make it work.

Is the cap not cost-containment enough? What will the cost be to oversee these regulations to elect and to revoke?

Senator DURENBERGER. Thank you very much, Florence.

[The prepared statement of Florence S. Wald follows:]

TESTIMONY OF FLORENCE S. WALD, ASSOCIATE CLINICAL PROFESSOR

YALE UNIVERSITY SCHOOL OF NURSING
FELLOW AMERICAN ACADEMY OF NURSING

ON PROPOSED RULE, MEDICARE PROGRAM; HOSPICE CARE

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

HEALTH CARE FINANCING ADMINISTRATION.

FOR: FINANCE SUBCOMMITTEE ON HEALTH HEARING

THURSDAY, SEPTEMBER 15, 1983, 2:30 P.M. ROOM SD-215

DIRKSEN SENATE OFFICE BUILDING

ISSUE: ELEMENTS OF THE ELECTION STATEMENT (SECTION 418.24 & 418.26)-AND

REVOKING THE ELECTION OF HOSPICE CARE (SECTION 418.28)

FEDERAL REGISTER/VOL 48, #163/ MONDAY, AUGUST 22, 1983

P 38166.

MY TESTIMONY CONCERNS THE REQUIREMENT THAT PATIENTS MUST SIGN A STATEMENT ACKNOWLEDGING THAT THE ILLNESS IS TERMINAL,WAIVING RIGHTS TO MEDICARE PAYMENTS AND WAIVING THE RIGHT TO RECEIVE CARE FROM OTHER HOSPICES THAN THE ONE ELECTED. IT FOLLOWS THAT THE PROCESS OF REVOKING THIS ELECTION (SECT 418.28) IS ALSO CONCERNED.

ALTHOUGH PREPARING THESE RULES MUST HAVE BEEN AN ARDUOUS TASK FOR THOSE WHO HAVE BEEN INVOLVED, IT IS A DIFFICULT TASK IN ANY REFORM MOVEMENT TO STRIKE THE BALANCE BETWEEN IDEALS AND STANDARDS ON THE ONE HAND, AND SHAPING REGULATIONS AND PROVIDING REIMBURSEMENT ON THE OTHER. YET CONSUMERS, PRACTITIONERS, LAWMAKERS AND TAXPAYERS MUST BE RECONCILED.

THE RAPID PACE OF THE HOSPICE MOVEMENT, THE ZEAL OF PRACTITIONERS, THE EAGER PUBLIC AND (ALAS) THE INSTITUTIONAL RIVALRIES FOR DOMAIN MUST HAVE MADE THE WRITING OF THIS RULE EXCEPTIONALLY DIFFICULT. SO MISTAKES ARE UNDERSTANDABLE BUT FORTUNATELY CAN STILL BE CORRECTED. THE DOCUMENT PUBLISHED AUGUST 22, 1983 HAS THREE SECTIONS (418.24), (418.26) AND (418.28) THAT ARE INAPPROPRIATE FOR GOOD PATIENT CARE, ENDANGER THE INTEGRATION OF HOSPICE CARE IN THE HEALTH CARE SYSTEM AND WILL ADD TO THE COST OF SUCH CARE RATHER THAN DECREASE IT. DELETING THESE SECTIONS CAN CORRECT THESE PROBLEMS FOR THE FOLLOWING REASONS:

1. IN ILLNESSES SUCH AS CANCER, THERE IS A DELICATE BALANCE WITH RISKS AND UNCERTAINTY IN CHOOSING ONE KIND OF TREATMENT OVER ANOTHER. DECISIONS ARE RARELY BLACK OR WHITE. THOSE WHO HAVE HAD PERSONAL EXPERIENCES WITH TERMINAL ILLNESS KNOW THE TENSION, ANXIETY, FEELINGS OF BLAME AND GUILT THAT ARISE AND HOW WORKING RELATIONSHIPS BETWEEN THE PRINCIPALS CAN BE SHATTERED.

FORCING A CHOICE ~~WHICH~~ IS WHAT THE ELECTION STATEMENT DOES AND IT CAN ONLY EXACERBATE THE DIFFICULTIES OF THIS DECISION. IF THE STATEMENT IS REVOKED, THE CRISES WILL BE EVEN GREATER. SITUATIONS SUCH AS THESE MOTIVATED THE INTERNATIONAL WORK GROUP ON DEATH, DYING AND BEREAVMENT TO SET DOWN THE PRINCIPLES OF CARE FOR THE TERMINALLY ILL AND TO ADVOCATE AN OPEN SYSTEM OF CARE. THIS WAS IN 1978 AND WAS BASED ON CARE IN CANADA, ENGLAND, SWEDEN AND THE UNITED STATES.

THE GROUP SAID:"PATIENTS WITH LIFE THREATENING ILLNESSES, INCLUDING PROGRESSIVE MALIGNANCIES NEED AN OPEN SYSTEM OF CARE THROUGHOUT THEIR ILLNESS - CURATIVE TREATMENT AND PALLIATIVE TREATMENT ARE COMPLEMENTARY SYSTEMS THAT INTERCHANGE AND OVERLAP."

BUT THE ELECTION STATEMENT LOCKS THE PATIENT INTO ONE SYSTEM AND THEN GOES ON TO LOCK THE PATIENT IN ONE INSTITUTION WITHIN THAT SYSTEM. (WOULD LEGAL ADVICE QUESTION THIS AS RESTRAINT OF TRADE?) IN ANY EVENT, REVOKING THE ELECTION STATEMENT THEN APPEARS AS TWO WRONGS ATTEMPTING TO MAKE A RIGHT.

2) THE ELECTION STATEMENT WILL ALIENATE CAREGIVERS FROM ONE ANOTHER.

THOSE OF US DEVELOPING THE FIELD OF PALLIATIVE CARE HAVE RESOLVED TO LINK OUR SKILLS IN MANAGEMENT OF SYMPTOMS WITH THOSE WHO (HAVE SKILLS TO) CURE. A PATIENT SHOULD NOT HAVE TO ASK, "DO I HAVE TO BE DYING TO GET SUCH COMFORT?", NOR SHOULD A PATIENT HAVE TO ASK, "COULD A SHOT OF RADIATION REDUCE THIS PRESSURE?", ONLY TO BE TOLD, "IT'S AGAINST THE RULES."

IT WILL TAKE CONSUMMATE SKILL AND TACT FOR PRACTITIONERS TO NEGOTIATE THE ELECTION PROCESS WHILE KEEPING WORKING PROFESSIONAL RELATIONSHIPS IN GOOD ORDER. MY OWN RESEARCH UNCOVERED THE STRONG FEELINGS OF INADEQUACY THAT ARISE WHEN PRACTITIONERS HAVE TO ABANDON A COURSE OF ACTION THEY THOUGHT WOULD HELP BUT DIDN'T. THEY NEED SUPPORT AND ENCOURAGEMENT FROM THE ONE'S WHO ARE ABOUT TO TAKE A SIFFERENT THERAPEUTIC APPROACH. THE ELECTION STATEMENT WILL ADD TO THIS BURDEN.

3) WAS THE ELECTION STATEMENT WRITTEN TO KEEP COSTS DOWN? I HAVE PRESUMED SO, BUT MY CLINICAL EXPERIENCE TELLS ME THAT IT WILL COST SOCIETY MORE. PUT YOURSELF IN THE POSITION OF THE PATIENT.

SIGNING A STATEMENT TO PUT CURE ASIDE AND ELECT HOSPICE CARE IS A STEP OF GREAT CONSEQUENCE; MOST PEOPLE WOULD PUT THAT ACT OFF AS LONG AS POSSIBLE AND CONTINUE IN CURATIVE TREATMENT THAT IS MORE COSTLY AND BECOMES INCREASINGLY INAPPROPRIATE. THE LATER HOSPICE CARE IS BEGUN, THE HARDER IT IS TO ACHIEVE ITS OBJECTIVES.

Senator **Durenberger**. Let me get right into that point as my first question. And let me ask you, all of you or any one of you, to respond to the question of how hospice organizations are treating this whole issue of acknowledging, if you will, the terminal nature of an illness when patients, enter hospice programs. What's realistic out there, and what might we do differently in the form of regulations to address this problem of election?

Ms. **Johnson-Hurzeler**. Well, Senator, the patient—to put it bluntly—is not hit over the head with the fact that they have a limited life expectancy. Patients need to be met. They are people, and they need to be met where they are. But at the same time, I know that this instruction about informed consent means that a person cannot go into the palliative mode, which may include radiation and so forth and so on, without having some knowledge that his disease has progressed to the point where curative treatment at the moment does not seem like a realistic possibility.

So, we don't anticipate, from the community physician, difficulty in terms of the certification, although they themselves have never had to certify, and the patient himself has never had to agree that this is happening, so that they have some problems in signing a form which actually has that focus.

On the other hand, there is that balance which is that the patient cannot come into a palliative mode when curative treatment is not being offered and not have some awareness, at least at the point of discussion.

I think it will have to be tested, and there is—the example that is used is, in a hospital situation, if a patient does not change beds and moves into hospice inpatient and stays in the same bed, does his name simply change at the nurses' station from hospital to hospice without the patient's knowledge? You know?

And in a community like ours where we have had hospice for 10 years, there is a fabulous knowledge at the grassroots level of what hospice means. But other communities may not have such community understanding.

Senator **Durenberger**. My second question deals with the home as part of hospice. Would you agree that home care should be a basic element of the hospice benefit? And were we right or wrong in adopting a 20-percent inpatient limit as a way of assuring home-based care?

Mr. **Gaetz**. Mr. Chairman, I think that the mainstream of hospice in this country reflects that hospice is home-care first. I think whether 80–20 or 70–30 or 85–15 are the magic numbers only experience will tell.

The problem with the regulations right now, Senator, is that the Department has gone beyond what we believe is the intent of the statute and has turned the 80–20 requirement from a condition of participation into a payment-denial mechanism, which is extremely unfair to hospital-based hospice programs.

In other words, what the Department has done is, they have indicated that if there is even a slight variance from the 80–20 that they will not allow a plan of correction as other medicare providers are enabled to do if there is a variance from a condition of participation, and instead payments will be withheld and denied from the hospice program without a chance to correct. That I think is a more serious and timely problem, given the situation we face today.

Again, I don't believe that legislative action is necessarily required there; but I believe that the regulations should and must be changed so that there is not a payment-denial mechanism where the Congress, we believe, meant a condition of participation.

Senator **DURENBERGER**. I think what I'm going to have to do, with apologies not only from me but from the chairman and other members of the committee, is to thank you, and to excuse you.

We are now on 10-minute votes—another 5 or so. So for the rest of you I'm going to consult with the chairman and find out how quickly we can be back. But thank you very much for your testimony.

[Whereupon, at 3:28 p.m., the hearing was recessed.]

AFTER RECESS

Senator **DOLE**. We will now move on to the second panel: Margaret Cushman, Dr. Schultz, and Beverly Tirrell.

They have now shortened the vote to 10 minutes, so it will even be more hectic than before. We know that many of you came long distances, and we regret that we have to sort of have a yo-yo hearing here. Otherwise you would have to wait until evening, and I think you would probably prefer not to do that.

So if you can summarize your statements, they will be made a part of the record in full. Again, I will start taking the testimony, then I will have to leave and Senator Durenberger hopefully will be here at that time.

Proceed in whichever order you wish.

STATEMENT OF RICHARD D. SCHULTZ, M.D., MEDICAL DIRECTOR AND PRESIDENT, GOLD COAST HOME HEALTH SERVICES, INC., AND HOSPICE OF GOLD COAST, POMPANO BEACH, FLA., ON BEHALF OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC., WASHINGTON, D.C.

Dr. **SCHULTZ**. Senator Dole, thank you.

I am Dr. Richard Schultz, medical director of the Hospice of Gold Coast, from Florida. I think that I am speaking for the rest of the members of the panel right now and representing the American Federation of Home Health Agencies.

First of all today I would like to make the point, stress the point, that hospice should not be construed as a new health care delivery system, but, rather, this is a nontraditional concept of health care which I think should be incorporated into our already very adequate and excellent health care delivery system in the United States.

Some of the existing hospice agencies are going to find it difficult to live with the proposed rules and regulations for several reasons.

I feel that hospice needs to be an all-inclusive aspect of medical care, not just incorporated into a handful of agencies which tend to monopolize the entire hospice program.

The points that I would like to stress today deal first with the very strict regulation regarding the contract which needs to be drawn up between an inpatient facility and the existing hospice. I feel this contract is very limiting. It is binding both the hospice and the inpatient facility; it is creating numerous possible legal ramifications, which hospices are not able to fathom at all in this day and age. Certainly in Florida what we don't need is higher malpractice premium rates.

The problem that we have in our particular area is that our patients come from a community which encompasses approximately 29 hospitals. It's obviously impossible for the hospice physician to be on the staff of each hospital; therefore, to bring up my second point, it is absolutely necessary that the primary attending physician be continued in the care of this terminally ill patient. This is no time to dump this patient into the hands of a new physician with whom he is not at all acquainted.

If there is one point that I would like to make today for everyone to take home with them, it is the fact that I feel for the first time in the history of medicine and medical care, the hospice concept finally encompasses the entire patient. It is a holistic approach to a complete individual.

No longer, in the hospice concept, is a patient "the gentleman in room 500 with the gall bladder," or "the lady in room 612 with a brain tumor."

In order for hospice to work in this country, it needs to encompass the entire patient, which includes their family, their friends, their loved ones, even their little quirks and their superstitions. This is the only way the hospice concept can grow and develop, and this is what we all want to see it do.

If any of us can answer questions which perhaps will be raised by this testimony, we would be happy to do so.

Thank you.

[The prepared statement of Dr. Richard Schultz follows:]

STATEMENT
OF THE
AMERICAN FEDERATION OF HOME HEALTH AGENCIES

ON
MEDICARE HOSPICE REGULATIONS

BEFORE THE
SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

SEPTEMBER 15, 1983

PRESENTED BY
RICHARD D. SCHULTZ, M.D.

SUMMARY

Hospices currently have little or no legal liability for actions taken by inpatient facilities in treating the hospice patient. AFHHA is concerned however, that the Medicare hospice regulations will now subject hospices who contract with an inpatient facility to a variety of possibly insurmountable legal obstacles by mandating a shared liability between hospice and hospital for inpatient treatment. Shared liability will preclude participation in the Medicare hospice program by hospices in many areas because of state or local requirements regarding the legal responsibilities of the hospitals. AFHHA urges modification of HCFA's regulations to eliminate provisions requiring shared liability which may be at odds with other legal responsibilities of the hospitals and would place an untenable burden on hospices.

These regulations also promote the use of two different physicians—attending and hospice—and increase the movement toward a separate delivery system for the terminally ill. Hospitals would be required to follow the dictates of the hospice physician because of the requirement for a legally binding contract, even if there is disagreement between the attending—often admitting—physician and the hospice physician, and even if the hospital determines that the actions of the hospice physician are not in the best interest of the patient. Decision making by the hospice rather than attending physician interferes with one of the most important methods of achieving continuity of care—the active involvement of the patient's own attending physician, who cannot have ultimate responsibility for his/her own hospice patient without becoming a hospice employee or volunteer. AFHHA urges a change in the regulations so that the attending physician can continue to supervise the care of his/her own patients and be paid for the care provided, as the Medicare program currently allows.

Mr. Chairman, my name is Dr. Richard Schultz. I am President, Medical Director, and Chief Fiscal Officer of the Hospice of Gold Coast and the Gold Coast Home Health Services of Pompano Beach, Florida. I am here today as the spokesperson for the American Federation of Home Health Agencies, a national association representing the concerns of both nonprofit and proprietary home health agencies and the patients they serve throughout the country.

I am accompanied here today by Mary Fay Verville, who is the Director of the Hospice of Gold Coast and the Gold Coast Home Health Services, and is also Chairman of the Hospice Committee and a member of the Board of Directors of the American Federation of Home Health Agencies.

We appreciate this opportunity to discuss with you today our concerns about HCFA's recently published hospice regulations.

I believe that it is appropriate for me to begin with a very brief description of my own involvement with hospice. With the establishment fourteen years ago of Gold Coast Home Health Services, the oldest private non-profit home health agency in Florida, we made a commitment to provide quality care to meet the needs of a community which had <u>no</u> adequate home health agency when I began my practice in the mid 1960's. In 1977, our agency's census indicated that twenty-five percent or more of our patients were terminally ill individuals who wished to remain in their own homes in their last days. At that time, our home health agency made a commitment to develop and train an interdisciplinary team for palliative care. It is this concept which has today come to be called "hospice" care.

It is within this context that we wish to raise the following concerns about the proposed rules on hospice care issued by the Health Care Financing Administration.

The Medicare statute requires that a hospice, which is a <u>concept of non-traditional care</u>, exercise "professional management responsibility" for non-core services that are provided through arrangements with other health care providers in the community. The legislation, Section 1861 (dd) (2) (A) (ii), does not define this critical term, although the Proposed Rules, 42 CRF Section 418.56 (e), is very specific in relation to the inpatient care standard. This section, as written, subjects providers that may undertake to contract with an existing facility to a binding written agreement that results in a variety of legal liabilities.

The requirement that all Medicare payment under the hospice benefit flow through the hospice does not need to dictate a change in the nature of current arrangements between home-care based hospices and inpatient facilities. These arrangements are informal written agreements providing for continuity of care, with little or no legal liability for the hospice. The proposed rule would require that these current agreements be converted to formal contracts to purchase services and thus creates a shared liability between the hospice and the hospital. This type of formal contract and the prospect of increased legal liability for the quality of care and patient management has caused much concern among the home-care based hospices. The concept of assuming shared liability for the malpractice risk exposure created by medical decision making in an acute care setting may present an obstacle to the participation in Medicare by many home-care based hospices because of licensure laws and legal responsibilities of hospitals, with whom they would be required to enter formal agreements.

The proposed rule requires legally binding contractual commitments that may be at odds with other legal responsibilities of those hospitals.

For example, the rule requires that a part of the contract specifies that the patient care management and plan of care decisions are the ultimate responsibility of the hospice interdisciplinary team (418.56 (e) (6)), which would include the hospice medical director. The hospital would have to prospectively promise to follow the dictates of hospice physicians on the care to be provided hospice patients. These commitments must be made without regard to whether there is disagreement between the attending physician, who may have admitted the patient, and the hospice physician, who, in accord with Section 418.54 of the proposed rule, must manage the care. And, under this provision, the hospital would be required to follow the instructions of hospice physicians without regard to whether the attending physician or hospital staff believed that specific hospice instructions in an individual case were in the patient's best interest. Consequently, the hospital would be faced with two competing legal obligations: one to follow the hospice physician's dictates per contract, and the other to provide care that is deemed necessary, appropriate, and in the patient's best interest. The only legally and ethically valid course for the hospital would be to act in accord with its quality of care standards and the decision of the attending physician.

Although the rule is designed to ensure continuity of care for critical aspects of hospice care, the core service requirement at Sections 418.80 - 418.88 restricts one of the most important methods for achieving continuity of care—active involvement of the attending physician. Even though the statute (Section 1861 (dd) (3) (B)) and legislative history recognize that the attending physician is the physician identified by the patient "as having the most significant role in the determination and delivery of medical care," Section 418.86 of the proposed regulations prohibits the attending physician from being the physician member of the interdisciplinary team unless he/she becomes an employee of the hospice or donates his/her services as a volunteer to the hospice.

Since the proposed rule (Section 418.304) would subject attending physician payments to the hospice cap amount when the attending physician is an employee, there are payment disincentives for both the physician and hospice program to establish an employment relationship. The statute's preservation of coverage for non-employee attending physician services is also <u>not consistent</u> with the requirement that substantially all hospice physician services be provided by hospice employees or volunteers.

If the attending physician and the hospice team physician are not the same person, most likely the attending physician would have hospital privileges and admit hospice patients to inpatient facilities. By promoting the use of two different physicians—attending and hospice—the proposed regulations increase the potential for conflicting medical opinions on appropriate care for hospice patients. Such conflicts will increase stress for patients and carry significant legal concerns with respect to the professional management required, as I have discussed above. The incentive for separate attending and hospice physicians will also perpetuate and increase the movement toward a separate delivery system for hospice care. I do not believe this was the intent of Congress. Promoting involvement of the attending physician in the delivery of both traditional curative care and non-traditional hospice care would best suit both the patient and Medicare program objectives.

Section 418.3, which defines hospice employee, complicates the problem. It provides that volunteers would be considered employees of the hospice. This provision would jeopardize the services currently volunteered to hospices by some attending physicians. Many attending physicians volunteer their services for some hospice services (typically as medical directors, team planning or inservice staff training) while seeking payment for other services (typically, for medical care rendered to their own patients). Deeming all volunteers to be employees also raises a host of legal issues in regard to concerns such as employee rights and termination of services, provision of health insurance and other employee benefits, and responsibility for malpractice insurance.

In order for a home-based hospice to participate in this Medicare hospice benefit, we believe the following changes should be made in the proposed regulations:

1. Modify the professional management requirements to provide the flexibility necessary to allow contract providers to meet all of their own legal obligations, by focusing on the establishment of procedures between the hospice and the contract provider that address coordination and continuity

of care planning, rather than mandating restrictive regulations without regard to other legal obligations, specifically in relation to the Inpatient Care Standard (418.56 (e)).

2. Modify the all or nothing regulation deeming volunteers to be employees in order that the attending physician could participate as the professional manager of his/her own patients and be paid for the medical care he/she provides, as is currently done for Medicare beneficiaries (418.304 and 418.3).

We appreciate the opportunity of testifying today, and would be happy to answer any questions that members of this Committee may have.

STATEMENT OF MARGARET CUSHMAN, R.N., M.S.N., EXECUTIVE VICE PRESIDENT, VISITING NURSE AND HOME CARE, INC., HARTFORD/WATERBURY, CONN. ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE, WASHINGTON, D.C.

Ms. CUSHMAN. My name is Margaret Cushman, R.N., M.S.N. I am the executive vice president of Visiting Nurse and Home Care of Waterbury/Hartford, and I am here representing the National Association for Home Care, as chairman of its Government Affairs Committee.

We would like to commend you in holding these hearings. We are concerned that if Congress doesn't act quickly to amend the law there will be legitimate providers, including many public, city, and county health departments, particularly in rural areas, not able to participate.

We also believe the hospice benefit is deficient with respect to its lack of emphasis on quality of care and strict accountability standards.

First, while the statute requires hospices to file cost reports, HCFA has taken the position of asking them to have ready cut-down version of the normal medicare cost report. We believe providers should have to submit the same detailed cost reports under the hospice benefits that they are required to do for other aspects of the medicare program.

Second, opportunities for fraud are multiplied by the insistence that providers already in the medicare program just as hospice inpatient care contracts require.

Third, there should be minimum Federal standards for all personnel qualifications; there should be volunteer standards; and there should be specification of services covered and not covered under the waiver.

Finally, provisions should be made to allow a physician who serves as both the attending physician and as the hospice voluntary physician to receive reimbursement.

Franchising should be disallowed until after the 3-year demonstration period, and hospices should be allowed to subcontract with other medicare-certified providers for nursing services, with appropriate contractural guarantees for continuity of care and professional management responsibility.

Thank you for the opportunity to present these comments. We will submit a written, more-detailed testimony.

Senator DURENBERGER. Right. I would say that your entire statements will be made a part of the record.

[The prepared statement Margaret Cushman follows:]

Testimony of
MARGARET J. CUSHMAN, MSN, RN
Executive Vice President
Visiting Nurse and Home Care, Waterbury-Hartford, Connecticut

on behalf of the
National Association for Home Care

Presented to the
Subcommittee on Finance
U.S. Senate

September 15, 1983

My name is Margaret J. Cushman, MSN, RN. I am Executive Vice President of Visiting Nurse and Home Care located in the Waterbury-Hartford region of Connecticut. I am here in my capacity as Chairman of the Government Affairs Committee of the National Association for Home Care (NAHC).

Our Association is the nation's largest professional organization representing the interest of some 2,000 home health agencies, hospices and homemaker/home health aide organizations.

We would like to commend you on holding these hearings. We believe there are severe problems both in the hospice law as enacted by the Congress last year and in the regulations recently promulgated in proposed form by the Department of Health and Human Services. Since we represent more hospices than any other organization we are here asking your help to remedy what we believe are serious problems.

We come before you today with the concern that if the Congress does not act quickly to amend the law, legitimate providers including many public, city and county health departments and particularly those in rural areas, may not be able to participate in the hospice benefit. At the same time, we think the serious lack of quality and fiscal controls leaves the program highly susceptible to fraud and abuse by those the Congress has put in a preferred position through legislation.

Our national organization has made a serious effort to encourage ethical behavior and high quality of care in the home care field. We have promulgated and enforce what we believe is one of the toughest Code of Ethics established by any professional association.

We are proud of the fact that historically there has been little fraud and abuse perpetrated by home care providers. We know of only 5 convictions going back 10 years in both the Medicare and Medicaid program. In New York State, which alone accounts for almost 25 percent of Medicare and Medicaid funds and which has the nation's most aggressive anti-fraud unit, there has only been one conviction as compared with the hundreds of others in other provider categories who have been convicted.

While we are proud of this historical record, it is clear that we cannot relax. Senator Roth held important hearings in 1981 which demonstrated that there is the potential for fraud in this field as well. As more and more money moves to home care through both government and third party sources, it is obvious that it will attract unscrupulous individuals intent on taking advantage of the public trust.

We believe the hospice benefit is deficient with respect to its lack of emphasis on quality of care and lack of strict accountability standards. Following is a list of concerns we have which, as I have noted, have their basis in the statute but which are exacerbated by the proposed regulations.

(1) While the statute requires hospices to file cost reports, HCFA has taken the position of asking them to have ready a cut down version of the normal Medicare cost report. Only those providers who are asked for them will need submit them in any year. We believe providers should have to submit the same detailed cost reports under the hospice benefit that are required in other aspects of the Medicare program. Moreover, all providers should be asked to file them telling the public how they used government monies. Moreover, the reports should contain a legally verified attestation as to the truth and accuracy of the statements made in the cost report. Absent this kind of provision it will be impossible to convict a hospice provider for fraud.

(2) The opportunities for fraud are multiplied because of the insistence that providers already in the Medicare program seek a second provider number for hospice. A hospital might have one number for its inpatient work, another for a skilled nursing unit, a third if it operates a home health agency and now a fourth if it operates a hospice. A provider bent on fraud can resort to double or triple or quadruple billing and charge the government two or three times for overhead and other costs unless there is some provision for common audit. We urge you to require common audits of providers with multiple Medicare numbers.

(3) There should be a prohibition against self-dealing between hospice employees, officers and directors, and firms in which they have a significant direct or indirect financial or ownership interest.

(4) Certification of the patient's terminal condition should be performed prior to each election period and must be done by both an outside physician and the hospice physician or medical director.

(5) An election form should be signed prior to each election period and certified legal guardians should be permitted to sign.

(6) The specific duties of the medical director and each member of the interdisciplinary team should be listed relative to the duties of the hospice. It should be clear he or she is the person legally responsible for medical care in the hospice. Minimum numbers of hours should be specified relative to the hospice's size and caseload. A minimum percentage should be set for the number of persons on the team who must be full time. As it currently stands, the hospice team is generally responsible for everything but no one is specifically responsible for anything.

(7) Volunteers should not be included in the definition of "employees" for reasons of liability and "professional management responsibility."

(8) The governing body's duties must be more specific and include evaluation of care without using hospice officers or employees for the evaluation.

(9) We feel that it is vital that there should be a patient's bill of rights included in the legislation. Such rights are spelled out with respect to patients participating in nursing homes and we see no reason why hospice patients shouldn't have the same protections.

(10) The standards promulgated for free-standing hospices and their inpatient units are inadequate. HCFA has mandated a watered-down version of the Medicaid standards applicable to Intermediate Care Facilities (ICFs). We think the proposed standards are deficient in the area of fire safety and the storage and administration of drugs and biologicals. We believe that hospice patients who are arguably more ill than those in Skilled Nursing Facilities (SNFs) are entitled to at least the same level of protection as patients in SNFs.

(11) The location of inpatient respite care (hospital, SNF, ICF) should be determined by the certifying physicians and reimbursed accordingly at a level which permits optimum care.

(12) Services which may be contracted out should have specific minimal requirements regarding continuity of care, quality of care, and professional management responsibility (beyond those of Section 418.56(b)) just as the hospice inpatient care contract requires.

(13) There should be minimum Federal standards for all personnel qualifications. State requirements should apply only where HHS deems them more stringent.

(14) Volunteer standards should have a specific training curriculum. There should be an interdisciplinary team written certification of a volunteer's qualifications to do specific direct patient care.

(15) There should be specification of services covered and not covered by other Medicare benefits and supplemental sources so as to better inform patients and families and safeguard them against possible fraudulent insurance schemes. Specification would include:

a. Specific services still covered under the waiver should be delineated.

b. Specific supplemental coverage (family, self-pay, private pay) allowable while under the hospice benefit must be specified.

c. Other Medicare reimbursable services usable after the 210 days expire must be specified for persons remaining under a hospice's care.

(16) Provisions should be made to allow a physician who serves both as an attending physician and voluntarily as the hospice physician (or medical director) to be reimbursed as an attending, at least on a rural, underserved or sole community provider basis.

(17) Continuous home care should be reimbursable based on advance physician certification of such care being medically necessary and reasonable for a projected minimum/maximum range of hours.

(18) We believe that Congress should permit hospices to choose between having their claims processed by the designated intermediaries as spelled out in the regulations or directly by the Office of Direct Reimbursement. A good case can be made that ODR should be the only intermediary to administer the program. ODR has been the intermediary for the 26 demonstration projects which have been operating over the past 4 years. It is the only one with any experience in evaluating and paying such claims. Again it is the only intermediary which can provide national data. Since ODR is the second most efficient (only one of 76 intermediaries administering the Medicare program had lower costs per claim last year) and it is connected with the government, ODR is in the best position to give the Congress the data that it needs when it is considering whether to extend the program in 1986.

(19) The Congress should wait to consider whether it would allow the franchising of hospice programs until after the program has been evaluated in 1986.

(20) Hospices should be allowed to subcontract with other Medicare certified providers for nursing services with appropriate contractual guarantees for continuity of care and professional management responsibility. Such a change in the law is necessary to provide effective and efficient competition and use of resources.

This issue is of crucial importance to an estimated 50 percent or more of the very hospice programs which impressed Congress enough to secure passage of the Medicare hospice benefit. The inability to have reasonable flexibility in subcontracting for nursing services severely limits the ability of many existing programs to continue and new ones to be created. The problem is particularly acute in rural and underserved areas where flexibility in subcontracting for nursing services is the only way hospice care can be provided. The combination of limited manpower and limited fiscal capital investment monies in such areas makes subcontracting flexibility essential. There are areas where there are only a few nurses in a large geographic area. They cannot be hired directly. No hospice will exist in such areas if subcontracting is not permitted.

These problems also extend to volunteer-based and small to middle-sized hospices, regardless of location, which can't afford the significant fiscal cost of labor and administrative expenses incurred when hiring all core service persons as direct employees.

And the inability to subcontract for nursing services poses problems for many hospital-based hospices, regardless of geographic location. The Joint Commission on Accreditation of Hospitals hospice project reports that 40 percent or more of existing hospices are hospital-based. A large portion of these hospitals arrange their home care component of hospice care (that is, nursing) with Medicare-certified home health agencies. To ban subcontracting for nursing services will force hospital-based programs either to drop their program (particularly in areas where pressures are great on hospitals, especially non-profits) or create their own home care programs. If the latter occurs, the Medicare hospice program aimed at cost-effectiveness ironically may spawn even more home health providers, even in areas where additional home health agency markets are saturated. This is not economical. It is not cost-effective.

We believe all of these recommended changes can be made by changes in the regulations except for the ability to subcontract for nursing services and a ban on chain and franchising hospice operations. We urge you to amend the law to allow for such subcontracting.

There currently are two bills pending in Congress which could accomplish this purpose. One is H.R. 3588, introduced by Congressman Bill Ratchford (D-CT). This bill would permit hospices to subcontract for nursing services only with Medicare-certified providers. We feel this is the most sensible approach.

Another bill (S. 1511/H.R. 3696) has been introduced by Senator Roger Jepsen (R-IA) and Congressman Norm Dicks (D-WA). This bill is more limited than H.R. 3588. It would allow two groups of hospices to subcontract for nursing services with Medicare-certified providers. One group would be any entity providing hospice services and either licensed by or legally incorporated in a State as of the enactment of TEFRA of 1982. The second group would be any hospice located in a qualifying rural or underserved area.

While we believe H.R. 3588 is the most appropriate approach, at a minimum, we feel the S. 1511/H.R. 3696 provisions must be enacted. These would at least protect those community-based hospices existing prior to TEFRA whose existence has been predicated on the ability to subcontract for nursing services. It also would insure that rural and other underserved communities with limited nurse manpower could be served by a hospice.

Given that HHS has taken nearly ten months to develop the proposed regulations and still has omitted significant fraud, abuse and quality of care safeguards, we also urge you to adopt a series of anti-fraud and quality of care amendments as we've suggested before November 1st.

I thank you for the opportunity to share our thoughts with you today and remain available to assist in any way possible.

Senator **Dole**. I think we will take just a brief recess. I have about 4 minutes to make the vote. I think Senator Durenberger is on his way and should arrive momentarily. Maybe if you would just remain seated, we will hear Beverly.

[Whereupon, at 3:43 p.m., the hearing was recessed.]

AFTER RECESS

Senator **Durenberger**. Our third witness—[laughter].

Or, our eighth witness: Beverly Tirrell.

We welcome you.

STATEMENT OF MS. BEVERLY TIRRELL, EXECUTIVE DIRECTOR, SOUTH PORTLAND HEALTH SERVICES; PRESIDENT, MAINE COMMUNITY HEALTH ASSOCIATION, PORTLAND, MAINE

Ms. **Tirrell**. Thank you, Senator Durenberger.

It is a pleasure to be here. With me is Marshall Cohen, the executive director of the Maine Community Health Association.

I represent an organization whose membership is composed of virtually every community health agency in the State of Maine. We are a small rural State, and community health agencies have been providing hospice-type care for several years now.

I come to you with some very specific concerns about the regulations.

First of all, in terms of the subcontracting issue, I propose that that is not adequate for the State of Maine and that, indeed, because of the lack of the subcontracting and the nursing shortage that Maine has presently, it would preclude many agencies from providing hospice care.

In terms of hospice issues, I believe that the proposed regulations would increase costs to medicare in the State of Maine. It will not only increase costs to agencies because of the provision of having to go and apply for a separate provider number, but it will also increase the costs to the State of Maine in terms of their role of having to survey agencies.

Another concern is the patient election and its inflexibility. The regulations impose barriers which I feel will keep many Maine residents from participating in a hospice program, and I would urge that there be more flexibility in terms of the patient election.

In summary, I would like to say that for the State of Maine the proposed regulations may destroy the existing system that we have to provide hospice care; second, that the regulations will definitely increase costs for home health agencies and patients; and that, third, the regulations pose barriers to patients' participation in the program.

Thank you.

[The prepared statement of Beverly Tirrel follows:]

Testimony of
The Maine Community Health Association, Inc.

To

The United States Senate
Committee On Finance
Subcommittee On Health

Hearing On
Medicare Hospice Regulations

September 15, 1983
Washington, D.C.

Presented By
Ms. Beverly Tirrell, R.N., C.N.A.
President
Maine Community Health Association

Senator Durenberger and members of the Committee:

My name is Beverly Tirrell and I am President of the Maine Community Health Association, which is made up of 15 non-profit and proprietary home care agencies serving every county in Maine. Our agencies provide visits each year to more than 50,000 Maine citizens, the majority of whom are frail elderly people.

We greatly appreciate the opportunity to provide testimony to the Senate Subcommittee on Health regarding the Medicare Hospice Benefit because of our long standing history of providing care for the terminally ill and our great concern over what the Medicare benefit, as now constituted, means for our ability to provide that care.

Home care agencies in Maine provide a very wide range of services to people in their homes and in the community. We provide the traditional home care services, such as skilled nursing, physical therapy, occupational therapy, social work, speech therapy, homemaker and home health aides. We also do much more, such as long term care, communicable disease control, maternal and infant care, blood pressure screening, referral and follow-up and, most importantly for today's hearing, care of the terminally ill.

We believe it is important for you to fully understand the way in which the terminally ill are cared for in our small, rural state. There are four important elements in how this care is now being provided and how future planning for this care is being developed.

The first element is our home health agencies. These agencies have been caring for the terminally ill as an integral part of their continuum of services for many years. We have not only been providing direct nursing and related skilled care; we have been arranging for other components of care equally important; respite, transportation, pastoral, counseling and so on.

As the hospice movement has spread in recent years, volunteer community resources came together with home health agencies to organize volunteer hospice services. As a result we now have 20 volunteer hospices in Maine. That is the second element of our system.

Earlier this year Blue Cross/Blue Shield of Maine, recognizing the developments I have described, and realizing the importance and value of hospice care, initiated a joint pilot program with our home health agencies to determine how insurance coverage for care of the terminally ill can best be provided. The focus of this pilot is to provide benefits for terminally ill patients through Blue Cross' existing Coordinated Home Health Program. Blue Cross decided that they should integrate this insurance coverage into their existing system rather than create an entirely new benefit program. This integration, accomplished primarily by waiving several requirements of their basic home health coverage plan, has resulted in strong support by home health and hospice organizations for the Blue Cross approach, and virtually every home health agency in the state has signed onto it. It allows the patient to receive hospice benefits without waiving other potentially necessary benefits and without being forced into an awareness of the terminal nature of the condition, for which they may not be ready. We will not be able to say the same for the Medicare hospice benefit.

The fourth element in our system is the establishment of a future planning group. In the summer of this year representatives of home health agencies, volunteer hospices, insurance companies, hospitals, state government, elderly advocacy groups and other health care professionals came together, at their own initiative, to discuss and look at the development of hospice care in Maine. This group is reviewing hospice standards, reimbursement issues, and is especially determined to impact public policy in and for the State of Maine.

Thus, we in Maine must look at the proposed Medicare Hospice benefit in the light of the developments described above. Our Association has done that. All of our agencies, with the assistance of legal and financial professionals, are reviewing the Medicare hospice regulations to determine their feasibility. While many decisions are yet to be made, I can report to you today that we have reached a clear consensus that as now constituted there are no incentives for our home care agencies to participate in the Medicare program for hospice. Likewise, there is a clear concern as to what the effects of a decision not to participate will mean for the citizens of Maine who are and will be eligible for this benefit.

The failure of many of the regulations to address the true needs of a viable, cost-effective hospice program, along with substantial legal and financial risks, are the basis of our concern. Following are some specific examples:

1. The intentions of Congress in enacting this benefit were laudable and we note with great pleasure that several of the statements included in the preamble to the regulations indicate an understanding and philosophy consistent with our view, and the view of others in the hospice movement, of care for the terminally ill.

Unfortunately, we must note with great concern that the reality of the regulations will not allow that philosophy and understanding to happen, at least through the Medicare program.

2. The statutory requirement for nursing services to be offered directly by the Medicare certified hospice virtually precludes rural home health agencies from becoming Medicare certified hospices. Let me explain this dilemma through use of a specific example.

One rural home health agency has committed its resources to seeking that comprehensive hospice care is a reality for the people they serve. The major hospital in the community has recognized their key role in hospice care as well. Therefore, they have joined together through an interdisciplinary team, to develop shared beliefs and goals about hospice care. With these as their foundation, they logically wished to pursue the coalition model of providing hospice care which would contract with community organizations, including themselves for the needed services.

The law as it presently stands would not allow this. In pursuing models of hospice programming which exclude contractual arrangements for nursing services, this community is faced with duplication of nursing services coupled with an already evident shortage of R.N.'s and L.P.N.'s.

Duplication should be of great concern to the payors of services as well as providers. One of the rural counties served, with 888 square miles and 27,013 people, has a population density of 30 people per square mile. On an average, a full-time nurse travels 14,000 miles per year to provide nursing services to residents of that county. Currently, there are four full-time equivalent nurses assigned geographically and providing care to patients with all types of disease, including the terminally ill. If a duplicate nursing service was set up to care exclusively for hospice patients, the cost to Medicare would be unnecessarily high in view of the extensive travel and duplicative general and administrative expenses spread over a small base of operations.

In addition, recent attempts to recruit licensed nurses (both R.N.'s and L.P.N.'s) for this rural area have been frustrating since there have been few or no applicants. What applicants there are very often have no experience in home health care in general, not to mention care of the terminally ill or elderly.

3. The requirement of a separate Medicare provider number for hospice agencies presents unique circumstances for the existing certified home health agencies.

Agencies who wish to provide hospice services to Medicare beneficiaries and receive reimbursement for services would seek certification through the State Agency. Upon completion of the certification eligibility requirements the State Agency submits the applicant provider's certification package to the Regional Office for review, final determination and approval. Regional Office approval thus enrolls the hospice agency into the Medicare program and assigns the agency a provider number. For the vast majority of potential hospice providers in Maine this will require that a second provider number be sought by agencies that have existing provider numbers for Medicare home health participation.

This means two things: (1) additional costs will be incurred by agencies starting hospice programs in Maine, and (2) additional costs will be incurred by the Maine Department of Human Services to conduct yet another certification survey on already certified agencies. This duplication of effort is costly, ill advised and contrary to the efforts of government and the health care industry to contain health costs.

With good reasons many home health agency providers are unclear as to whether they should seek Medicare reimbursement as a hospice or continue to provide home care services to the terminally ill under traditional agency programs and services.

In addition, the regulatory requirement to have a separate hospice provider number may negatively impact a home health agency's cost report. If, for example, a home health agency elects to become a hospice provider and provides care services itself under its own organizational structure, those costs of services will be recorded in the agency's general ledger.

The potential problem lies in the methodology of cost reporting required of home health agencies. The Medicare cost report provides for the step-down of overhead costs based upon the cost of the various reimbursable and non-reimbursable cost centers within the individual agencies. Under the hospice reimbursement system, with two provider numbers, a significant amount of overhead costs may be allocable to the hospice based upon the process used in the cost report. If the hospice reimbursements a home health agency receive do not compensate for the overhead allocation, the home health agency will incur a deficit caused by the requirements of current cost reporting. The net effect of an agency deficit could potentially destroy the home health agency's fiscal integrity and jeopardize the provision of services to all Medicare beneficiaries. Clearly, home health agencies will be caught in the regulatory web of cost reporting requirements.

In Maine, this very dilemma has been demonstrated in agencies beginning to provide long term care (extended hours of services) programs. If long term care services reimbursements don't adequately compensate for the overhead allocable to the long term care program, the results are devastating, particularly to the medium and smaller sized agencies. The identical situation exists for all non-reimbursable programs in Medicare certified home health agencies.

There should be no separate hospice provider number required for existing Medicare certified agencies wishing to provide hospice care.

4. The continuous care requirement of preponderance of nursing care may result in an unnecessary level of care which costs more than home health aide or homemaker care.

Most hospice patients do not need 8-24 hours of licensed nursing care, even though they may desire that kind of support. The experience in Maine in caring for terminally ill patients has proven that the type of care needed over a period of a day is the home health aide level of care which is much less costly than licensed nursing care. We suggest that a revision be made in the regulations to allow home health aide and homemaker care to be covered under the continuous home care rate regardless of whether skilled nursing care is the preponderance of care.

5. The requirement that only the patient can elect the hospice benefit poses a serious obstacle to reaching the many people who might need the care. For example, it may be evident to the interdisciplinary team and family a patient has only a few weeks to live, yet the patient may continute to refuse to accept the

the terminal illness. The family wishes to elect the hospice benefit because of the support and help it gives them and the patient in dealing with the remaining days of life. However, the proposed election system does not allow a family in this situation to elect Medicare coverage. In fact, it almost appears through the proposed regulations that the Medicare hospice beneficiaries will be a select group of people who have had the educational, emotional, and financial breaks in life to enable them to deal head-on with their death. Our experience as providers of care to the terminally ill is that the ability to accept dying is a major struggle and one that for many just does not happen. The preamble to the regulations recognizes the goal of hospice care is to help the terminally ill continue life with minimal disruption in normal activities while remaining in the home environment.

We must recognize that it may be essential that the best way for one individual to continue his or her life with minimal disruption while remaining at home is to deny the fact that he or she is terminally ill.

6. In the proposed regulations (Sec. 418.22), the hospice must obtain the certification that an individual is terminally ill and that the individual's medical prognosis is that his or her life expectancy is six months or less. It has been our experience in Maine that many physicians - specialists and generalists alike - have not been able to admit to the patient that he or she will die within six months and would benefit from the specialized services of a hospice. One physicians expressed the opinion that to certify imminent death and the need for hospice is

equal to abandoning all hope for his patient and admitting that nothing more can be done to preserve life. This particular physician is unwilling to accept the role of a "certifier" of near-future death. We believe that regulations that require certification of death within six months or less violate many physicians' basic philosophy of practicing curative medicine.

Physicians are in a "gatekeeping" role in referring patients to appropriate sources of care. This role is vital to the viability and cost-effectiveness of the health care continuum and must not be upset by regulations that offend many physicians.

Furthermore, this regulation creates still one more obstacle and roadblock to individuals and families in need of hospice care and the Medicare benefit.

The "six months certificate of death" should be removed from the regulations.

7. Critical legal requirements for the patient's informed consent form are lacking. Since the patient electing hospice care is giving up certain other benefits, the consent form requirements absolutely must include a clear delineation of what the patient is giving up, what the alternative is that they are electing, what the risks are involved with those alternatives, what right there is to revoke the election,what right there is to select another hospice, and what right there is to see members of the clergy. Given the legal ramifications of an informed consent, for quality assurance purposes, and protection of providers, patients and families, we believe it imperative that H.C.F.A. require the above items on the informed consent form.

8. The requirements for volunteer participation do not address the legal implications of use of volunteers. The governing body of the hospice will be responsible for the action of the volunteers and, therefore, the regulations should require certain quality assurance standards for the volunteers such as liability insurance coverage.

9. The regulations are seriously lacking when it comes to appeal rights, both for patients and providers.

Patients have few rights in the procedures established by these regulations, lacking even the basic right to appeal denial of admission into the hospice. A patients bill of rights is needed.

Providers have no appeal rights for critical certification and coverage disputes. Providers of hospice under Medicare should be entitled to the same rights and procedures of appeal as any other Medicare provider.

I have provided you today with a summary description of our home health system in Maine, our concerns about the problems these regulations present to Maine people and our suggestions for resolution of some of these problems.

I would like to conclude by presenting our suggestions and recommendations for steps the Congress should, in our judgment, consider not only to ameliorate these vast and serious problems, but to develop a policy and program of care for the terminally ill that will truly result in community based hospice coalitions and free-standing hospices capable of providing all the patient and family centered services needed with adequate and efficient reimbursement through Medicare. We in Maine want to work a Medicare benefit into our current programs, as we have done under the Blue Cross/Blue Shield pilot program. Instead, we are being forced to take a great many complicated, risky and costly steps to qualify our patients for the Medicare hospice benefit under these proposed regulations.

What should Congress do?

Congress must assure itself and the American people that hospice regulations more clearly reflect the needs of patients, families and providers in the provision of hospice care.

Congress should enact amendments to the law that may be necessary and appropriate to eliminate problems created by the regulations.

Congress should look not only at the H.C.F.A. hospice demonstration projects for information and evaluation, but should utilize the unique strength of the hospice and home care movements in America, recognizing their history, use of volunteers and community resources. You should also look at private third party hospice and home health payor programs as I have described here. Only by viewing all the hospice and home care activity now taking place will you get the full understanding you need to make policy.

Congress must take a long-term view of hospice and determine a national policy for care of the terminally ill that recognizes the uniqueness of this type of home centered health service, and the strengths of delivery systems which have been in place for the past decade.

Finally, Congress should translate that national policy into appropriate action through statute and regulations, and assure that the regulations faithfully implement your policy.

Thank you again for the opportunity to present our views to you. We look forward to the steps you will be taking.

Senator DURENBERGER. Thank you very much.

Obviously we are all going to be very concerned about that last statement that you just made about the regulations adding to the cost of delivering the services.

One of the questions I wanted to ask the last panel, also, I'll ask all of you to respond to, or any of you:

A hospice must meet a number of standards when it arranges for services which cannot be provided directly by the hospice. These include the need for a legally binding agreement and hospice retention of professional management responsibility for the services. To what extent, in your opinion, will these standards require modifications of a rather serious nature in your current arrangements? And will they in any way affect your organization's ability to arrange for needed services? And, if so, in what way?

Dr. SCHULTZ. Ms. Verville, why don't you respond to that?

Ms. VERVILLE. I will be glad to respond to it. Presently in the State of Florida we also are a State which has a licensure law and a certificate-of-need law for hospices. We have been able to work out with our medicare facilities in the geographic areas of where our patients are from a very simple written agreement providing continuity of care when that patient has to be admitted to an inpatient unit. And it has worked beautifully, because the attending physician gives the home care team the orders, and then he follows it right into the hospital and gives the orders there and has been very responsive in ordering palliative care.

With this legally binding contract as it is stated in the regulations right now, I don't know that our team or any hospital in my area will allow what is requested of those regulations. There is too much risk involved in liability, both for the hospice and for the hospital. No way can we ask that hospital to prospectively agree that our team is going to be able to dictate to their staff the care provided while they are in that hospital bed.

I just feel that the rule as it is written right now is much too restrictive. It can most certainly be simplified and it can be much more flexible so that every model of hospice can work within the rules and regs. The statute certainly is not that rigid.

[The information follows:]

Senator DURENBERGER. Are there any other responses? That was fairly comprehensive.

[No response.]

Senator DURENBERGER. The core service concept, as I understand it, was adopted to prevent the establishment of storefront organizations that would have little interest in the real needs of the patient.

How would the members of this panel suggest we prevent that kind of abuse while at the same time accommodating the concerns expressed here today about the restrictions involving core services?

Ms. CUSHMAN. I would comment that the proposal that the National Association for Home Care supports is that the subcontracting which is allowed for core services be with a medicare-certified provider. And certainly with existing certification processes, there are some assurances that these agencies both have to be competent to provide care, have been surveyed, that the quality of care is satisfactory within the existing medicare standards.

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HOSPICE
of Gold Coast
Home Health Services, Inc.

November 7, 1983

Edgar R. Danielson
Senate Committee on Finance
SH 231
Washington, D.C. 20510

Dear Mr. Danielson,

This is the type of agreement we have with 9 hospitals in our large service area which was mentioned by Mary Fay Verville in our testimony.

Sincerely,

Richard D. Schultz, M.D.
President/Medical Director

4699 North Federal Highway, Suite 205, Pompano Beach, Florida 33064-6597
BROWARD 785-2990 or 462-8390 PALM BEACH 737-8180 or 734-3474
A Licensed Non-Profit Agency

This Agreement made and entered into this ____ day of ______________ by and between the HOSPICE OF GOLD COAST HOME HEALTH SERVICES, INC. and ______________________________

PURPOSE

The purpose of this Agreement is to provide continuity of care to those patients, who had been cared for at home by the Hospice team, and have been admitted to ______________________________ by their primary care physician.

PROVISIONS

Hospice of Gold Coast Home Health Services, Inc. agrees:

1. To provide the nursing staff of the hospital with a summary of the plan of care and any pertinent information about the patient/family which will help in carrying out their professional duties when the patient is under their care.

2. To participate with other health personnel of the hospital in planning and evaluating the needs of the patient/family.

______________________________ agrees:

1. To allow the professional staff of the Hospice team, when recommended by the primary care physician, to visit with the patient/family while institutionalized.

2. To allow the Patient-Family Coordinator of the Hospice team to communicate directly with the charge nurse who is caring for the patient, so there will be continuity of care between providers.

Amendment to Original Agreement

This Agreement shall continue and be binding by both parties unless terminated by either party by the giving of 30 days written notice of intention to the other party.

Approved:

Administrator

Director
Hospice of Gold Coast Home
Health Services, Inc.

September 1983

Ms. TIRRELL. In terms of that issue, I feel that there will definitely be problems posed without the subcontracting ability.

In the State of Maine, for instance, where we have witnessed a nursing shortage, I am very concerned about hospice patients in the rural areas, in which perhaps nurses are not as available as in other areas of the State. And I feel that subcontracting, then, allows for hospice care to happen in a very cost-effective manner.

Senator DURENBERGER. Let me ask some questions about the present state of affairs. And let me go to the State of Maine:

To what extent does medicare currently reimburse member agencies for home health care services provided to terminally ill patients? Just give us a picture of today, so we can compare it with what we hope to see tomorrow.

Ms. TIRRELL. The development of care of the terminally ill in the State of Maine has been over a period of years. The certified home health agencies have been providing hospice-type services for many years now, using the existing organizations that have evolved in the State of Maine.

The volunteer hospice organizations in the State of Maine have been a grassroots development in which interested people, sometimes church groups, would get together and start providing the volunteer services.

Currently in the State of Maine, home health agencies have been quite successful in terms of caring for the terminally ill and providing all the services needed through arrangements with other organizations.

Now, currently in Maine, Blue Cross-Blue Shield has embarked on a pilot program which has enabled home health agencies to provide care of the terminally ill by simply waiving some of the previous regulations. And in terms of how we have been providing care for the terminally ill, it has been quite successful.

Senator DURENBERGER. But is Blue Cross-Blue Shield acting in their role as a medicare intermediary? Is that what you are saying?

Ms. TIRRELL. Under their program of coordinated home health care. There are several States that are embarking on pilot projects for hospice care.

Senator DURENBERGER. And what kinds of services are being reimbursed now, versus the kind of service reimbursement that we will see in the future under these regulations? Can you give us some examples of that?

Ms. TIRRELL. The kinds of medicare services that are being provided in the home care?

Senator DURENBERGER. Right.

Ms. TIRRELL. Skilled nursing services, home health aids, therapies—including physical, occupational, speech—medical/social services are being reimbursed, just a wide variety and array of services.

Senator DURENBERGER. Are you able, or do you have enough information so that you might be able to give me some notion in dollars-per-day that the current reimbursement system provides? About 50 percent? Or 60 percent? Or 70 percent of what you might be reimbursed for under the new system?

Ms. **Tirrell.** We can try to provide that for you, but I'm afraid I do not have those figures here.

Senator **Durenberger.** Why don't you give me a figure for Maine? I see another witness with figures.

Ms. **Verville.** Last year in our 1982 evaluation of our hospice team, our cost-per-patient came in at approximately $1,040-some odd dollars. Most of that, and I would say probably about $1,100, was reimbursed by medicare—the other is a voluntary component that, if I had to put a dollar and cents sign to it, it would bring it up to that—with the result, our patients' average length of service is 61 days, and it's coming in about $14 or $17 a day.

Senator **Durenberger.** Dr. Schultz?

Dr. **Schultz.** In our agency the benefits which a hospice patient would derive under the new law would include some reimbursement for medication and prescriptions. This is essentially the only thing extra that they will receive that they do not get now in some form or another.

We have been able to provide not only the skilled care but also respite care through donations, contributions to our agency. The patients up until this time have received all of the facilities and the care which will be available to them under the new law, with the exception of medication reimbursement.

Mr. **Cohen.** Senator, if I might, very quickly—we have discussed briefly in our written statement the Blue Cross Blue Shield pilot program, because one of the interesting things about it was that it was developed in such a way to coordinate with their home care reimbursement system that all of the agencies in Maine signed on and felt it was a very flexible system that was integrated with what they were able to do, which is a statement that we cannot say about the hospice benefit as now structured under the regulations.

We will provide to the committee some of the data that Blue Cross used in developing that, some of their cost data with respect to hospice care, and some information in more detail about the program for you.

Senator **Durenberger.** Thank you. That would be helpful.

[The data follows:]

Blue Cross
Blue Shield
of Maine

110 Free Street
Portland, Maine 04101
207/775 3536

October 25, 1983

RECEIVED OCT 2 8 1983

Ms. Beverly Tirrell, RN CNA
President
Maine Commmunity Health Association
114 State Street
Augusta, Maine 04330

Dear Ms. Tirrell:

We would like to thank you for your remarks before the Subcommittee on Health of the Senate Finance Committee regarding the recently published regulations for hospice reimbursement under Medicare. We were pleased that you were able to bring the Maine experience to the deliberations on this important issue.

As you know, Blue Cross and Blue Shield of Maine initiated a pilot program to test hospice care for the terminally ill last spring. This pilot is scheduled to run for another six months, with a three month extension to allow time for an evaluation. We believe, however, that this is an opportune time to share with you the experience we have gained to date. We also believe the Health Care Financing Administration and Congress may find this experience instructive.

When we developed the pilot, we were concerned that it be in tune with the conditions in Maine. The hospice movement in Maine was characterized by a number of all-volunteer groups which focused on providing emotional support to terminal patients and their families. If the patient was at home, medical type services would usually be provided by a home health agency. If the patient needed inpatient care he would be admitted to a nursing home or hospital, but the volunteers from the hospice group would continue to serve patients and their family wherever they were. We wanted our pilot program to respect this informal network of services which had developed independent of any reimbursement system. We were concerned that providing payment for some of these services would tend to threaten the community orientation and the sense of cooperation the hospice movement had acquired in Maine.

At the same time a small inpatient hospice unit had opened in Auburn, Maine. This unit was clearly dedicated to providing a kind of care that had not been available before to those patients who could not remain at home. We viewed this unit (The Clover Hospice) as a potentially valuable addition to the scope of services available to the terminal patient in Maine.

Our intention, then, was to develop a program that was suited to the actual conditions in our state, and to encourage the kind of networking that had already begun. We already had an excellent home care benefit in place and had participating agreements with home health agencies throughout Maine. We also had a benefit available for care rendered in Skilled Nursing Facilities. We decided simply to tailor these benefits to the hospice movement, by removing the existing requirement that the patient be homebound and need skilled care on the home side. On the inpatient side we waived our requirement that a skilled nursing facility be Medicare certified (Clover Hospice had been licensed as a SNF by the state, but had decided not to seek Medicare certification). These changes in eligibility requirements would be triggered by a physician's prognosis of death within six months.

Some things we decided not to do included: Requiring Volunteer Involvement. We believed that volunteers are key to a successful hospice program, but we did not feel our membership should be denied the benefits of this pilot simply because no one in their town had set up a volunteer program. There are many areas of Maine which are rural and quite remote. These areas are served by home health agencies which are able to provide incentives to their staff to make calls in the area. Very often, patients in these areas receive excellent "volunteer" support from neighbors, their clergy, and family members. We do not believe, however, that these people should be compelled to organize a formal volunteer program simply to satisfy some reimbursement criteria. Rather, we have been encouraging the natural growth of volunteer groups and have urged our home health agencies to work closely with such groups.

. Reimburse for Bereavement Counseling - One way to discourage the community/volunteer aspects of hospice is to professionalize all services. We believe that bereavement counseling is one of the most appropriate services volunteers can provide.

. Develop Hospice as a Wholly Separate Benefit - All the principles of reimbursement and benefits are the same for hospice care as for regular home health care. The changes we have made for hospice have been made administratively and communicated to the agencies. All they have to do is indicate on the form that this is a hospice patient and we take care of the rest. We felt it was important to integrate our hospice program into our regular benefits, both for administrative ease and because in practice there is not a very distinct and sharp difference between a patient who is terminal and another patient.

. Require Patient Awareness of the Prognosis - This is an exceedingly sensitive and individual process. We believe it would be an unwarranted intrusion into the physician-patient relationship for us, as payors, to have such a requirement.

We have compiled some data for you based on six month's experience with the pilot. Frankly, we had not intended to release anything until the pilot year was complete, but we recognize the importance of your deliberations and are happy to contribute in any way we can.

In the first six months of the pilot, thirty-three patients have been admitted to the program. Twelve of these have died, three were discharged to hospitals and one to a nursing home. All but three cases have been cancer patients. There have been twenty-two women and eleven men. The average age has been 59.7 (Table 1). Patients have come from 12 of Maine's 16 counties with four each from Penobscot, Knox, Kennebec, and York (Table 2).

Of the 33 patients, 30 have been in home-care hospice and only 3 have been at Clover Hospice. Eight agencies have been involved in the program to date. There have been 25 separate attending physicians. Only one has attended to more than 2 hospice patients. Physicians have been the primary source of referrals, referring 10 of the patients. Twenty of the patients have been admitted directly from a hospital (Table 3).

There have been some surprises in terms of costs and services rendered. For both inpatient and home care, we are well within our projected costs and the figures we projected for cost per day were very accurate. Our projections for numbers of patients and lengths of stay were way off, however. Under home care we've had twice the number of patients we expected but the average days in the program were almost half (Table 4). Just the opposite happened on the inpatient side. We've had less than one-third the number of patients but the length of stay has been more than double our expectations (Table 5). The main surprise in terms of services rendered is that only half of the claims received to date have included pharmaceuticals (Table 6). We don't yet understand the reasons for this.

Again it needs to be emphasized that this data includes only the claims received in the first six months, so it encompasses the first month in which agencies were just learning about the program, and excludes many claims for services incurred the first six months but not yet billed. The second half of the year may contain considerably different data.

I hope this information has been useful to you. If there is any other assistance we can render, we will, of course, be happy to offer it.

Sincerely,

Greg Scandlen

Greg Scandlen
Administrator, Research Services

GS/dmr

cc: Mr. Stephen W. Woodberry
Vice President, Community Services

The Honorable George J. Mitchell

TABLE 1

HOSPICE PATIENTS BY AGE/SEX

April 1 - Sept. 30, 1983

	Total	F	M
0-19	0	0	0
20-29	0	0	0
30-39	2	2	0
40-49	3	3	0
50-54	6	5	1
55-59	6	4	2
60-64	14	7	7
65 +	2	1	1
	33	22	11

Hospice Pilot Program

Patient Origins

April 1 -- Sept. 30, 1983

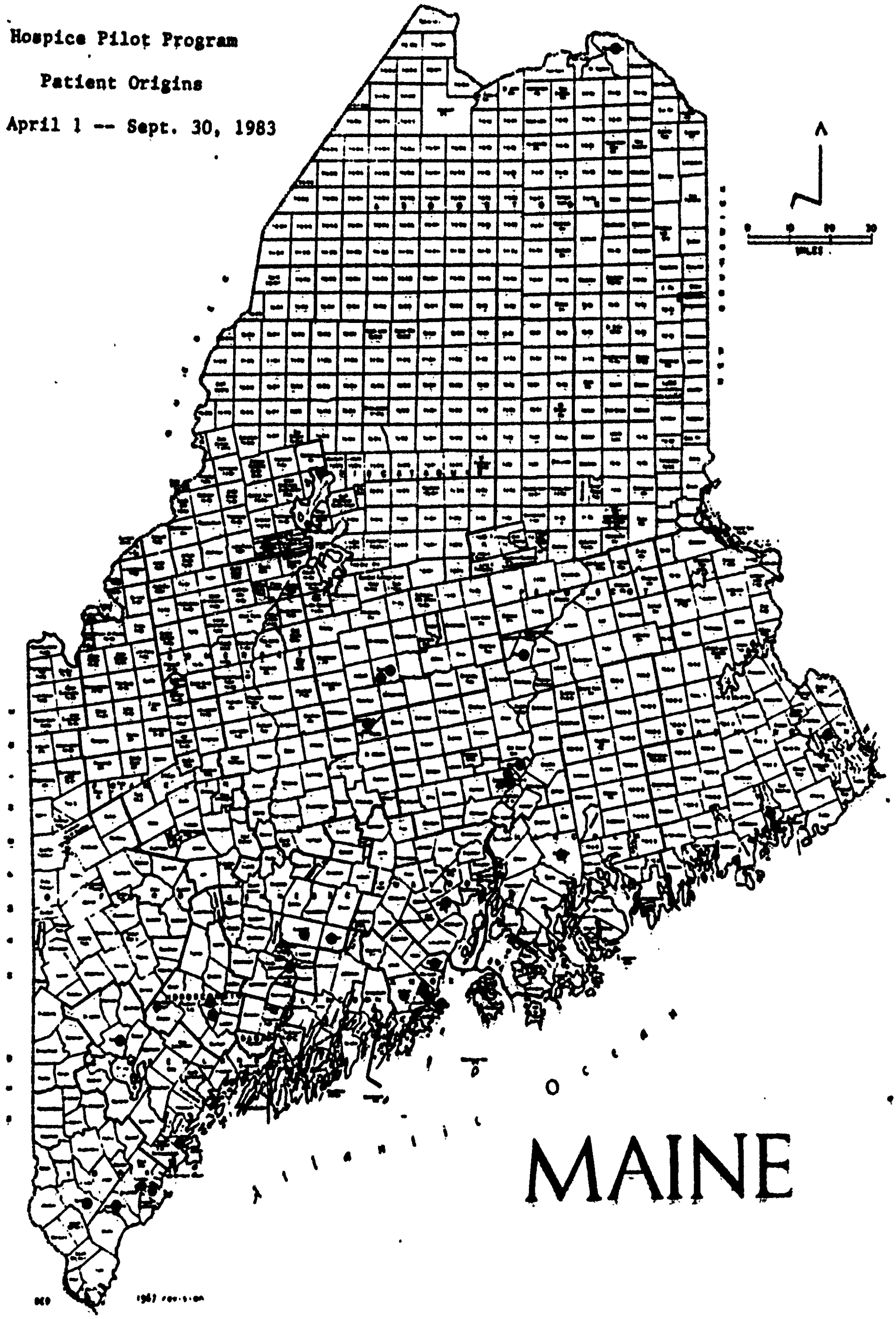


TABLE 2

HOSPICE PILOT PROGRAM
PATIENT ORIGIN BY COUNTY
April 1 - Sept. 30

Aroostook	1
Washington	3
Penobscot	4
Hancock	1
Waldo	1
Knox	4
Piscataquis	1
Somerset	1
Franklin	0
Oxford	0
Lincoln	0
Sagadahoc	0
Kennebec	4
Androscoggin	2
Cumberland	2
York	4

TABLE 3

Hospice Pilot Program

Patient Sources

April 1 - Sept. 30, 1983

REFERRAL SOURCES	
Social Service Worker	6
Discharge Planner	8
Physician	10
Family	2
Unknown	7

ADMITTED FROM	
Hospital	20
Direct	10
Unknown	3

TABLE 4

Home Care Hospice Data

First Six Months of Pilot Program

April 1 - September 30

	Actual	Projected
Number of Patients	30	15
Dollar Amount of Claims *	$13,768.83	$18,300.00
Total Number of Days	685	915
Average Days per Case	32.61	61
Average Dollars per Day	$ 20.10	$ 20.00
Average Dollars per Case	$ 655.66	$ 1,220.00

* based on 21 patients for whom claims have been submitted

TABLE 5

Clover Hospice Data

First Six Months of Pilot Program

April 1 -- September 30

	Actual	Projected
Number of Patients	3	10
Dollar Amount of Claims	$21,399.97	$27,000.00
Total Number of Days	133	180
Average Days per Case	44.3	18
Average Dollars per Day	$ 160.90	$ 150.00
Average Dollars per Case	$ 7,133.32	$ 2,700.00

TABLE 6

HOSPICE PILOT PROGRAM
SERVICES RENDERED
April 1 - Sept. 30

Services	Number of Cases Using This Kind of Service	Total Rendered	Avge. per Case
RN Visits	20	215	10.75
Home Health Aide Hours	12	172.8	14.4
Physical Therapist	4	19.	4.75
Occupational Therapist Visits	2	3	1.5
Pharmaceuticals	10	1970.68	197.07
Medical Supplies	14	1017.4	72.67

Based on 21 claims received to October 1, 1983

Senator DURENBERGER. Let me ask another Maine question: Are there sufficient numbers of nursing personnel available in Maine to provide hospice services to all of those potentially in need of care? Or are there other skills that might be lacking in the State?

Ms. TIRRELL. Senator, I'm sorry, I didn't hear the last part of your question.

Senator DURENBERGER. Are there sufficient numbers of nursing personnel available in Maine to provide hospice services to all those potentially in need of such care?

You predict the amount of hospice care needs there are going to be in Maine, and then tell me whether or not you believe there are sufficient numbers of nursing personnel in the State of Maine to meet those needs.

Ms. TIRRELL. I believe that in Maine there is indeed a nursing shortage, and I feel that the proposed regulations have an emphasis on skilled nursing care. If that is indeed true, then Maine is going to have a very difficult time providing hospice care.

However, if there is a recognition that a certified nurses aid or a home health aid can provide a vast majority of the services that hospice patients potentially need, then we can fill that need very comfortably.

In terms of the nursing, because there is a shortage I can't say that's particularly true.

Senator DURENBERGER. On the matter of election, should family members be the only other persons allowed to elect hospice care for the terminally ill? And, if so, which family member? Or has anyone given that any thought?

Ms. CUSHMAN. Yes. It is the position of the National Association for Home Care that consideration should be given to allowing designation of a legal guardian.

One of the reasons why designation of a legal guardian might be considered is because, for those individuals who previously have a legal guardian appointed prior to the time that they go to elect hospice care, under the current regulations they would not potentially be allowed to do so, because they would no longer be allowed to elect nor could their guardian.

Senator DURENBERGER. Anyone else?

Ms. TIRRELL. May I answer that, too?

Senator DURENBERGER. Yes.

Ms. TIRRELL. It has been my experience in my agency in caring for the terminally ill that at times when a patient is referred to our agency, that patient may not be in a position to be able to make a valid decision. And I have great concerns for that patient and the meaning of the proposed regulation. I am afraid that that patient is going to be excluded from hospice benefits because they might not be able to understand the rights that they have under the hospice program and the rights that they are waiving under the medicare program.

I think that there needs to be another responsible family member to make that decision.

Senator DURENBERGER. I guess I am going to have to submit the balance of my questions to all of you so I can get over and vote.

I will excuse this panel with our gratitude.

I will put the next panel on notice, and I will let Chairman Dole call you up.

Thank you very much.

[Whereupon, at 3:58 p.m., the hearing was recessed.]

AFTER RECESS

Senator **Dole**. All right, Bill, do you want to start off?

Mr. **Hermelin**. Sure.

STATEMENT OF WILLIAM HERMELIN, VICE PRESIDENT, CONGRESSIONAL AFFAIRS, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, D.C.

Mr. **Hermelin**. Thank you, Senator.

Good afternoon. I am Bill Hermelin, vice president of Congressional Affairs for the American Health Care Association, the Nation's largest organization of providers of long-term care.

Long-term care facilities historically have taken a prominent role in caring for our Nation's terminally ill. However, I am concerned that because of the hospice provisions of TEFRA and the implementing regulations issued a few weeks ago, long-term care providers will be excluded or at least discouraged from full participation in the hospice program, and that as a result beneficiaries will be denied access to humane and cost-effective services to which they should be entitled.

Legislative provisions that concern us include, first, the arbitrary requirement that not more than 20 percent of hospice care can be provided on an inpatient basis. This requirement cannot be justified in terms of cost or quality care and will serve to deny services to many in need.

Second, the requirement that a hospice may not contract out home nursing services. We think this matter needs to be clarified. We would like to believe that inpatient-based hospices would be permitted to structure or restructure their relationship with its nurses so as not to run afoul of the statute. We would hope the regulations could be modified so as to achieve appropriate staffing for inpatient hospices. To the extent they do not, we would think statutory changes would be necessary.

And third, the mandatory stipulation that volunteers must assume positions that otherwise would be filled by paid staff. Long-term care facilities are prohibited from this practice.

In addition to these legislative provisions, the following regulatory provisions tend to further limit long-term care facility involvement:

First, requirements that the facility providing respite and inpatient services turn over to the hospice such critical functions as total patient care planning and responsibility for staff education; and

Second, requiring 24 hour registered nurse coverage, when most long-term care facilities adequately meet patients' needs with licensed nurse coverage on evening and night shifts.

We call these matters to your attention in the hope that Federal support of hospice care can be reexamined so as to assure that all providers capable of delivering hospice services, including long-term care facilities, are allowed to fully participate in this most important program.

Thank you, Mr. Chairman.

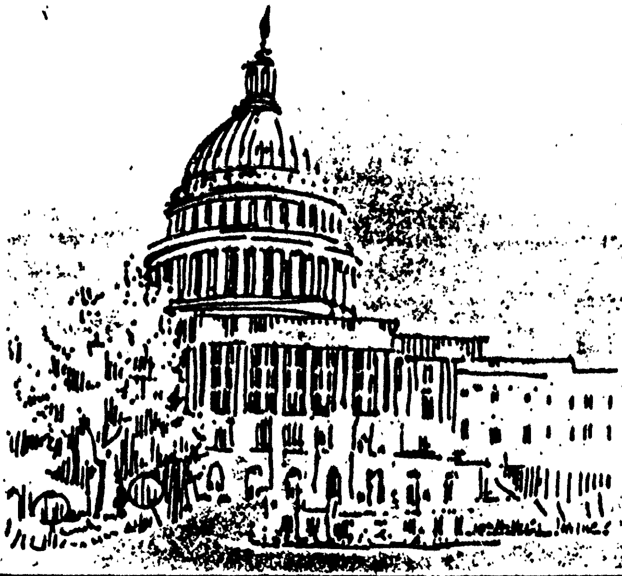
Senator DURENBERGER. Oh. Thank you very much, Mr. Hermelin. [Laughter.]

I didn't believe you were going to speak only 1 minute when I saw you the other day, but——

Mr. HERMELIN. I don't know if I came close, or whether the light wasn't on giving me additional time. [Laughter.]

Senator DURENBERGER. Next will be Sister Mary John Sapp.

[Mr. Hermelin's prepared statement follows:]



Statement of the American Health Care Association

ADMINISTRATION'S REGULATIONS TO IMPLEMENT THE MEDICARE HOSPICE BENEFIT

STATEMENT BY
WILLIAM HERMELIN
VICE PRESIDENT, CONGRESSIONAL AFFAIRS
BEFORE THE
U.S. SENATE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
SEPTEMBER 15, 1983

ahca
American Health Care Association 1200 15th Street, Washington, DC 20005

For Futher Information Contact: CHERYL BEVERSDORF

BEST AVAILABLE COPY

I am William Hermelin, Vice President of Congressional Affairs of the American Health Care Association. AHCA is the nation's largest association of long-term care providers, with a membership of over 8,000 facility based providers. This includes both proprietary and non-proprietary facilities providing a wide range of services in a variety of institutional settings. Our Association is dedicated to quality long term health care for the nation's elderly convalescent and chronically ill.

We welcome this opportunity to offer our perspectives on the Administration's regulations to implement the medicare hospice benefit enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Earlier this year at the time the Health Care Financing Administration was developing these regulations, we submitted to the agency comments regarding our concerns about specific provisions within the statute. Those provisions, now included as part of the regulations to implement the Medicare hospice benefit, are still problematic for long term care facilities and their ability to provide hospice services. As a result, we believe that unless significant changes are made in both the legislation and in the regulations, the extent to which nursing homes can participate in the hospice program will be quite limited.

Long Term Facilities and Terminal Care

Before we comment specifically about the hospice regulations, we would like to discuss briefly the important role long term care facilities have played and continue to play in the provision of terminal care.

Long term care and hospice care are similar in that they care for the chronically ill and for those suffering from chronic pain due to terminal illness. Long term care facilities have considerable experience in providing care to the terminally ill.

The principles of hospice care are not new to the long term care provider. Traditionally, long term care facilities are major providers of terminal care and have been applying the principles of hospice care for many years. Long term care is the provision of health and social services which provide physical, social and spiritual support to the chronically ill and their families. Long term care services are provided under the supervision of a physician by a team of professionals. The services are provided in a variety of settings: institutions, community centers and the home. Home and community based care are provided on a 24-hour basis in conjunction with long term care facilities. Because of their extensive experience in caring for the terminally ill, many long term care facilities are logical vehicles for the delivery of hospice care.

Hospice Legislation and Regulations

Having acknowledged long term care facilities as an appropriate resource for providing hospice services, one of our major concerns about the new hospice program is that although the Medicare beneficiary entitlement to hospice care is increased, the provision of services, particularly inpatient hospice care is restricted. Moreover, it appears that the regulations generally contain a strong bias against inpatient services. The implication seems to be that the needs of the terminally ill can more appropriately and cost effectively be served by home care hospice services. We do not agree.

Legislative provisons that discourage long term care facility involvement include:

- The requirement that not more than 20% of hospice care can be provided on an inpatient basis. This mandate has no basis in terms of cost or quality care and will serve to deny services to many in need. While we realize many patients will prefer to remain in their homes throughout a terminal illness, we know that home-based care is not ways an option. This restriction may serve as a road block to those terminally ill patients who may need and want inpatient hospice care but who have access only to those programs which are already committed for the 20%. Further, AHCA is concerned when it hears that approximately 40% of current hospice patients are dying in inpatient facilities. If this is the case, AHCA believes it will be difficult for programs to operate under the 20% requirement and serve the maximum need of the community.

- The requirement that the hospice must provide its own home health nursing service. This restriction favors the home health based provider which can contract out for inpatient services while it discriminates against the inpatient-based hospice provider which cannot contract out for home nursing services. AHCA recommends that nursing services be permitted to be contracted out.

- The requirement that volunteers must assume positions that otherwise would be filled by paid staff. Long term care facilities are prohibited from this practice. The use of volunteers in long term care, especially in hospice programs is critical. However, their use must be to enhance the quality of patient and family member life, not substitute for the essential services of paid staff.

In addition to legislative provisions that discriminate against inpatient hospice programs, certain provisions in the regulations tend to further limit long term care facility involvement. These include:

- The requirement that the facility providing respite and inpatient services turn over to the hospice such critical functions as total patient care planning and responsibility for staff education. While the legislation made clear that the inpatient provider must deliver care that is consistent with the hospice concept of care, the regulations far exceed this directive. In fact, the regulations go so far as to prohibit the inpatient unit from providing any service without the express authorization of the hospice. This provision will tie the hands of the inpatient facility, will be impossible to carry out and will not be in the best interest of the terminally ill patients. The regulation ignores the fact that dying patients develop problems and needs for which there must be prompt decisions and immediate action.

- The requirement that in the event that a hospice program arranges for inpatient care in a long term care facility, the hospice maintains responsibility for implementation of the hospice plan of care. (This is implied in the legislation and specified in the regulations concerning care planning. It is also similar to the concern mentioned above.) Unless an extremely coordinated effort in this regard can be worked out, which may be unlikely considering the complexity of care which must be provided to a terminally ill patient, such a requirement may only add confusion to the overall treatment modality not to mention additional hardship to the patient. A question of "who's in charge" should not be one of the problems to be dealt with when caring for the terminally ill. It seems more appropriate that if the patient is receiving care in a long term facility, that facility should be responsible for developing the patient's care plan and assuring that the services are implemented. We agree that the hospice and inpatient facility and hospice should work together to coordinate care and to ensure that the principles of hospice are being maintained, but the plan of care must be the ultimate responsibility of the provider carrying out the plan.

The requirement that there be 24-hour registered nurse coverage. Most long term care facilities adequately meet patient needs with licensed practical nurse coverage on evening and night shifts. Additional registered nurse coverage can be added when the facility admits patients needing more intensive nursing services.

Long term care facility providers are interested in participating in hospice care. Our facilities are available to provide inpatient care to those hospice patients needing such care. Other facilities are competent to become hospice providers. We hope that sufficient changes can be made in both the legislation and regulations so that long term care facilities are not precluded from such participation and so that terminally ill patients are not denied access to facility based services.

CB/dm

9/13/83

831278.05

STATEMENT OF SISTER MARY JOHN SAPP, OSB, ADMINISTRATOR, ST. BENEDICT'S HOSPITAL AND NURSING HOME, SAN ANTONIO, TEX., ON BEHALF OF THE CATHOLIC HEALTH ASSOCIATION, WASHINGTON, D.C.

Sister SAPP. Thank you, Mr. Chairman.

Today I am representing the Catholic Health Association. I am from St. Benedict's Hospital and Nursing Home in San Antonio, Tex., which is also one of the 26 HCFA hospice demonstration sites.

The Catholic Health Association commends Congress for recognizing the value of hospice and extending this special care to medicare beneficiaries. However, we are concerned that the proposed regulations seriously threaten the essence of what we consider hospice to be.

In order to preserve, therefore, the integrity of hospice consistent with our principles, reflecting our tradition of respect for the human person, we recommend:

That a hospice be permitted to provide all the core and noncore services, either directly or by employees of a parent organization, or under arrangements.

We recommend that the patient be permitted to retain his or her attending physician regardless of the latter's employment status with the hospice.

We recommend that the patient and family be more strongly emphasized as a unit of care and that they be more actively involved in the plan of care.

We recommend that the patient not be required to acknowledge his or her terminal illness in order to participate in the program.

We recommend that an authorized person be permitted to make the election and to give the informed consent on behalf of a patient who is unable to do so.

We recommend that the standard on professional management responsibility be replaced with a standard requiring mechanisms for coordination of care planning between providers to assure continuity and quality of care.

We recommend the elimination of the 20-percent limit on inpatient care, and we also recommend an interpretation of home setting which allows patients to receive hospice benefits in settings other than private homes.

Mr. Chairman, the Catholic Health Association is most anxious to work with you in making whatever changes are necessary to preserve and enhance the value of hospice.

Thank you.

Senator DURENBERGER. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF
THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

ON

THE PROPOSED RULE FOR THE MEDICARE HOSPICE PROGRAM

PRESENTED BY

SISTER MARY JOHN SAPP, OSB
ADMINISTRATOR
ST. BENEDICT'S HOSPITAL AND NURSING HOME
SAN ANTONIO, TEXAS

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

SEPTEMBER 15, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

MY NAME IS SISTER MARY JOHN SAPP. I AM THE ADMINISTRATOR OF ST. BENEDICT'S HOSPITAL AND NURSING HOME IN SAN ANTONIO, TEXAS, A 220-BED HEALTH CARE CENTER OFFERING A CONTINUUM OF SERVICES INCLUDING ACUTE CARE, HOME HEALTH CARE, ADULT REHABILITATIVE DAY CARE, RESIDENTIAL TO SKILLED NURSING CARE, AND HOSPICE. TODAY, I REPRESENT THE CATHOLIC HEALTH ASSOCIATION WHOSE MEMBERSHIP INCLUDES ALMOST 900 CATHOLIC HOSPITALS AND LONG-TERM CARE FACILITIES NATIONWIDE. THERE ARE 150 CHA-MEMBER INSTITUTIONS PROVIDING HOSPICE CARE, FOUR OF WHICH (INCLUDING ST. BENEDICT'S) ARE AMONG HCFA'S 26 HOSPICE DEMONSTRATION PROJECTS. I APPRECIATE THIS OPPORTUNITY TO PRESENT THE ASSOCIATION'S VIEWS ON HOSPICE AND THE NEW MEDICARE HOSPICE BENEFIT.

IN 1977, THE CATHOLIC HEALTH ASSOCIATION'S BOARD OF TRUSTEES ENDORSED THE CONCEPT OF HOSPICE AS AN INTEGRAL PART OF A CONTEMPORARY HEALING MINISTRY. CHA'S COMMITMENT TO HOSPICE IS SIMPLY A LOGICAL CONTINUATION OF THE CATHOLIC CHURCH'S TRADITION OF RESPECT FOR THE DIGNITY OF THE HUMAN PERSON, A DERIVATIVE OF WHICH IS ITS DEEP CONCERN FOR THE SPECIAL NEEDS OF THE DYING. THROUGHOUT

HISTORY, THE CHURCH'S RELIGIOUS COMMUNITIES HAVE RECOGNIZED THESE NEEDS AND HAVE RESPONDED WITH CARE THROUGH THEIR HEALING MINISTRY. THIS CARING APPROACH, WHETHER RENDERED IN HOME, HOSPITAL, HOSTEL OR HOSPICE, WAS THE ANCESTOR OF THE MODERN HOSPICE. THE SAME TRADITION IS EQUALLY REFLECTED IN THE CATHOLIC HEALTH ASSOCIATION'S CONCERN TODAY FOR HOSPICE.

IT IS IMPORTANT TO NOTE THAT THE ASSOCIATION'S POSITION ON HOSPICE IS PREMISED ON THE FOLLOWING BASIC PRINCIPLES:

- WE BELIEVE HOSPICE SHOULD AFFIRM LIFE.

- WE BELIEVE THAT THE PATIENT AND FAMILY SHOULD BE THE UNIT OF CARE.

- WE BELIEVE THAT PALLIATIVE AND SUPPORTIVE SERVICES WHICH MEET THE PHYSICAL, PSYCHOLOGICAL, SOCIAL AND SPIRITUAL NEEDS OF THE PATIENT AND FAMILY SHOULD BE AVAILABLE.

- WE BELIEVE THAT EMPHASIS SHOULD BE ON THE PATIENT REMAINING IN THE HOME, BUT THAT HE/SHE SHOULD ALSO HAVE ACCESS TO CARE IN THE ENVIRONMENT MOST APPROPRIATE TO HIS/HER NEEDS.

- WE BELIEVE THAT THE RELATIONSHIP BETWEEN THE PATIENT AND

HIS/HER ATTENDING PHYSICIAN SHOULD BE MAINTAINED AND FOSTERED.

- WE BELIEVE THAT BEREAVEMENT SERVICES SHOULD BE AVAILABLE TO THE FAMILY OR SIGNIFICANT OTHERS.
- WE BELIEVE THAT THE PATIENT AND FAMILY SHOULD HAVE THE FREEDOM TO COME TO TERMS WITH THE TERMINAL ILLNESS IN THEIR OWN WAY AND THAT HOSPICE SHOULD SUPPORT THEM IN THAT PROCESS.
- WE BELIEVE THAT NO PATIENT SHOULD BE EXCLUDED FROM HOSPICE BECAUSE OF HIS/HER INABILITY TO PERSONALLY ELECT HOSPICE.
- WE BELIEVE THAT COMMUNITY INVOLVEMENT, SUPPORT AND COORDINATION IN THE DELIVERY OF SERVICES SHOULD BE MAXIMIZED.

MR. CHAIRMAN, THUS FAR MY TESTIMONY HAS POINTED TO THE CHURCH'S HISTORICAL INVOLVEMENT WITH THE DYING AND HAS DEMONSTRATED THAT CHA'S SUPPORT OF HOSPICE IS GROUNDED IN A SET OF FIRMLY-HELD PRINCIPLES, REFLECTIVE OF OUR VALUE SYSTEM. THESE PRINCIPLES REPRESENT THE CRITERIA AGAINST WHICH WE HAVE EVALUATED THE PROPOSED HOSPICE REGULATIONS. BEFORE COMMENTING ON THESE REGULATIONS,

HOWEVER, THE CATHOLIC HEALTH ASSOCIATION COMPLIMENTS BOTH CONGRESS AND THE ADMINISTRATION IN MAKING HOSPICE CARE A MEDICARE BENEFIT. AS THE AUGUST 22, 1983 EDITORIAL IN THE WASHINGTON POST STATED: "IT IS RIGHT AND COMPASSIONATE FOR THE GOVERNMENT TO ASSIST THEM [PATIENTS] AND THEIR FAMILIES THROUGH THE TRAUMA OF TERMINAL ILLNESS AND TO HELP, WHEN THERE IS NO CURE, TO PROVIDE SOLACE AND CARE AT HOME." WE ARE AWARE THAT CONGRESS HAD SPECIFIC EXPECTATIONS FOR THIS PROGRAM AND SHARES MANY OF THE VALUES WE HAVE JUST ENUNCIATED. NEVERTHELESS, THOSE EXPECTATIONS MAY NOT BE ACHIEVED NOR MAY THOSE VALUES BE FULLY REALIZED. THE HOSPICE PROGRAM, AS PRESENTLY DEFINED, SERIOUSLY THREATENS THE VERY ESSENCE OF WHAT WE CONSIDER HOSPICE TO BE. WE ARE GREATLY CONCERNED THAT THIS MEANINGFUL PROGRAM MAY BE HEADED IN A DIRECTION AWAY FROM MANY OF THE VALUES WE ESPOUSE.

THEREFORE, IN ORDER TO PRESERVE THE INTEGRITY OF HOSPICE, CONSISTENT WITH THOSE VALUES, WE ARE SUBMITTING A NUMBER OF RECOMMENDATIONS. AND WHILE ALL OF THE RECOMMENDATIONS REPRESENT MAJOR CONCERNS, WE STRONGLY BELIEVE THAT THE VIABILITY OF THE HOSPICE PROGRAM WILL STAND OR FALL ON THE MANNER IN WHICH THE REGULATIONS FINALLY ADDRESS THE PROBLEMS RESULTING FROM THE CORE SERVICES PROVISION, ESPECIALLY THE EROSION OF THE RELATIONSHIP BETWEEN THE PATIENT AND HIS/HER ATTENDING PHYSICIAN. THEREFORE,

- WE RECOMMEND THAT A HOSPICE BE PERMITTED TO DETERMINE HOW TO PROVIDE ALL OF THE SERVICES, BOTH CORE AND NON-CORE,

CURRENTLY REQUIRED BY THE CONDITIONS OF PARTICIPATION, EITHER:

- DIRECTLY THROUGH THE HOSPICE,
- OR BY EMPLOYEES OF A PARENT ORGANIZATION WHO DEVOTE A PORTION OF THEIR WORK TIME TO THE HOSPICE UNIT,
- OR UNDER ARRANGEMENTS.

OTHERWISE, WE FEAR THAT QUALITY OF CARE WILL BE THREATENED BECAUSE OF AN INTERRUPTION IN THE PATIENT'S EXISTING PROFESSIONAL RELATIONSHIPS. IN ADDITION, UNDERUTILIZATION OF STAFF AND DUPLICATION OF SERVICES WILL LESSEN COST-EFFECTIVENESS OF THIS PROGRAM AND WILL PRECLUDE MANY EXISTING HOSPICES WHICH NOW PROVIDE EFFECTIVE CARE THROUGH COOPERATIVE AGREEMENTS FROM QUALIFYING FOR CERTIFICATION.

- WE RECOMMEND THAT THE PATIENT BE PERMITTED AND ENCOURAGED TO RETAIN HIS/HER ATTENDING PHYSICIAN, REGARDLESS OF THE LATTER'S EMPLOYMENT STATUS WITH THE HOSPICE.

OTHERWISE, THE MOST SIGNIFICANT PERSON IN THE DETERMINATION AND DELIVERY OF THE PATIENT'S MEDICAL CARE WILL BE EXCLUDED.

IN ADDITION,

- WE RECOMMEND THAT THE PATIENT AND FAMILY BE MORE STRONGLY EMPHASIZED AS THE UNIT OF CARE AND THAT THEY BE INVOLVED IN THE DEVELOPMENT, REVIEW AND IMPLEMENTATION OF THE PLAN OF CARE.

  OTHERWISE, THE ROLE OF THE FAMILY AS THE PRIMARY CARE-GIVER IS DIMINISHED AND THE PATIENT'S BASIC RIGHT OF SELF-DETERMINATION IS AT RISK.

- WE RECOMMEND ELIMINATION OF THE ELEMENT OF THE ELECTION STATEMENT REQUIRING THE PATIENT TO ACKNOWLEDGE HIS/HER TERMINAL ILLNESS.

  OTHERWISE, THE UNIQUENESS IN WHICH EACH PERSON COMES TO TERMS WITH HIS/HER DEATH CAN BE VIOLATED.

- WE RECOMMEND THAT AN AUTHORIZED PERSON BE PERMITTED TO MAKE THE ELECTION AND TO GIVE THE INFORMED CONSENT ON BEHALF OF A PATIENT WHO IS UNABLE TO DO SO.

  OTHERWISE, MANY PATIENTS WHO WOULD BENEFIT FROM THIS PROGRAM WILL BE EXCLUDED.

- WE RECOMMEND THE REPLACEMENT OF THE STANDARD ON PROFESSIONAL MANAGEMENT RESPONSIBILITY WITH A STANDARD REQUIRING MECHANISMS BETWEEN THE PROVIDERS FOR COORDINATION OF CARE PLANNING AND CONFLICT RESOLUTION TO ASSURE CONTINUITY AND QUALITY OF CARE.

  OTHERWISE, WORKING RELATIONSHIPS BETWEEN PROVIDERS WILL BE UNDERMINED DUE TO UNREASONABLE ADMINISTRATIVE CONSTRAINTS.

- WE RECOMMEND THE ELIMINATION OF THE 20% LIMIT ON INPATIENT CARE. WE ALSO RECOMMEND AN INTERPRETATION OF HOME SETTING WHICH ALLOWS PATIENTS TO RECEIVE HOSPICE BENEFITS IN SETTINGS OTHER THAN PRIVATE HOMES (E.G., ICF, GROUP HOMES, PERSONAL CARE HOMES, DOMICILIARIES, ETC.).

  OTHERWISE, PATIENTS WHO LACK ADEQUATE HOME SUPPORT WILL BE DEPRIVED OF ACCESS TO HOSPICE CARE.

- WE RECOMMEND IN THE EVENT THAT A PATIENT IS MEDICALLY-CERTIFIED TO BE IN A STATE OF REMISSION THERE BE SOME PROVISION FOR THE SUSPENSION OF SERVICES BY THE HOSPICE UNTIL SUCH TIME AS THE PATIENT'S CONDITION AGAIN WARRANTS HOSPICE CARE.

OTHERWISE, THE ABILITY OF THE PROVIDER TO OFFER HOSPICE CARE WILL BE SERIOUSLY THREATENED BY ITS POTENTIAL FINANCIAL LIABILITY.

- AND LASTLY, WE RECOMMEND THE INSTITUTION OF AN OUTLIER PROVISION FOR THE REIMBURSEMENT OF ATYPICAL CASES, E.G., THOSE THAT HAVE EITHER AN EXTREMELY LONG LENGTH OF STAY OR EXTRAORDINARILY HIGH COSTS.

  OTHERWISE, THE FINANCIAL VIABILITY OF THE PROVIDER IS JEOPARDIZED.

IN CONCLUSION, MR. CHAIRMAN, THE CATHOLIC HEALTH ASSOCIATION IS CONVINCED THAT WITHOUT SIGNIFICANT CHANGES TO THE PROPOSED RULE EVEN THE LIMITED MODEL OF HOSPICE ENVISIONED BY THE REGULATIONS WILL BE LESS AUTHENTIC, LESS AVAILABLE, LESS ACCESSIBLE AND LESS COST-EFFECTIVE THAN ORIGINALLY INTENDED.

THE CHANGES WE HAVE RECOMMENDED ARE NECESSARY TO MAINTAIN THE INTEGRITY OF HOSPICE AND TO CORRECT OBVIOUS CONTRADICTIONS IN THE REGULATIONS. WE WILL BE SHARING OUR CONCERNS WITH THE HEALTH CARE FINANCING ADMINISTRATION AND WILL BE WORKING WITH THEM TO IMPROVE WEAKNESSES IN THE NOTICE OF PROPOSED RULE MAKING.

IT IS UNCLEAR THE DEGREE TO WHICH ALL OF OUR RECOMMENDED CHANGES CAN BE MADE BY AMENDING THE NPRM. IT MAY, THEREFORE, BE NECESSARY IN CERTAIN INSTANCES TO AMEND THE UNDERLYING STATUTE. CHA WILL BE MOST HAPPY TO WORK WITH YOU, MR. CHAIRMAN, AND YOUR STAFF TO MAKE WHATEVER STATUTORY CHANGES MAY BE NECESSARY TO PRESERVE AND ENHANCE THE VALUE OF HOSPICE ... NOT TO THREATEN ITS FUTURE.

STATEMENT OF LYNETTE A. RAUSCHER, R.N., M.S., DIRECTOR, HOSPICE DULUTH, DULUTH, MINN.

Ms. RAUSCHER. Mr. Chairman, I have heard a lot of comments here today, and many of them are concerns that I share. I am going to touch on one in particular that is close to home for me and one that hasn't been touched on a lot from this perspective today.

I am the director of a hospital-based hospice program in Duluth, Minn., which as you know serves a rural and medically underserved area which is very much economically troubled right now.

In our hospice program we have tried it both ways in terms of the core service issue. We started out providing some of our services under an arrangement with other departments, finding that we really didn't have the kind of control we needed to provide a really good quality of hospice care and the accessibility that our patients needed.

I have also been talking with some neighboring communities up in the Iron Range area in northern Minnesota who share my concern. They have also tried providing services under contract and have now decided to provide their own core services in order to maintain quality hospice care. I can submit a number of those names to you, if you wish.

After trying it both ways we believe that in order to provide the care we feel hospice patients deserve, we must provide our own core services.

Senator DURENBERGER. Thank you.

[The prepared statement of Lynette Rauscher follows:]

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TESTIMONY OF LYNETTE RAUSCHER
DIRECTOR, HOSPICE DULUTH
ST. LUKE'S HOSPITAL
DULUTH, MINNESOTA
to the

SENATE FINANCE SUBCOMMITTEE ON HEALTH
September 15, 1983

Mr. Chairman, members of the Committee:

Since July of 1979, I have been responsible for the development and direction of a hospital based hospice program at St. Luke's Hospital in Duluth, Minnesota. I represent Hospice Duluth on the Board of Directors of the Minnesota Hospice Organization and am the Northwest Central Regional Representative to the Licensure and Reimbursement Subcommittee of the National Hospice Organization. The Northwest Central Region includes Minnesota, Iowa, Nebraska, North Dakota and South Dakota. In addition to the medium-sized city of Duluth, our service area includes a thirty-mile radius encompassing a sister city of Superior, Wisconsin as well as sparsely scattered small towns and farms in both Northeast Minnesota and Northwest Wisconsin. This area, along with its neighboring Iron Range communities, is currently experiencing severe economic conditions and record unemployment.

I am a registered nurse with a baccalaureate degree from South Dakota State University and a Master of Science degree in Public Health Nursing from the University of Minnesota. The majority of my professional experience prior to hospice was in Public Health Nursing.

A Community Service of St. Luke's Hospital of Duluth

Our patients at Hospice Duluth have ranged in age from one through 99 years. 75% of our patients are over the age of 65 and would, thereby, qualify for the Hospice Medicare benefit.

During past months, regional representatives to the National Hospice Organization Licensure and Reimbursement Committee from throughout the nation have met to review the proposed Hospice Medicare regulations. In our most recent review, it was clear to us that your support and the responsiveness of Secretary Heckler have moved those regulations much nearer to providing patients with the kind of quality care that you originally envisioned in passing the legislation. Through a technical amendment you have also succeeded in raising the overall cost cap to an amount closer to that which you intended at the time the law was passed. While improved from previous drafts, the current proposals still contain some major roadblocks to fulfilling our promise to the terminally ill to add comfort and quality to their final days through accessible and affordable hospice care.

One such obstacle is the proposed per diem rates which are inadequate to cover the costs of providing this care for these Hospice Medicare patients. The proposed $271.00 general inpatient rate does not cover the highly labor intensive skilled care required by these terminally ill patients. Additionally, in our economic area the current wage index adjustment would further decrease this payment rate to $258.00 per day. Testimony presented before the House Select Committee on Aging on May 25, 1983, by Michael Rosen, Chairman of the National Hospice Organization Subcommittee on Licensure and Reimbursement, demonstrated that average costs per day in 1982 for such care was $318.00. Per diem cost for our program in Duluth is very comparable to this figure. By definition the focus of hospice care is upon helping patients remain at home with their families for as much time as possible. However, at times during their care, patients must be admitted to a hospice unit. Those patients admitted as inpatients tend to be the sickest patients whose care needs cannot be managed at home. Again, testimony presented by Mr. Rosen demonstrated that the level of care for such inpatients lies between that experienced on a traditional medical-surgical floor and that of a hospital's intensive care unit. Our experience in Hospice Duluth shows that care for these inpatients requires 40% more nursing time per patient then is required by the traditional medical-surgical floor. The Health Care Financing Administration's proposed rate of $271.00 per day is too low to cover costs for such care. This is due in part to their use of the medical care expenditure component of the Consumer Price Index that was used to adjust for inflation between 1981 and 1984. It is our recommendation that the hospital care component of the Consumer Price Index would be more appropriate to use in adjusting inpatient rates.

A similar problem occurs concerning reimbursement for patients cared for in the home. HCFA has proposed a daily reimbursement rate of $53.17 per day. When adjusted using the Duluth area wage index figures this reimbursement would be reduced to $50.44 per day for such patients. Again, if appropriate adjustments for inflation were to be included, this figure would approach $70.00.

HCFA's construal of the statutory 80/20 home care to inpatient ratio into a retroactive payment denial mechanism, rather than a condition of participation, poses another obstacle to the terminally ill receiving the hospice services intended for them. As a result, an incentive was created which I am sure neither you, Senator Durenberger, nor the Senate,nor those of us supporting the legislation intended. Hospice programs, especially those in rural and economically troubled areas, fearing for survival, would be forced to turn away more acutely ill patients who would appear to need more inpatient care. Exceeding the inpatient limit by only a few percent and the subsequent denial of payment could push such programs over the edge. Selections of only the less ill patients for care by hospice programs would not only provide a disserviceto those most in need of the benefits of hospice care, but also defeat the cost saving potential otherwise afforded by the Medicare Hospice Program.

We support both the statute and components of the proposed regulations which reflect an understanding of the importance of the hospice program's professional responsibility and responsibility for the plan of care. In development of our hospice program we have experienced providing some of the core services directly through the hospice department and some under arrangement with other departments. We quickly learned that despite the good intentions of the caregivers from other departments, we were less able to be truly responsible for the direction and quality of the care provided. The caregivers were torn by the differing priorities of two administrators while hospice patients lost in terms of quality and accessibility of care. From a fiscal standpoint, particularly in the current Duluth and Iron Range economic environment, contracting for services from another Agency would add dual administrative costs. This situation would take scarce financial resources away from direct patient care. Speaking from my experience in a hospital-based program serving both sparsely populated and medically underserved areas, I recommend that you maintain the requirement that those care providers so essential to the integrity of the hospice program, the nurse, the physician, the social worker and the pastoral or other counselor, be the direct responsibility of the hospice program.

The denial of access to care to appropriate hospice patients might also occur because hospice regulations now specify that only the terminally ill individual can elect or revoke the hospice benefit. We regularly encounter instances in which a patient is comatose, disoriented or otherwise incapable of making this decision, yet meets the other criteria for participation in this benefit. In such cases, another authorized individual as permitted by State law should be allowed to sign for the patient. We have found that the patient can still benefit from the physical aspects of hospice care and the family is helped both physically and emotionally to deal with the patient's care and impending death. This is consistent with the hospice standard of serving both the patient and the family as the unit of care.

Finally, HCFA has requested comments regarding volunteer requirements. We believe that the standards they have proposed are very appropriate. Our only recommendation is to add a statement that each patient family unit must have access to the services of a trained volunteer. Any attempt at setting a specific quota would be quite arbitrary. Volunteer availability within communities, program needs, and patient and family acceptance of volunteers can vary significantly. We have found that many patients vehemently refuse volunteer services while others will accept all services offered. Requiring a specific number of volunteers to patients would deny the hospice philosophy of patient choice. If HCFA insists upon setting a numerical standard we feel the most appropriate would be a percentage of total volunteer hours to total paid staff hours. Our regional representatives reviewing these regulations agree that 5% total volunteer hours to total staff hours would be an acceptable figure.

To conclude, I would sincerely like to thank you for responding with such insight to the needs of those persons in this country experiencing their final months of life. It is reassuring to know that this country's political process and leaders do struggle with and address the very real human needs of its citizens.

None of the recommendations I have presented here today would require changes in the current law. Rather, we ask only your continued support in improving the regulations so that we can deliver the kind of quality hospice care you intended for us to provide.

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ADDITIONAL MATERIALS FOR RECORD OF SENATE FINANCE SUBCOMMITTEE ON HEALTH HEARING
SEPTEMBER 15, 1983

TESTIMONY OF LYNETTE RAUSCHER, R.N., M.S., DIRECTOR
HOSPICE DULUTH, DULUTH, MINNESOTA

I. Hospice Programs/Directors in Northern Minnesota alluded to in verbal testimony.

Margo Rankin, R.N.
Virginia Medical Center Hospice
901 - 9th Street North
Virginia, Minnesota 55792
(218) 741-3340

Rosemary Leciejewski
St. Cloud Hospital Hospice
1406 - 6th Avenue North
St. Cloud, Minnesota 56301
(612) 251-2700

II. Information requested by Senator Durenberger on types of patients who might exceed the $6500 cost cap.

Ten patients died on our program during the three month period which included May, June and July who received both hospice home care and inpatient care. Of those ten, five exceeded the cap amount as follows:

A. Age: 67
Diagnosis: Cancer of Breast with Lung Metastasis

Inpatient Days			Charges
1st admission	12		$3,358.54
2nd admission	5		1,508.21
Total:	17		
Home Care Days	107		3,945.00
Total Days on Hospice Program:	124	Total:	$8,811.75

A Community Service of St. Luke's Hospital of Duluth

II. Continued

B. Age: 73
Diagnosis: Cancer of Ovary and Emphysema

Inpatient Days		Charges
1st admission	11	$2,918.61
2nd admission	11	2,823.99
3rd admission	11	2,362.14
4th admission	35	11,051.03
Total:	68	
Home Care Days	304	7,972.35
Total Days on Hospice Program:	372	Total: $27,128.12

C. Age: 69
Diagnosis: Cancer of Colon with Bone Metastasis

Inpatient Days		Charges
1st admission	18	$4,236.40
2nd admission	14	4,405.91
Total:	32	
Home Care Days	34	802.00
Total Days on Hospice Program:	66	Total: $9,444.31

D. Age: 76
Diagnosis: Cancer of Penis & Bladder, Diabetic

Inpatient Days		Charges
1st admission	12	$2,227.55
2nd admission	19	4,017.16
Total:	31	
Home Care Days	88	1,111.70
Total Days on Hospice Program:	119	Total: $7,356.41

E. Age: 90
Diagnosis: Cancer of Lung, Respiratory Disease, Arthritis

Inpatient Days		Charges
1st admission	15	$4,534.88
2nd admission	7	2,591.80
3rd admission	7	2,632.52
4th admission	1	721.49
Total	30	
Home Care Days	111	3,376.75
Total Days on Hospice Program:	141	Total: $13,857.44

Senator **Durenberger**. Our last witness is Gordon Sprenger, president of Abbott Northwestern in Minneapolis.

STATEMENT OF GORDON SPRENGER, PRESIDENT, ABBOTT NORTHWESTERN HOSPITAL, MINNEAPOLIS, MINN., ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, CHICAGO, ILL.

Mr. **Sprenger**. Thank you, Mr. Chairman. Good afternoon.

I am Gordon Sprenger, as you indicated, president of Abbott Northwestern Hospital, which is a 756-bed hospital in Minneapolis, and an organization that has offered hospice care since March of 1980.

I am here this afternoon on behalf of the American Hospital Association to present its views and provide some insights as to how some of these issues affect hospitals like ours.

First of all, as has been indicated before, Congress is to be commended for enacting a hospice benefit. However, methods to deliver care, consistent with the hospice concept, are still evolving and should not be jeopardized by a rigid, overly restrictive approach to implementation.

We urge the subcommittee to reassess the extent to which the medicare hospice benefit is pushing hospice care in the direction of a separate health care delivery system. Such a separation would severely compromise the cost effectiveness of hospice care, create additional discontinuity of care for beneficiaries, and eliminate alternative hospice program models.

As I see it, Mr. Chairman, there are four issues:

First is the issue of core service which we have been discussing. I would urge you to carefully look at the written statement that we have presented from the American Hospital Association as a possible compromise in that area.

Second is compliance with the 80-20 rule. This certainly is difficult for hospitals like ours because many patients do not have primary care givers, such as patients in our MAO program which, Mr. Chairman, you are familiar with in our area. Many of these low-income seniors do not have primary care givers in their immediate family—living with them; or they are too ill or too close to death when they choose hospice. Some of our hospice patients are only put on hospice—a couple of days. And there is no chance to send them home. They are totally in an inpatient setting, and that 80-20 rule is very difficult.

Third is the inflexible payment structure, which may provide disincentives for hospice programs to seek certification, which certainly is going in the wrong direction.

And the last one is the rigid professional management issue which we think needs to be addressed.

I would be pleased to answer questions on any of these issues.

Senator **Durenberger**. Well, thank you all very much. It goes without saying that your full statements will be part of the record, and we will all pore over them in great detail, as you well know from our past experience.

[Mr. Sprenger's prepared statement follows:]

American Hospital Association

444 North Capitol Street N.W.
Suite 500
Washington D.C. 20001
Telephone 202.638.1100
Cable Address: Amerhosp

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION TO THE SENATE FINANCE COMMITTEE''S SUBCOMMITTEE ON HEALTH ON COVERAGE OF HOSPICE CARE UNDER MEDICARE

September 15, 1983

SUMMARY

Terminal illness is a significant issue for the Medicare program. The majority of persons who die each year are age 65 or older and are Medicare beneficiaries. For the elderly, terminal illness creates severe physical, emotional, and financial strss and anxiety. For the Medicare program, terminal illness presents significant expenditure issues.

Congress is to be commended for enacting a hospice benefit. However, methods to deliver care consistent with the hospice concept are still evolving and should not be jeopardized by a rigid overly restrictive approach to implementation. We urge the Subcommittee to reassess the extent to which the Medicare hospice benefit is pushing hospice care in the direction of a separate delivery system. Such a separation would severely compromise the

cost effectiveness of hospice care, create additional discontinuity of care for beneficiaries, and eliminate alternative hospice program models.

The major issues of concern include:

1. The core services requirement will damage important working relationships with physicians and community home health agencies, and will cause inefficient use of staff.

2. Compliance with the 80/20 rule limiting inpatient utilization will be difficult for many hospices because many patients have limited primary caregiver support in the home or are too ill or too close to death when they choose hospice.

3. The inflexible payment structure may make it infeasible to seek hospice certification, particularly in light of the required programmatic changes that would cause inefficiencies in small programs.

4. The rigid professional management responsibility requirement will cause severe legal problems for many hospices and contracting inpatient facilities.

INTRODUCTION

Mr. Chairman, I am Gordon Sprenger, President of Abbott-Northwestern Hospital in Minneapolis, Minnesota. Abbott-Northwestern is a 756-bed hospital that has offered hospice care to its terminally ill patients since March 1980. I am here to present the views of the American Hospital Association. The AHA, which represents most of the nation's hospitals, is pleased to comment on the Medicare hospice benefit and the recently promulgated regulations. The Association has long been committed to increasing the scope of cost-effective, community-based health services and programs for the elderly and for the terminally ill.

Terminal illness is a significant issue for the Medicare program. The majority of persons who die each year are age 65 or older and are Medicare beneficiaries. For the elderly, terminal illness creates severe physical, emotional, and financial stress and anxiety. For the Medicare program, terminal illness presents significant expenditure issues. Medicare beneficiaries who died represented only 5.2 percent of Medicare enrollees in 1978, but during the last year of their lives they accounted for 28.2 percent of total Medicare expenditures.

We commend Congress for enacting a hospice benefit in response to pressing needs of both the beneficiaries and the Medicare program. However, methods to deliver care consistent with the hospice concept are still evolving. Major studies, including one by the Joint Commission on Accreditation of Hospitals (JCAH) and the current HHS demonstration project, continue to provide insights into the variations in hospice program design that are essential to high quality care while remaining responsive to community and patient characteristics.[4, 5, 7, 8, 9]

Preliminary results from these studies indicate that the viability of many hospice programs could be jeopardized if Congress waits three years to make modifications to the approach included in the legislation. Additionally, serious issues have been raised regarding the potential effect that the current hospice benefit could have on the Medicare Hospital Insurance trust fund, which already is faced with severe funding problems.

We are pleased that the Subcommittee is holding hearings to consider changes that should be made now, rather than when the hospice benefit sunsets in 1986. As part of your considerations, we recommend that the Subcommittee reassess the extent to which the Medicare hospice benefit is pushing hospice care in the direction of a separate delivery system. Such a separation would severely compromise the cost effectiveness of hospice care, create additional stress and discontinuity of care for Medicare beneficiaries, prematurely eliminate alternative hospice program models, and limit the positive effects that involvement in hospice can have on the delivery of care to all patients, including the entire population of terminally ill Medicare beneficiaries.

We urge that the Subcommittee maintain a flexible approach in conducting this three-year experiment by making necessary changes and that you consider the legislative and regulatory alternatives discussed below. We believe these recommendations, if adopted, would result in the most valuable use of the three-year trial period.

SPECIFIC ISSUES

Several issues are raised by the Medicare hospice legislation and proposed regulations in two areas: (1) barriers to Medicare certification; and (2) payment for hospice care. Recommendations for legislative and regulatory amendments follow the discussion of each issue below. It should be noted that regulatory recommendations were developed within our understanding of the constraints of the current hospice law.

Barriers to Medicare Certification

The Medicare legislation limits hospice certification to programs that can meet three critical requirements: the 80/20 limit on inpatient care, the core services requirement, and the professional management responsibility requirement. Taken together, these requirements could prevent the vast majority of existing hospice programs from receiving certification as Medicare hospice providers, thereby limiting beneficiary access to the hospice benefit. Also, if rigidly interpreted, the Health Care Financing Administration's (HCFA) proposed patient care area standards could present severe financial barriers to certification.

The 80/20 Utilization Rule

The legislation requires that the aggregate number of inpatient days (general and respite) not exceed 20 percent of the total number of Medicare days of care provided by the hospice.

Preliminary data from the National Hospice Study[9] suggest that variations in inpatient utilization between inpatient-based and home care-based hospice programs are strongly related to differences in their patient populations regarding the availability of extensive home support, level of disability, degree of illness, and the amount of time prior to death when patients select hospice care. Hospices that serve higher proportions of patients who have less home support and are more ill can usually delay inpatient admission through use of broader home care services if patients are referred to them more than a few days before death. We support the emphasis of home care under hospice programs. However, we are concerned that the 20 percent inpatient utilization would impose inequitable and restrictive hospice admission criteria.

Consequently, AHA recommends the following amendments:

Legislative:	Eliminate the 20 percent limit on inpatient utilization in order to remove unjustified and inequitable access barriers for Medicare beneficiaries who do not have adequate home support or who are too ill to be cared for at home.
Regulatory:	Modify the rigid application of the 20 percent limit on inpatient care as a certification requirement, by allowing hospices to work toward that goal and by not penalizing those hospices that exceed the limit due to their mix of patients.

The Core Services Requirement

The statute requires that "substantially all" physician, nursing, social work, and counseling services be "routinely" provided by employees of the hospice program, either directly by or under the supervision of the hospice interdisciplinary team. The team must include at least one professional registered nurse, one physician, one social worker, and one counselor, all of whom must be employees of or volunteers in the hospice program. This "core services" requirement presents three distinct problems.

- Negative Impact on Cooperative Arrangements. Of the 450 hospital-based hospices, only 40 percent directly provide home health care as well as inpatient care. The remaining hospices would be ineligible for certification unless they dissolve or substantially reduce cooperative arrangements with community-based home health care and visiting nurse associations. Substantial efforts were made to achieve coordinated delivery of home health care and to develop specialized hospice home care services in these communities. Also, urban hospices that extend their services to surrounding rural communities may be forced to reduce their service areas if the geographic area is too large to be served by a centralized staff and the number of hospice patients in a rural community are too few to support out-based home care staff.

- Role of Attending Physicians. Although designed to ensure continuity of care, the core services requirement restricts one of the most important methods for achieving continuity -- the continued active involvement of the patient's own attending physician. Although the statute explicitly preserves coverage for non-employee attending physicians, it still bars them from being physician members of the interdisciplinary team and requires that substantially all hospice physician services be provided by hospice employees or volunteers. Moreover, HCFA has gone further by including the general "day-to-day, hands-on medical services required by hospice patients" in the definition of hospice physician services. As a result, hospices will be forced either to supplant or duplicate the hands-on care provided by attending physicians, unless an employment relationship can be established. We believe promoting active involvement of the attending physician in the delivery of both traditional curative care and hospice care would best suit both patient and Medicare program objectives.

- Prohibited Use of Parent Provider Employees. HCFA's proposed regulations state that employees of a hospice's parent organization can be considered hospice employees only if they are assigned and work substantially full-time for the hospice unit. This approach presents severe problems for hospital-based hospices that use the resources of other hospital departments. The relatively small size and low patient census in most hospice programs limits the feasibility of full-time staff for social work services, dietetic counseling, patient/family education, etc. The requirement could diminish continuity of care and patient support systems as well, especially in the case of social work services, where a member of the hospital's social work department had been responsible for the patient/family before the decision to enter the hospice program.

To resolve all three problems, AHA recommends the following amendments:

Legislative: Remove the core services requirement and require instead that the hospice directly provide counseling services, coordination and care planning across all settings, and at least one level of care (home care or inpatient care).

Provide a positive incentive, or at least remove the current disincentives, for attending physicians to continue providing day-to-day medical care to their patients and to participate as hospice team physicians in care planning activities.

Regulatory: Remove the restriction on using the services of parent provider employees who are not assigned substantially full-time to the hospice program.

Modify the interpretation of the core services requirement as it pertains to physician services to allow provision of day-to-day medical services to hospice patients by their attending physicians.

Professional Management Responsibility

The "professional management responsibility" requirement applies to non-core services provided under arrangements with the hospice and, as elaborated by HCFA, subjects hospices and contracting providers (primarily hospitals) to a variety of untenable legal problems.

For hospices without their own inpatient beds, the Medicare requirements dictate that current referral arrangements -- carrying little or no legal or financial liability for the hospice -- be converted to formal contracts that create a shared liability between the hospice and the contracting facility. Assuming shared liability for medical decision-making in an acute care setting may present an obstacle that cannot be overcome by many hospices. For the facilities that would provide inpatient care to these hospices, HCFA's regulations would require contractual commitments that may be at odds with their other legal responsibilities. Requirements for contracts must preserve the ability of each party to negotiate provisions that enable it to meet all of its obligations.

The purpose of the "professional management responsibility" requirement is to ensure that the hospice gives effect to its case management and continuity of care responsibilities. We believe these responsibilities can more appropriately be met by making the following modifications:

Legislative: Remove the professional management responsibility requirement and require instead that a hospice providing care under arrangements with other providers establish mechanisms that allow the hospice to meet its coordination/care planning responsibilities and to resolve any differences of opinion on the care to be provided to individual patients.

Regulatory: Require mutually agreed-upon procedures between the hospice and the contract provider that address coordination and planning of care and resolution of conflicting opinions, rather than mandating contractor compliance with hospice orders without regard to the other legal obligations.

Inpatient Care Standards

HCFA's prorosed regulations state that when a hospice provides inpatient care in a facility already certified by Medicare or Medicaid, the inpatient facility must meet two additional standards: (1) 24-hour R.N. supervision and staffing; and (2) patient areas that provide physical space for patient/family privacy, and special accommodations for overnight stays by family members, visits by small children, homelike decor, and oxygen availability.

The strengthened nurse staffing standards are an appropriate requirement for hospice inpatient care because hospice patients require the higher levels of nursing care found in an acute care setting. However, the additional standards on patient areas are appropriate only if flexibly interpreted. Without a clear interpretation by HCFA, the requirement to provide "physical space for private patient/family visiting" could be interpreted to require rooms or space reserved solely for the purpose of patient/family visits, rather than simply ensuring appropriate accommodations. Also, the requirement for "decor which is homelike in design and function" could be interpreted to require a devoted unit of beds/rooms in an area renovated to provide patient/family kitchens and laundry facilities, dining, and living-room type areas, rather than focusing on non-structural decor and the relaxation of normal institutional policies. Moreover, devoted beds also could require applications for revised state licenses and/or certificate-of-need (CON) and Sec. 1122 applications for approval of a "new service" or of capital expenses for remodeling.

Given the hospice goal of maximizing care in the home and Congress's desire to achieve cost-effective hospice care, we believe it would be inappropriate to focus on expensive remodeling and rigid physical structure requirements, rather than on facility policies and staffs attitudes in meeting patients/families needs. Consequently, AHA recommends the following modifications:

Regulatory: HCFA's proposed inpatient area standards should accommodate the needs of hospice patients and their families flexibly, specifically precluding any interpretation that would require devoted beds/units or extensive physical structure renovation.

Medicare Payment for Hospice Care

The major issues regarding Medicare payment for hospice care fall into three areas: (1) the appropriateness of a prospective pricing system for hospice care at this time; (2) the method used to set the "cap" on total hospice revenues; and (3) the failure of the prospective rate structure to accommodate the full range of services and settings currently used by hospice patients.

Appropriateness of a Prospective Pricing System for Hospice Care

HCFA has proposed a prospective pricing system, rather than adopt the reasonable cost reimbursement mechanism envisioned by Congress. As the Subcommittee knows, AHA supports the adoption of prospective payment mechanisms under Medicare. A prospective price-setting mechanism is likely to provide more predictable expenditures for the Medicare program, more predictable payment levels for hospice programs, and stronger incentives for efficient operation. However, a prospective pricing system is feasible only when a solid base of knowledge concerning patient characteristics, costs, and utilization has been established. At this time, the base of information on hospice care is inadequate. Once a firm knowledge-base has been developed, a prospective pricing system for hospice services would be appropriate. Consequently, AHA recommends the following modifications:

Legislative: Require cost-based payment until the knowledge-base needed to design a workable prospective pricing system has been accumulated. If experimentation with prospective pricing for hospice services is viewed as desirable at this time, each hospice should be allowed to choose either cost-based reimbursement or prospective pricing. In addition, any experimentation with prospective pricing methods should explicitly address capitation methods of payment for hospice care.

Regulatory: Collect cost and utilization data from all participating hospices during the initial three-year trial benefit period.

"Cap" on Total Payment

The payment method established by the hospice statute included a "cap" on total Medicare payments. The cap amount originally was expressed in terms of a formula intended to represent the relationship between average hospice costs and average Medicare expenditures for cancer victims. Having discovered technical problems with the formula, Congress has set the cap at $6,500 in the first year. Increasing the cap to $6,500 reduces the degree of financial risk, but does not address other issues regarding the validity of the cap itself.

The cap formula is an attempt to superimpose elements of a capitation payment method on a cost-based payment method in order to guard against increased expenditures, rather than to create desired incentives. Capitation payments must be actuarially adjusted to reflect the age, disability status, geographic location, etc., of the enrolled population because all these factors will affect utilization and costs. The hospice per capita limit is not adjusted for any actuarial factors other than geographic region, thereby putting the hospice at risk for all variations in utilization related to the need for care. This risk is inordinate given recent study findings regarding significant variations in patient populations, the duration of hospice care, and expenditures for different types of cancer.[4, 9] HCFA has itself stated in the preamble to the regulations that a pure capitation method was not -- and cannot be -- adopted due to the severe lack of knowledge concerning the critical relationships among costs, utilization, and patient characteristics (both medical and social). However, the inability to adjust for these factors makes the cap equally invalid as a payment limit until it can be appropriately adjusted.

Because the HCFA demonstration cost data represents only a small sample of hospices, implementation of the Medicare hospice program will provide the only comprehensive source of data on costs, utilization, and case mix. HCFA's proposed regulations indicate, however, that only limited cost and utilization data will be collected from "selected" hospices each year, despite the fact that all hospices will have to maintain such data in the event they are selected at the end of the year. Without data from all participating hospices, it will be difficult to determine if the selected hospices are a representative sample.

Consequently, AHA recommends the following modifications:

Legislative: Eliminate the cap amount, because its use is inappropriate unless modified into a true capitation payment with positive incentives for cost containment, not just negative sanctions. If Congress decides that it must retain the aggregate cap limit, the cap provision should be amended to:

- Provide an exceptions adjustment process to review payment to hospices that experience significant utilization or patient mix variations.

- Require that within 12 months the HHS Secretary establish a method to adjust automatically the cap amount to account for patient utilization and service mix variations that are due to disability status, duration of care, and diagnosis.

Regulatory: Collect cost and utilization data from all participating hospices during the three-year trial benefit period.

The Proposed Prospective Rate Structure

If Congress allows a prospective price-setting mechanism, several modifications are necessary in the proposed rate structure and the methods used to set the rates. HCFA's proposed four levels of care are unnecessarily inflexible and could cause hospices to make available treatment options or care settings solely on the basis of the adequacy of payment, rather than a consideration of the best interests of the patient/family. Several specific problems underscore the inflexibility of the rate structure.

- Failure To Recognize Home Respite Care. HCFA recognizes only two types of home care: routine and continuous nursing. Respite care delivered in the home fits neither level. While inpatient respite care is appropriate for many patients, some hospices have found that in providing respite care, it is often less disruptive for the family, rather than the patient, to leave the home. Although the statute discusses respite care only in the context of inpatient care, it is unclear whether Congress intended to limit respite care to the inpatient setting. The failure to recognize home respite care could force a significant change in hospice care patterns by moving virtually all respite care into the inpatient setting. Such a change is inconsistent with the hospice philosophy of keeping patients in the home to the maximum extent possible and could consume too many of the severely limited inpatient days allowed by the 80/20 rule, rather than reserving inpatient days for acute pain and symptom management.

- Failure To Recognize Special Procedures. The second example relates to the failure to recognize the special procedures that are sometimes required to manage pain and symptoms effectively. Examples include palliative surgery such as nerve blocks, chemotherapy, or radiation. HCFA's rate structure does not appear to recognize such procedures, whether performed on an outpatient or inpatient basis. However, if a nerve block or outpatient chemotherapy is the only way to relieve a terminally ill patient's pain effectively, it would be inappropriate to force hospices to withhold that treatment because of a rigid payment structure.

- Use of Unadjusted 1981 Cost Data. In developing the two rates for routine and continuous home care, HCFA used 1981 cost and utilization data from the 26 HCFA demonstration hospices. These data were not adjusted for inflation between 1981 and 1984, the year to which the rates will apply. In addition, HCFA plans to update rates only when it believes it is necessary based on available cost data, rather than providing a mechanism for annual updating. This lack of appropriate adjustments could seriously undermine the adequacy of the two home care rates.

To address all of these problems, AHA recommends the following modifications:

Regulatory: If HCFA's proposed price-setting mechanism is implemented, it should be modified to:

- Adjust for inflation in the cost base used to set rates for both the initial year and subsequent years.
- Modify the level of care rate structure to allow more flexibility in choosing the appropriate care setting, specifically including recognition of home respite care at a level that falls between routine home care and continuous home care.
- Establish separate payment rates for specific procedures, such as certain palliative surgery, radiation or chemotherapy, provided on an outpatient or inpatient basis.

CONCLUSION

Hospice care provides one alternative way to address the problem of terminal illness for both the Medicare program and for terminally ill Medicare beneficiaries. Even though it represents only potential -- not guaranteed -- savings in total Medicare expenditures, hospice care definitely responds to the care needs of a segment of the terminally ill Medicare population. Additionally, some benefit design aspects of hospice care may be effectively offered to terminally ill beneficiaries who are not ready to consider the hospice option. For these reasons, maximum use should be made of the three-year trial period to obtain the information needed to design permanent changes in the Medicare program.

Senator **Durenberger**. Senator Heinz?

Senator **Heinz**. Mr. Chairman, thank you.

First, I apologize to all of the witnesses, as someone who has been very deeply involved in this legislation, for not having been here for most of the testimony.

I do have a set of questions that I want to submit for the record to Dr. Carolyne Davis, which I understand were not touched upon directly during the previous questioning of Dr. Davis. They are seven in number.

Senator **Durenberger**. And she has agreed to respond to several questions, including yours.

Senator **Heinz**. Well, I hope she will respond, because the chairman will join me in requesting a response.

Senator **Durenberger**. That is agreed.

[Senator Heinz' questions and Dr. Carolyne K. Davis' answers follow:]

1. Q. Hospice as Program Savings or Cost. Dr. Davis, the Congressional Budget Office has made a preliminary estimate of savings for this Medicare hospice benefit of about \$55 million over the next 3 years, including offset of payments that would have been made for other health care covered under Medicare. HCFA estimates this benefit to cost an additional \$350 million over the same 3-year period, also including offset. Can you explain the reasons for these substantial differences?

A. The cost estimate of the Congressional Budget Office is based upon a major methodological flaw: The estimate implicitly assumes that every hospice patient stays in the hospice for the average length of stay thus implying the hospital savings attributable to hospice are equal to the cost of hospital care during the average hospice stay. However, this is not the case. Many hospice patients stay in the hospice for only a few days and save very little in hospital costs. The longer stays, on the other hand, do not make up for the reduced savings on the shorter stays.

2. Q. Payment Rates. In this proposed final version of the HCFA hospice regulations, I understand HCFA has made adjustments in the 1981 base year data in calculating prospective payment rates for inpatient respite and inpatient general care to adjust for increases in the medical care component of the CPI from 1981 base. Why wasn't the home care rate adjusted for 3 years' inflation in reasonable costs of items such as nursing and home health services and drug costs?

A. The final home care rates have been adjusted for inflation through 1984.

3. Q. Twenty Percent Inpatient Care: Condition of Participation or Payment. The statute extending Medicare coverage to hospices required that the total number of inpatient days not exceed 20 percent of the aggregate number of days of hospice care. This was intended by Congress as a condition of participation in the Medicare hospice benefit, but the HCFA regulations make it a condition of payment and require a refund of any reimbursement made in excess of this limit (for "excess" care). Did HCFA consider making the 20 percent inpatient day requirement simply a condition of participation — as Congress intended? Did HCFA consider, alternatively, imposing a less stringent penalty — for example, requiring a plan of correction for providers in excess of 20 percent rather than a refund of reimbursement due for services provided?

A. We rejected this alternative because the nature of the survey and certification process, with its plans of correction, resurveys and appeals of termination, is not a process geared to fiscal accountability. Under that process, a hospice could repeatedly exceed the ratio so long as it periodically corrected its behavior in time for the resurvey called for under its plan of correction. Thus, if left as only a condition of participation this statutory requirement could remain imperfectly implemented by many providers for the entire 3-year life of the benefit. Under the final regulations, hospices have a financial incentive to correct inappropriate patterns of utilization. Hospices will be paid the routine home care rate for each day of inpatient care in excess of the 20 percent statutory limit. We believe this measure will soften the impact of the payment limit without blunting the incentive it provides for more appropriate utilization.

4. Q. Election of Coverage. Under the HCFA regulations, is the beneficiary the only one who may elect hospice care or are there circumstances under which the relatives or legal guardian may do so?

A. Under the proposed regulation, only a beneficiary could execute a hospice election. Relatives and legal guardians were not permitted to do so. On the basis of comments we received on this provision, however, we are satisfied that some provision is necessary to enable a patient who is in need of hospice care to receive it even though he or she may not be able, at the time of election, to execute the election statement. At the same time, we continue to be concerned that the patient's access to the full range of curative (rather than palliative) care covered under Medicare not be foreclosed by an election executed by an individual who may not be exercising an appropriate choice. We have considered several alternatives and have included a provision in the final regulations which permits an election (or revocation) to be made by another individual when authorized in accordance with state law.

5. Q. HCFA Examination of Cost Reports. Will HCFA's examination of selected cost reports require all hospices to prepare cost reports or only those preselected hospices whose cost reports will be examined by HCFA? How will HCFA treat cost incurred by the hospices in preparing these reports?

A. Under the final regulations, all hospices are required to prepare and submit cost reports for examination by HCFA. Costs that hospices incur in preparing these reports are administrative expenses and are part of the overhead costs included in the service components comprising the rates.

6. Q. HCFA Monitoring. How will HCFA monitor hospice practices relating to beneficiaries approaching the $6,500 cap to assure appropriate care continues to be provided?

A. State survey and certification agencies will conduct onsite reviews of hospice plans of care and medical records and will observe patient care to assure that patients whose costs of care approach or exceed the cap are not receiving diminished services or being discharged. These agencies may also interview patients and their families in the home to verify that care is appropriately delivered.

7. Q. Demo Results. Outcome studies from the HCFA 2-year demos (26 hospices treating Medicare/Medicaid patients from October 1980 to 1982) is due to be published at the end of September 30 — when will we see the results of the HCFA demos?

A. A preliminary report with data on almost 4,000 patients who participated in the National Hospice Study was submitted in October by the independent evaluator, Brown University. The final report, covering 6,000 hospice patients, is scheduled to be available in the summer of 1984.

8. Q. Hospice Consortiums. Some hospices, such as South Hills Hospice in Pennsylvania, have been formed as hospice consortiums through cooperative arrangements among providers of hospice services. How many of your hospices are of this type? Will this type of hospice be eligible for the hospice benefit under these regulations?

A. We do not know how many existing hospices are consortiums or coalition hospices. The law and the current regulations do not prohibit an organization which arranges for some services from participating in Medicare so long as it provides the "core" services -- nursing care, physician services, medical social services, and counseling -- directly through hospice employees. A hospice may arrange for other services, such as short term inpatient care or physical or speech therapy, with other providers. It is true, however, that an organization may not be certified as a Medicare hospice provider if it obtains substantially all nursing care, physician services, medical social services, or counseling services from another organization or agency. These services can be provided under contractual arrangements only under extraordinary circumstances or to meet peak workloads. It is our view that this result is required by section 1861(dd)(2)(A)(ii)(I) of the Act.

In the final regulations, we have tried to make the definition of "employee" as flexible as possible, consistent with the statute. In many cases, we believe that hospices can comply with the core services requirement with a minimum of organizational change.

Senator HEINZ. I have only one question for the providers here: Do any of you represent hospice consortiums?

[No response.]

Senator HEINZ. No.

Then I am going to submit my question to Don Gaetz of the National Hospice Organization.

Senator HEINZ. I would only observe that there is in my home State of Pennsylvania, South Hills of Allegheny County, just outside of Pittsburgh, a hospice which has served some 400 patients over the last 3 years. It's composed of Mercy Hospital, South Hills Health System, the South Hills Interfaith Ministry, St. Clare Memorial Hospital. Because it is a consortium and because of the regulations, it does not expect to be certified as a hospice provider, and this is a serious problem.

I will propound my questions elsewhere, Mr. Chairman.

Senator DURENBERGER. All right. I thank you very much.

Let me start with Gordy Sprenger, a question about the American Hospital Association and what appears to be an increase of vertical integration in the hospitals of this country; that is, hospitals are starting to establish their own home health agencies, their own skilled nursing facility beds, in part in preparation for medicare's DRG-based prospective payment system.

In your opinion is it possible that we will shortly see more of the 450 hospital-based hospices referred to in your statement providing home health care directly? Is that quite likely?

Mr. SPRENGER. Yes. I think that a number of hospitals are considering that, Senator; but there are also a number who are working with well-recognized agencies within their community, where they don't find a need to develop them themselves. And I think that's the thing we are pushing for here, some flexibility in being able to respond, in the most appropriate way in a given community.

In our community, for instance, a number of the hospitals are developing their own home health care agencies as part of the hospital; but there are some who are choosing not to and are using community resources in order to provide that care.

Senator **Durenberger**. Let me ask those of you who are representing the hospitals to tell me how hospital-based hospices typically coordinate hospice care provided by the hospice and a patient's attending physician. Give me some idea, in each of your cases, how that works.

Ms. **Rauscher**. OK.

The patient's attending physician is the entry point for the patient to get into the hospice program. In other words, we don't accept a patient into the hospice program unless his attending physician agrees that hospice care is appropriate for him and also agrees to follow him after he has entered the program.

Senator **Durenberger**. Does anybody else have other observations?

Sister **Sapp**. Ours is basically the same, yes.

Senator **Durenberger**. How do hospital-based hospices supervise and monitor home care provided under arrangements with other providers? Does anybody here have experience with that? Gordy?

Mr. **Sprenger**. We have an interdisciplinary team that operates out of our hospice program, of which we meet with and establish some very rigid criteria with the home health care agency or the Visiting Nurse Association—whoever is delivering care. We put those expectations out and expect them to be met. If they don't, then obviously we have to change the provider that we have contracted with to do it.

Senator **Durenberger**. Is there much of that going on throughout the country?

Mr. **Sprenger**. There certainly is. In our community, for instance, visiting nurse service is heavily used in Hennepin County and in Bloomington and other sections of the metropolitan area.

Recent data that I saw indicates a good number of the hospice programs, at least that are hospital based, do use community resources to provide all of the services.

I think what we have to remember is that we are trying to manage the hospice patient, and we need to have centralized case management of that patient. But to say that all of the care that is given that patient needs to all be centrally controlled—I think we would question that.

Senator **Durenberger**. Lynette?

Ms. **Rauscher**. The hospice regulations at this point identify that the nurse is the patient care coordinator, or coordinator of the patient care plan. My concern as we negotiated with community agencies in trying to provide nursing service for hospice through our program is that we could not have enough direct control over the evaluation of that nurse and the time that that nurse was allowed to spend caring for hospice patients. It also presented massive administrative problems in terms of having the patient care record centrally located while the nurse is in another agency doing the care.

It really would add on significant administrative costs. It is sometimes an administrative nightmare, anyway, trying to administer your own staff and keep them coordinated as a team. And to try to do this with a number of agencies—at least from our perspective—would have been virtually impossible.

Senator DURENBERGER. Gordy, are you satisfied with the proposed level of payment for general inpatient care in the regulations?

Mr. SPRENGER. Well, we are concerned that the cap was arrived at without a good data base. We know we are obviously going to have to live with it and see if it is going to be adequate or not.

I think we are more concerned with some of the other restrictions in the regulations that are coming out than specifically that cap at that point. But, you know, certainly we do have some concerns, because there isn't a good data base to know what is the right cap amount.

Senator DURENBERGER. And I take it, Sister Mary, you would agree with that?

Sister SAPP. Yes, I would.

Senator DURENBERGER. Let me ask you one question before I have to leave:

From your experience, how often do hospice patients have extremely long lengths of stay or extraordinarily high costs? To what would you attribute either of those kinds of situations? What is the typical case that results in either long stays or high costs?

Sister SAPP. You can look at an individual who at first would appear to be very imminently terminal, within 6 months. It was our experience during the demonstration, however, that the prognosis was not always accurate.

I was looking at the statistics last night, and we had one case that was 480 days, and the person eventually then went to a long-term care facility.

But because of remission the case can be extended.

Senator DURENBERGER. I wonder if on that issue—and I really am going to have to leave, with my apologies—if all of you might put some answers on the record, just to give us an illustration of what we are dealing with.

Mr. SPRENGER. We appreciate the opportunity.

Senator DURENBERGER. Thank you all very much. I hope we get back for the next panel.

Mr. SPRENGER. Thank you, Senator.

[Whereupon, at 4:25 p.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. If anyone is left, we will call our final panel, consisting of Dr. Robert Enck, Binghamton, N.Y., chairman, Hospice Committee of the Association of Community Cancer Centers in Rockville, Md.; Dr. Steven P. Lindenberg, counselor, Hershey Psychiatric Associations, and past president; chairman, Hospice Task Force, American Mental Health Counselors Association, Hershey, Pa.; and Charles E. Marvil, director of social work, Wilmington Medical Center of Delaware, Wilmington, Delaware, on behalf of the National Association of Social Workers.

We welcome you all, and we will start with Dr. Enck.

STATEMENT OF ROBERT E. ENCK, M.D., BINGHAMTON, N.Y., CHAIRMAN, HOSPICE COMMITTEE, ASSOCIATION OF COMMUNITY CANCER CENTERS, ROCKVILLE, MD.

Dr. **Enck**. Mr. Chairman and members of the Senate Finance Committee: There are several points that the Association of Community Cancer Centers wishes to make. All three points relate to our concerns about the quality of care that may be delivered to patients under the proposed legislation and regulations.

First, unlike the other prospective payment reimbursement system, the current hospice legislation and regulations do not provide for a systematic peer review of the appropriateness of care.

We believe the legislation should be revised to include the attending physician in the recertification of patients, to assure that patient quality-of-care is adequate.

Second, for similar reasons, we believe that the committee should incorporate the accreditation of hospices utilizing the JCAH criteria into the requirements prior to reimbursement. Hospice patients deserve to know that they can be confident of the facilities and personnel to which they will entrust the last days of their lives.

Finally, we are concerned over the artificial constraints within the legislation of the 80-20 split in patient time between home care and inpatient care. Given that some patients require more extensive management, and given there is no case mix formula involved in the hospice legislation or regulations, we believe that more latitude should be provided to the program.

Thank you for this opportunity to express our concerns.

Senator **Durenberger**. Thank you for your brevity, and all of your prepared statements will be made part of the record.

[The prepared statement of Dr. Robert Enck follows:]

FULL TESTIMONY

Senate Finance Committee Hearing On Hospice

TESTIMONY OF ROBERT ENCK, M.D., CHAIRMAN
HOSPICE COMMITTEE
ASSOCIATION OF COMMUNITY CANCER CENTERS

Mr. Chairman, and Members of the Senate Finance Committee, there are several key points the Association wishes to make in the time alloted relating to both the initial legislation and the recently issued hospice regulations.

Perhaps it is important to preface these remarks with some information on the Association and its relationship to the hospice movement.

The Association of Community Cancer Centers was one of the first U.S. organizations to sponsor conferences on the hospice concept in the mid-1970's. Our membership includes institutions across the United States that have developed sophisticated community cancer programs. Over 90% of these hospitals and community organizations have some relationship to an established hospice program. Many of our members are Medical Directors of hospice organizations, in addition to their duties as oncologists in the care of cancer patients. While we are winning the war against cancer in many ways, many of our cancer patients are still in need of the kind of care that the hospice concept may make possible.

All three points I wish to make relate to our concerns about the quality of care that may be delivered to patients under the proposed legislation and regulations:

First, unlike the other prospective payment legislation and regulations, the current hospice legislation and regulations do not provide for systematic peer review of the appropriateness of care. We believe the legislation should be revised to include the attending physician in the recertification of patients to assure that patient quality of care is adequate.

Concerns over quality led the Congress in the Social Security Amendments of 1983 to require that hospitals contract with a PRO to monitor the quality of care, thus assuring that quality does not decline under prospective reimbursement.

Where is that monitoring system under the hospice legislation and regulations? Simply because patients are not opting for curative care, does not mean they are abandoning quality care.

We are concerned that under the current regulations patients could be turned over to a hospice and hospice physician who could then manage the patient without any involvement of any outside group. Surely our past experiences with these kinds of situations has taught us that this is a situation with great potential for abuse. It is when patients are isolated from review, with little if any outside contact...when they have little recourse and are essentially totally dependent...that there is need for significant concern. Hospice must not become a way of warehousing the dying at discount rates. But, who is to assure that the patient's management will be properly handled?

We believe that one simple way that the hospice activities can be monitored is to require that the attending physician be involved in the recertification of hospice patients for hospice care. The initial legislation required their involvement in the initial certification.

By involving the attending physician in the recertification, we assure that a number of outside community physicians will check on the progress of their hospice patients. If care is improper, they can refuse to recertify the patient. Moreover, hospice programs that cannot satisfy physicians as to the quality of their programs will quickly lose referrals. This is a quick and efficient method of quality control.

Further, the Committee might consider the unusual circumstance where a hospice physician is reimbursed at 100% of the Medicare reasonable charge, while other physicians involved with the patient are reimbursed at 80 percent. If the Medical Director is also the key leader of the hospice, there is potential for abuse once again. Who will insure that these charges are reasonable and what recourse is available if these physician program costs exceed the cap in multiple instances? Unlike other prospective pricing programs which have "unbundled" physician services from other services, the hospice legislation and regulations are "bundling" them together.

If a hospice administrative director is to monitor and direct the physician care, do we not have the potential for an administrative director to require a Medical Director to give the lowest cost alternative care? With isolated hospice patients, this does not paint a very pretty picture.

Perhaps the costs of the hospice physician should be "unbundled" again, with the Medical Director's services subject to utilization review by peers who are much more likely to be able to monitor the quality and extent of services provided.

Second, for similar reasons, we believe that the Committee should incorporate the accreditation of hospices utilizing the JCAH criteria, into the requirements prior to reimbursement. Hospice patients deserve to know that they can be confident of the facilities and personnel to which they will entrust the last days of their lives.

The Joint Commission on Accreditation of Hospitals assembled an excellent panel representing multiple organizations involved in hospice care. This organization held hearings and formulated strong, quality oriented criteria for hospice accreditation. This kind of outside peer review will assure that hospice programs meet quality standards.

Finally, we are concerned over the artificial constraints within the legislation on an 80/20 percent split in patient time between home care and inpatient care. Given that some patients require much more extensive management and given that their is no case mix formula involved in the hospice legislation or regulations, we believe that more latitude should be provided to the programs.

Some research on hospice suggests that hospices will be similar to other health care organizations, they will see different types of hospice patients which will require different levels of care. Those hospices which see patients and families in need of different sets of resources should have the flexibility to respond to these needs within the total fixed price for hospice reimbursement.

We would be happy to assist the Committee with any additional information.

Respectfully Submitted

Robert E. Enck, M.D.
Chairman,
Hospice Committee
Association of Community Cancer
Centers

STATEMENT OF STEVEN P. LINDENBERG, Ph.D., CCMHC, COUNSELOR, HERSHEY PSYCHIATRIC ASSOCIATES, PAST PRESIDENT; CHAIRMAN, HOSPICE TASK FORCE, AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION, HERSHEY, PA.

Dr. LINDENBERG. Thank you, Mr. Chairman.

I come today to speak first of all in the interests of dying patients who are served by hospices throughout the country.

Second, I also wish to present myself as past president of the American Mental Health Counselors Association and its hospice task force leader.

The Tax Equity and Fiscal Responsibility Act of 1982 expanded medicare reimbursement for hospice care by an accredited hospice. Sections of this law dealing with staffing provided for the delivery of counseling and pastoral counseling services.

Now that the regs are being finalized, I think that it is important that these regulations recognize a number of disciplines as being qualified to provide the counseling component of care for the dying patient and his or her family and for bereavement counseling for the patient's family.

My current understanding of the proposed regulations as well as standards proposed by JCAH is that, while counseling is mandated in terms of staffing and hospice care delivery, definition as to who shall provide counseling as a member of the interdisciplinary team would be restricted to those persons who have either a doctorate in psychology or a masters degree from a school of social work accredited by CSE.

One of the very positive aspects of the legislation as passed is that its implementation will save patients and their families, by some estimates, as much as two-thirds of the cost of care for the dying in a hospital setting. It is therefore important, in my opinion, to be certain that no legitimate discipline is excluded from consideration as a provider under this important legislation.

I would like to recommend that the language of the regulations include as providers of counseling and psychosocial services for hospice care delivery persons who have a doctorate in psychology or mental health counseling, a masters degree in social work, a masters degree in psychology, a masters degree in mental health counseling, a masters degree or its equivalent in psychiatric nursing, and/or a psychiatrist. Of course, all persons should have obtained their credentials from accredited institutions.

The effect on service delivery of including other mental health care providers is that it would substantially increase the workforce pool from which hospice boards and administrators could hire and designate as the provider of psychosocial services for delivery to patients and their families. In effect, this would increase competition and therefore allow hospices, particularly those in rural areas and small communities, the opportunity to qualify their hospice for JCAH accreditation and thus Medicare reimbursement for their patients.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Dr. Steven P. Lindenberg follows:]

Administration Regulations to Implement Medicare Hospice Benefits Enacted as a Part of the Tax Equity and Fiscal Responsibility Act of 1982

Testimony Presented to the

Senate Committee on Finance

Subcommittee on Health

On Behalf of the

AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

Steven P. Lindenberg, Ph.D.
Hershey Psychiatric Associates
20 Briarcrest Square
Hershey, PA 17033
(717) 533-4797

September 15, 1983

THE AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION recommend that it is in the patients and taxpayers best interest to have all credentialed disciplines represented as potential psychosocial and counseling service providers as members of the interdisciplinary team of hospice workers for Medicare reimbursement.

Mr. Chairman:

My name is Steven P. Lindenberg. I received my Ph.D. from the University of Georgia in 1977 and have been in private practice as a counselor and a partner with Hershey Psychiatric Associates, Hershey, Pennsylvania. In addition to my private practice, I am co-founder, past-President and current board member of Hospice of Central Pennsylvania. I am a former advisor to the Harrisburg Chapter of the Compassionate Friends, a self-help group for bereaved parents. I have recently authored a book entitled Group Psychotherapy With People Who are Dying (Charles Thomas, publishers, Springfield, IL, 1983). I have taught classes, presented numerous workshops and written a number of articles on the subject of death, dying, grief and bereavement.

I come to you today to speak, first of all, in the interest of dying patients who are served by hospices throughout our country. Secondly, I also wish to present myself as past-President of the American Mental Health Counselors Association (AMHCA) and as the Hospice Task Force Leader for this organization.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) expanded Medicare reimbursement for hospice care by an accredited hospice. Sections of this law dealing with staffing provided for the delivery of counseling and pastoral counseling services.

Now that the regulations are being finalized, I think that it is important that these regulations recognize a number of disciplines as being qualified to provide the counseling component of the care for the dying patient and his or her family and for bereavement counseling for the patient's family. My current understanding of the standards that have been prepared by the Joint Commission for the Accreditation of Hospitals (JCAH) is that while counseling is mandated in terms of staffing and hospice care delivery, definition as to who shall provide counseling as a member of the interdisciplinary team would be restricted to those persons who have either a doctorate in psychology or a masters degree from a school of social work accredited by the Council on Social Work Education.

It is my understanding that guidelines for writing the regulations concerning hospice care are being provided to the Senate by the JCAH. Also, the JCAH will be accrediting hospices for Medicare reimbursement once the regulations have been signed into law.

One of the very positive aspects of the legislation as passed is that its implementation will save patients and their families, by some estimates, as much as two-thirds of the cost of care for the dying in a hospital setting. It is therefore important, in my opinion, to be certain that no legitimate discipline be excluded from consideration as a provider under this important legislation.

My major concern regarding the delivery of hospice care services by an accredited hospice is that representatives of all mental health care disciplines should be considered as potential providers of counseling/psychosocial services in the regulations governing Medicare reimbursement under this legislation.

I would like to recommend that the language of the regulations include as providers of counseling and/or psychosocial services for hospice care delivery persons who have a doctorate in psychology, a masters degree in social work, a masters degree in psychology, a masters degree in mental health counseling, a masters degree or its equivalent in psychiatric nursing and/or a psychiatrist. Of course, all persons should have obtained their credentials from accredited institutions.

The effect on service delivery including other mental health care providers is that it would substantially increase the "work force pool" from which hospice boards and administrators could hire and designate as the provider of psychosocial services for delivery to patients and their families. In effect, this would increase competition and therefore allow hospices, particularly those in rural areas and small communities the opportunity to qualify their hospice for JCAH accreditation and thus Medicare reimbursement for their patients.

There is a second level which to my mind should be considered concerning the inclusion of counseling as a discipline in the regulations. The language of TEFRA clearly states that counseling is a distinct interdisciplinary function that is integral to the organizational matrix, philosophy and practice of the delivery of hospice care services. Yet the language of the law fails to include mental health counseling as a discipline from which providers might be sought to administer counseling and psychosocial services. Counselor education involves core curriculum that includes coursework in areas such as sociology, psychology, abnormal psychology, human relations, family dynamics and applied psycho-therapeutic techniques. In other words, mental health counselors are the best qualified to provide counseling.

In summary, there are five core mental health care disciplines: mental health counseling, psychology, psychiatry, social work and psychiatric nursing. As an expert in the field I would recommend that it is in the patients' and taxpayers best interest to have all of these disciplines represented as potential psychosocial and counseling service providers as members of the interdisciplinary team of hospice workers for Medicare reimbursement.

Thank you for this opportunity to present my testimony today.

Harley M. Dirks
Washington Representative
American Mental Health
Counselors Association
(202) 347-7878

STATEMENT OF CHARLES E. MARVIL, A.C.S.W., DIRECTOR, SOCIAL WORK, WILMINGTON MEDICAL CENTER OF DELAWARE, WILMINGTON, DEL., ON BEHALF OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC., SILVER SPRING, MD.

Mr. MARVIL. Thank you, Senator.

From 1978 until 1981, I was a member of the Standards and Accreditation Committee for the National Hospice Organization. Since 1981 I have been a member of the Joint Commission for the Accreditation of Hospitals' Hospice Advisory Committee and have watched these regulations be developed as an evolution of those two initial efforts.

One of the basic concerns that the National Association of Social Workers has about these regulations is that there is not enough emphasis, not enough attention paid to the fact that in hospice care, as it is unique from traditional health care, the unit of care is the patient and family. And, these regulations they do not speak to that issue, and therefore are too much like the existing system which, in fact, is the reason for the development of the concept. If the existing system could meet the needs of terminally ill patients and their families, there would be no need for hospice care.

A couple of specific issues of concern to social workers:

There is a statement in the regulations which exclusively designates a nurse as the hospice care coordinator. We feel this is unnecessary and inappropriate, and in fact, as a result of the team concept being applied in hospice, any qualified health care professional can coordinate the hospice care team, and in fact many quality programs are coordinated by persons other than nurses.

There is also no need for medical direction of social work. A qualified social worker in a hospital is not directed by a physician; we see no need for this regressive kind of language in the hospice regulations.

Thank you.

[The prepared statement of Charles E. Marvil follows:]

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.
7981 Eastern Avenue, Silver Spring, Maryland 20910 (301) 565-0333

Statement on

Federal

Hospice Regulations

Before the

Senate Finance Committee

Subcommittee on Health

Charles E. Marvil
Director of Social Work
Wilmington Medical Center

September 15, 1983

Mr. Chairman,

My name is Charles E. Marvil, Director of Social Work at Wilmington Medical Center in Wilmington, Delaware. Today, I am representing the National Association of Social Workers which with 92,000 members is the largest organization of professional social workers in the world. In addition to my work at Wilmington Medical Center, I have also been a member of the Standards Committee of the National Hospice Organization and a member of the Hospice Advisory Committee of the Joint Commission on Accreditation of Hospitals.

We appreciate the opportunity afforded by today's hearing to comment on the Administration's regulations to implement the Medicare hospice legislation enacted last year. NASW was pleased to have been a part of that legislative effort to provide a more humane and cost-effective way to care for the terminally ill.

Social work has been an integral part of the hospice movement in this country since it began. Social work services have been available to patients, their families, to hospice staff, and significant others to enable them to deal with the impact of illness on individual and family functioning, and to achieve optimun benefits from hospice and community services. The American Hospital Association has estimated that there are 1,200 hospices around the country. Virtually all provide social work services.

We are pleased that the original legislation embodied the widely applauded interdisciplinary approach to hospice care. This cooperative approach by professionals and others, paid staff and volunteers, fosters the total caring environment which characterizes a hospice and makes it a viable alternative method of care for the dying and their families. And, because of the emphasis on in-home care, hospice care can be a far less expensive alternative then now exists.

While there were problems with the proposed payment amounts in draft regulations, the reimbursement issues appear to have been significantly resolved in the August 22nd proposed rule. Most importantly, the proposed rule recognizes that the cost-effectiveness of hospice care derives from the comprehensive services aspect of hospice care programs which are thus less expensive than the institutional care offered under Medicare.

Although the cap amount, the reimbursement rates, and the proposed 80/20 test have been at the heart of the controversy over the regulations, NASW believes that there are other provisions in the regulations that must also be addressed if cost-effectiveness and high-quality hospice care is to be provided.

Our comments today focus on social work services as addressed in the regulations and as related to other services.

First, we believe that an explicit statement is needed emphasizing that the family is the basic unit of care in the hospice. While this concept is implied in statements about the importance of in-home care and such services as bereavement counseling, increased emphasis would help to clarify the importance of such other services as respite care for the family and in-service training of staff in relationship to the family.

Clarification is also needed regarding use of volunteers. The reality is that volunteers, even full-time volunteers, cannot be expected to run hospice programs. The terminally ill and their families expect and should receive continuity of care as well as quality of care. Thus, there must always be at least a minimum core of paid staff who will train and coordinate volunteer efforts. Core staff services, however, can be extended through the use of volunteers. These volunteers might themselves be interested individuals. It is crucial, however, that patients and their families be able to rely on the availability of staff to assure the continuity of care which only a core staff can provide. It is, therefore, necessary that the regulations clearly affix responsibility for care and clarify the use of volunteers vis-a-vis staff.

With respect to the social work component of hospice care the regulations present several problems.

One is created by the use of the term "medical social services." The term "medical social services" is not as widely used as when it was first written into the 1965 Home Health statute. The professional literature now refers to "social work in health care settings" and "clinical social work." The rule might more appropriately reflect the state of the art if it dropped the word "medical." We believe "social work services" is a sufficient term, the use of which would reduce the likelihood of confusion among users and providers of services.

A second concern is the redundant requirement in the regulations that social work services be provided under the direction of a physician. While we realize this is statutory language, the regulations make clear elsewhere that it is the responsibility of the entire interdisciplinary team (including a social worker) to establish and monitor the plan of care. If direct supervision by a physician were actually put into practice, however, we believe this would be time consuming, unnecessary, and more costly. We believe the statute should be changed to reflect this. However, at this juncture we see no need to repeat this requirement in the regulations. It should be noted that requiring an additional layer of supervision would be burdensome for both the physician and the social worker and superfluous in view of their equal participation on the team. Moreover, the rule does not make a similar requirement for physician's direction of the registered nurse, counselor, or any other persons providing services. Physical, occupational and speech therapists, for example, are to provide services "in a manner consistent with accepted standards of practice." (Sec. 418.92).

We recommend that the regulations reflect the actuality of team work within the hospice program and the capacity of social work to provide services in a manner consistent with accepted standards of practice.

A third, and particularly critical issue concerns the definition of a "social worker", and the subsequent reference to provision of services by a "qualified social worker." We do not know if these terms are intended to be synonymous. A "social worker" is defined in terms of someone with "at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education" (Sec. 418.3).

We believe that this is in conflict with existing federal law and with many state licensing requirements. For example, the regulations for conditions of participation in Medicare for home health agencies, from which the term "medical social services" appears to have been taken in the hospice legislation has a different requirement. The home health regulations use these definitions:

b. Medical social worker - qualifications.
A medical social worker is a graduate of a school of social work accredited by the Council on Social Work Education and has had social work experience in a hospital, outpatient clinic, medical rehabilitation or medical care program.

c. Social work assistant - qualifications.
A social work assistant has a baccalaureate degree and the agency provides on-the-job training in medical social service tasks and assignments.

The intent and current practice is for the use of a person with at least a masters degree in social work (MSW) for the core service staff. Clearly, these regulations should not impose a lower standard for hospice care services by lowering the qualifications of the professional staff involved.

A further complication is posed by the licensing requirement of Sec. 418.72 which states: "The hospice and all hospice employees must be licensed in accordance with applicable State and local laws and regulations."

Thirty-one states currently regulate the practice of social work. Most of these require a masters degree in social work as one of their licensing provisions. As written, these regulations may be in conflict with the licensing requirements of a number of states which call for a higher level of professional training than that set forth in the proposed regulations.

Finally, the lower qualification falls short of NASW standards for health care, long-term care facilities, and hospitals. Social work services of the nature and complexity provided in a hospice clearly require masters-level social work training and experience. NASW, has defined a "qualified social worker" in our standards as one with a master's degree in social work plus two years of post-graduate experience (See, for example, <u>NASW Standards for Social Work Services in Long-Term Care Facilities</u>).

We strongly urge that these standards be adhered to and that the qualifications for social work practice in a hospice be established at the masters degree level.

Thank you for affording us this opportunity to present our views on these proposed regulations.

Senator DURENBERGER. Thank you all very much.

Let me start with Dr. Enck. You asked that JCAH accreditation be incorporated in the regulations. Could you tell us how and to what extent the JCAH hospice standards differ from those in the proposed regulations?

Dr. ENCK. Well, like Mr. Marvil, I have been a member of the Hospice Advisory Committee of the Joint Commission now for the past 2 years, so I think Charlie and I have had a unique opportunity that probably very few people in the country have had, that is, the opportunity to see how hospice care is really given across the United States.

I think that the standards—I can't speak for the Joint Commission, but it is to be published sometime in October—really define hospice care as it is in the United States, which is with a great deal of flexibility, versus this legislation and the regulations, which are very rigid.

I think that one thing that was done with the standards, was to have had input from anybody with a hospice in this country who came to any of the 6 national days, or other standards related activities. We have had a great deal of input from people around the country.

Again, the standards do describe hospice care as it exists across the country.

Senator DURENBERGER. Any other comments on that one?

Mr. MARVIL. I agree.

Senator DURENBERGER. OK.

Dr. Lindenberg, I have a couple of questions from Senator Heinz, who is at a meeting I just left on health care for the unemployed, so he couldn't come, and he asked me to ask you these questions.

How do you feel about the proposed requirement that care service providers on the hospice care team be full-time employees?

Dr. LINDENBERG. I come from Harrisburg, Pa. Hospice of Central Pennsylvania, and I'm on its board. I have some concerns about the rigidity of having to employ full-time staff providers.

Currently our hospice has a volunteer medical director, and we have many volunteer social workers, counselors, and nurses, who provide their care free of service.

Under this proposed law, it would increase our budget approximately three times what it is now, which I would say is about $50,000 a year. It would go from $50,000 to $150,000 a year.

I would rather see some sort of flexibility where we could contract out for a medical director or a director of certain kinds of services, on a part-time basis, until our hospice would reach such a point where the demand and the patient flow would command a full-time position.

Senator DURENBERGER. The second question I don't fully understand; maybe it means something to the folks in Harrisburg.

What is your opinion concerning the potential for duplication of hospice services in communities under the proposed regulations?

I don't know whether he's talking about the fact that we are encouraging excess of services, or something. Maybe you know.

Dr. LINDENBERG. I think that's exactly what I would speak to to that question.

Right now the Hospice of Central Pennsylvania is what I would call a community-based hospice that has cooperative arrangements with home health care agencies, several nursing homes, and has the cooperation of the social services departments in the three or four major hospitals in our particular service area.

Under the regulations, I know of at least three home health care agencies that will apply for medicare coverage under this act. This would provide—there might be as many as half a dozen hospices in our community, should our own hospice not be able to provide full-time coverage. Because we are partially funded by United Way and mostly by charitable donations, we do not charge a cent to any of our hospice patients.

So I am concerned for the potential for the duplication of services, the watering down particularly of the volunteer pool. Our organization depends on volunteers, and I think there would be confusion to some of the patients in the community about which hospice they should go to, and the like.

So my personal preference would be to see some sort of demographic research done to enable that there are plenty of flexible hospices so that the patients can make choices, and to keep some competition at some level to hold costs down; but at the other hand, that there is not such a proliferation that it provides a duplication of services and confusion to the patients and to the community.

Senator DURENBERGER. I guess I'm a little unclear about how it is that he calls it duplication of services; I would take it more service is available than there is demand, or something like that. Am I getting that right?

Dr. LINDENBERG. Yes, I think that's correct.

Senator DURENBERGER. Isn't that the essence of it?

Dr. LINDENBERG. Yes, that's the essence of my concern.

Senator DURENBERGER. But isn't that also the essence in a community, or part of the essence, of giving people choices? It creates a little competition?

Dr. LINDENBERG. I don't have any problem with competition. I think people should have choices. And I think one of the nice things about hospice, or the unique things about hospice, is that because of the team approach that people do have more of a say in their own destiny, particularly in terms of choosing how they would like to die. So my philosophy is consistent with what you are stating.

Senator DURENBERGER. Mr. Marvil, let me ask you to elaborate a little bit, since you talked about the regulations as they differentiate between nursing skills and social worker skills.

Can you give us some specific evidence of kinds of services that are provided by social workers in a hospice setting, and give us that assurance we all want that social workers are capable of handling a lot of these services?

Mr. MARVIL. Well, the basic concept of hospice care includes the idea of role blurring, Senator, and social workers have a basic skill development which is directed toward counseling with patients and families in terms of their emotional stress related to the terminal illness. They also are probably the primary profession involved in coordinating the community services, because that's basic to their educational training.

In addition in hospice care a social worker will need to know how to do some hands-on care, how to address the spiritual needs of patients when they are expressed, because when one has chosen to deal with those issues, that need must be met at the point of need, and the needs of patients and families are not specific to the turf; they are interested in dealing with the person with whom they establish a trusting relationship.

The social workers can provide direct service in terms of psychotherapy; they also provide administrative services, because many social workers are administering hospice programs, and in addition to that they develop the skills necessary through the mutual education which in part of hospice training and education. So, they understand what physicians do, what nurses do, what chaplains do, and they all work together. The traditional division of labor is not so extreme in the hospice, and that's one of the values of hospice care.

The problem with these regulations, to some extent, is that that issue of role blurring is not dealt with the way it should be. It should be made a part of the whole concept as it's expressed in the regulations, as well as in program planning.

Senator DURENBERGER. Can you tell me, related to that, why your recommendation that the minimum qualification for social work practice in the hospice would be at the masters degree level? I would like to believe that it's something more than a jobs bill for MSW's.

Mr. MARVIL. Well, that would be my recommendation, although I don't think that I said that specifically, Senator. In any case, the way the regulations are expressing the issue, the level for management of social work services would be at the bachelors level.

We feel at the National Association of Social Workers that that is the entry level for direct service, and that the person with more experience and education should in fact be responsible for supervision and management of those services.

I am sure that the other professions which make up the core of hospice care would feel that they have a minimal level also. I don't see any effort put forth in terms of there being any deletion of the expectation that a qualified licensed physician be the person who would be primarily responsible for providing medical care. There isn't any flexibility there.

I am not saying there shouldn't be flexibility in terms of the different professional organizations and their members who are competent to deliver psychological and emotional services and social work services. Mental health counselors who are setting practice limits at the masters level I trust feel that those people are competent to direct the services. My concern is that beneath a certain level there is too much risk involved for patient case and that the result will be that these services will be shoddy or nonexistent.

In fact, the Joint Commission in the surveys they have done across the country have found that one of the major problems in hospice care has been the inattention paid to the provision of psychosocial services. This is a major problem in many hospice programs which were surveyed by the Joint Commission.

Senator **Durenberger**. Well, I thank you all very much. I thank you for your patience, and I thank the organizations that you represent and you individually for your commitment to the program. Thank you very much.

The hearing is adjourned.

[Whereupon, at 5:08 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

AMERICAN AAHA
ASSOCIATION OF
HOMES FOR THE
AGING NATIONAL ORGANIZATION OF NON-PROFIT HOMES

Suite 770
1050 17th Street, N.W.
Washington, D.C. 20036
(202) 296-5960

Sister Marie Michelle Peartree
President
Sheldon L. Goldberg
Executive Vice President

September 29, 1983

The Honorable David Durenberger,
Chairman
Subcommittee on Health of the
Committee on Finance
221 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Chairman Durenberger:

On behalf of the American Association of Homes for the Aging (AAHA), I, Charles Edwards, would like to request this letter be made a part of the hearing record of September 13, 1983, regarding HCFA's Proposed Medicare Hospice Care Rules. AAHA greatly appreciates the opportunity to share with you our views and comments. We hope our analysis will help in formulating a hospice financing program which fully carries out Congress' intent to provide strong support for this humane, cost-effective method for caring for the terminally ill.

AAHA is the nonprofit association representing 2,100 nonprofit homes for the aging, housing, and health-related facilities which serve more than 300,000 elderly individuals in this country. In providing shelter and essential health and social services to the elderly, AAHA members are guided by the philosophy that the provision of quality services in an integral part of our commitment to communities throughout the nation. Over 75 percent of AAHA homes are affiliated with religious organizations and nearly 25 percent are sponsored by private foundations, government agencies, unions, fraternal organizations, and community groups.

AAHA strongly believes in the hospice concept and recognizes that its members are uniquely situated to provide supportive, comforting, high-quality care for those in need of services. Our homes have historically been at the forefront in promoting efforts to contribute to making the lives of the people we serve comfortable, satisfying, and dignified.

As proponents of the view that the particular needs of the individual are paramount, AAHA endorses Federal initiatives which provide financial assistance to the elderly in need of totality of care. AAHA homes hope to play an active role in contributing to the hospice care concept by drawing upon our vast experience in caring for the elderly, and maintaining our comitment to render high quality medical, counseling, and supportive services across the United States.

Our comments are organized according to subheadings in the supplementary information center outlined under "III. Provisions of the Regulations."

B. Election of Hospice Benefit: Duration of Benefits

AAHA recommends that a provision be included in the regulations to permit a family member or legal guardian to make an election on behalf of the beneficiary under certain circumstances. Such a decision is appropriate when the beneficiary is incapacitated and not capable of giving informed consent. Safeguards must be included so that elections are not made against the interests or preferences of the beneficiary. No one but the beneficiary should be permitted to make an election when he or she is of sound mind and capable of understanding the implications of his/her decisions.

The rules should strive to present clear guidelines concerning the "exceptional and unusual circumstances" for which Medicare payments would not be waived. Beneficiaries should not have to revoke election -- and be penalized by losing benefits -- before receiving certain emergency Medicare services. For example, hospice election should never constitute a waiver of minor surgery and follow-up care for fractures, burns or other accidental injuries.

Similarly, HCFA should issue guidelines within the first six months of program implementation as to which services received outside the hospice are covered or are among those services waived through the hospice election. HCFA, rather than individual intermediaries and carriers, can best assess the need for and the propriety of such coverage as they have greater access to national data and can thereby institute uniformity and predictability throughout the entire program. Such guidance would help to avoid the time consuming conflicts that would arise if such questions were handled in a case-by-case manner by different intermediaries.

AAHA agrees that, with additional guidance, the election and revocation procedures outlined here can serve as an effective mechanism for attaining hospice care. We further concur with HCFA's intention to closely monitor the election and revocation process but urge that a specific system be proposed for public comment as soon as possible.

C. Conditions of Participation

As advocates of individual rights and high quality care, AAHA is supportive of the proposed rule's emphasis on professional management, written plans of care, continuation of care, informed consent, in-service training, quality assurance, and the use of volunteer services. Our homes have set high standards for these areas in the nursing home industry and will continue to champion these concerns in the hospice care arena. AAHA hopes its member homes will be able to play a vital role in helping to provide hospice services; elements of the proposed rule, however, cause us concern in this regard.

Our primary concern regarding conditions of participation is that skilled nursing facilities and independent care facilities not be restricted from participating in providing this care option under Medicare. Rather, we would hope that such facilities, particularly those that are not motivated solely by economic incentives, be encouraged through these rules to join in the hospice endeavor. In this regard, AAHA is concerned that some of the provisions articulated in the proposed rules would, in fact, discourage the participation of many of our homes. For example, it is unclear whether a hospice which is a subdivision of another agency or organization would be required to have a governing body and Medical Director completely independent from those serving the agency or organization. For many organizations, particularly skilled nursing facilities, such a requirement would be unnecessary and may be prohibitive. The governing body and Medical Director of a SNF could effectively serve an affiliated hospice as the clients and concerns are not divergent. AAHA is concerned that such a requirement could result in duplication and needless costs and could diminish participation by highly qualified long-term care providers.

Similarly, in the case of a SNF having a hospice subdivision, it would be unwise to limit the ability of SNF nurses and staff to dedicate time and effort to the hospice program, and vice versa. Flexibility is essential in this regard as staff and resource needs within each entity will constantly fluctuate as a function of changing occupancy rates. Qualified employees should not be precluded from serving in those areas where the need is greatest at a particular time. We believe that concerns about cost efficiency suggest that flexible staff policies be maintained to handle these variations in occupancy rates; otherwise labor costs could prove prohibitive.

AAHA supports the use of qualified volunteers in hospice programs. Our homes have been particularly active in utilizing volunteer clergy and supplying counseling services of various types. We believe, however, that documentation requirements articulated in the proposed rules may be overly burdensome. Volunteer services are often obtained in an informal setting, as many volunteers are often reluctant to make guarantees regarding the extent of their assistance. By strictly formalizing this process, these regulations may actually discourage growth in this area. While we agree with the training standards in the proposed rules, we fear that the recruitment, evaluation, and cost-saving requirements set forth may become cumbersome and time-consuming for staff and potential volunteers. This increased administrative burden would be unlikely to foster maximum utilization of important volunteer services. If such documentation requirements are deemed necessary, we urge that the additional overhead costs incurred by compliance (e.g., an additional staff person may be necessary) should be figured into the reimbursement rates established.

AAHA takes strong exception to the inclusion of in-patient respite care days in the 20 percent limitation on total in-patient days. While we can understand that general in-patient care should be covered by the cap, in-patient respite care serves an entirely different purpose, and is in much greater harmony with the palliation objectives of the hospice concept. Respite care is essential to fostering the assistance provided by family and friends and is even more important for the many who lack such relationships. This, coupled with a reimbursement rate that is virtually the same as the rate paid for routine home care, together with the five continuous day limitation on this benefit, argues strongly for the exclusion of in-patient respite care from the 20 percent maximum requirement.

E. Approval of a Hospice Program and Provider Agreements

With regard to extending deemed status to an entity such as JCAH, we agree that, at the present time, it would be premature to take action in this area. It would be more appropriate to consider this issue after expiration of the sunset period.

F. Reimbursement

AAHA supports efforts to promote quality care and provide for efficient operation. We cannot, however, support some of the rate determinations set forth in the proposed rules. For example, analysis of previous hospice care cost studies reveals that the daily cost of drugs in a typical hospice is much higher than the estimate established here. Hospices would be unable to provide the type of palliative care that their patients need if drugs are reimbursed at the low figure proposed. AAHA suggests that HCFA not limit itself to the data accumulated from the 26 demonstration sites in their study. Examination of prior studies and interviews with hospice administrators would disclose the inadequacy of the prospective rate set for drugs in the proposed rules.

The calculation for the routine costs per day for SNFs also is unreasonably low as it fails to take account of differences inherent in various types of facilities, urban and rural facilities, as well as the intensity of care provided by these facilities. Hospital-based facilities and government-owned facilities would be effectively excluded from participating in the hospice program since their mean routine operating costs in 1983 were $77.88 and $65.94, respectively -- significantly higher than the $44.85 estimate contained in the proposed rules. Many urban and nonprofit facilities serving patients with high care needs would also likely be unable to participate in the program at this reimbursement level. We must, therefore, assert that HCFA's conclusion that "hospices would have relatively little difficulty arranging for the availability of such services" is a fallacious one. To the contrary, we believe that many SNFs would encounter difficulties or be unable to provide their services at the low rate specified. The unfortunate result will be that the families will be forced to shoulder a greater burden than they can manage, since in-patient settings will not be readily available. AAHA strongly urges HCFA to re-examine this reimbursement figure in light of the critical variables that will determine the extent of SNF participation.

AAHA is strongly opposed to the suggested methodology of setting rates <u>at</u> the mean rather than slightly above the mean as other prospective payments uniformly do. This quite atypical proposal would obviously result in losses for half of the providers. As HCFA knows, prospective reimbursement schemes typically set rates at approximately 110 percent of mean costs (including New Jersey's DRG mechanism). Participation, as well as the quality of care, would suffer if rates were set at the mean. Providers would also have much greater incentive to turn away potentially severe cases. The experience of other prospective payment schemes makes it clear that the rate must be set above the mean in order for the system to function properly. While AAHA is also concerned about runaway health care costs, the proposed reimbursement methodology is too stringent, as it seems to ignore the detrimental effect that such a system would have on facility participation and quality of care. AAHA recommends that HCFA institute a payment system similar to other successful prospective reimbursement plans in setting rates at 112 percent of the mean.

It is very important to adjust payment rates to account for inflation and other changes in the market. These regular adjustments are critical if the rates are to accurately reflect actual costs. The new Medicare hospital prospective payment plan further acknowledges the fact that no prospective system can work unless appropriate adjustments are made annually.

In sum, AAHA cannot help but express some degree of surprise and dismay at the prospective payment rates proposed here. Congress' clear and strong support for the hospice concept is being contravened by the inadequate reimbursement rates and the methodologies proposed. These financing proposals are incongruous with Congress' intention and commitment to provide a new care option under Medicare to the terminally ill.

AAHA sharply disagrees with the estimated net cost figures set forth in the impact analysis section. These estimates are astoundingly more pessimistic than the cost-saving estimates predicted by the Health Policy Alternatives consulting group and the Congressional Budget Office. The net increase projections do not adequately account for the substitution effect which will increasingly emerge as hospice care becomes more available and visible.

We assume that the average cap per beneficiary estimate of $4,232 will be raised to $6,500, as mandated in P.L. 98-90. We also urge that the level of care rates be adjusted upward to reflect this increase.

Unless the adjustments suggested above are made, AAHA fears that the hospice program may be doomed to failure. Until reimbursement rates are set at levels conducive to broad provider participation, we will never know if hospices will be able to achieve the objectives that Congress had hoped for when it established this program. It is also paramount that the clear intent of the legislation to support the provision of quality of hospice care not be sacrificed. AAHA is confident that the comments and recommendations contained herein will help to ensure that the will of Congress -- to promote the growth of alternative programs in which the terminally ill of our nation can die in comfort and with dignity -- be carried out to the fullest possible extent.

Sincerely,

Charles Edwards

Charles Edwards
General Counsel and
Director of Government Affairs

CE/pm

LEGISLATIVE MEMORANDUM

cancer care, inc.*
and The National Cancer Foundation, Inc.*

ONE PARK AVENUE • NEW YORK, N.Y. 10016
(212) 679-5700

William C. Pelster,
Chairman, Public Affairs Committee

Werner Weinstock,
Vice-Chairman, Public Affairs Committee

Doris B. Nash
Public Affairs Director

September 20, 1983

TO: Senator David Durenberger, Chairman
Subcommittee on Health
U.S. Senate Committee on Finance

RE: Proposed Regulations on Medicare Coverage for Hospice Services

Cancer Care, Inc. is a voluntary social service agency which for thirty-nine years has been dedicated to helping cancer patients and their families. Our experience has made us knowledgeable about the needs of terminal patients and their relatives, as well as how these needs may best be met. We, therefore, feel confident raising questions about the proposed regulations, particularly as they refer to "medical social services" and "counseling."

While we are not a hospice - nor do we intend to be - we have for almost four decades provided many of the services which hospice provides: help with care at home, counseling services for patients and relatives, and individual and group bereavement counseling. Our staff is composed of Master's level social workers, and our agency is used for field work placements for social work students from several universities.

Long Island Office
20 Crossways Park North, Suite 304
Woodbury, N.Y. 11797 * 516/364-8130

New Jersey Office
466 Old Hook Road, Suite 18
Emerson, N.J. 07630 * 201/261-3003

Our philosophy has always been to help the family maintain the patient at home as long as possible; we believe that this enhances the quality of life for the patient while serving in the interest of the mental health of the family. A major difference between our agency and hospice is that we do not assume control over the patient's physical/medical care. However, our social workers do, when indicated, and in consultation with the patient's physician, discuss with the family or spouse the appropriateness of continuing medical treatment to combat the cancer. Our decision to continue as we are without attempting to be a "complete" hospice is based on our conviction that not all patients will choose hospice and the concept of palliative care only.

Following are our questions and comments about the proposed regulations:

Firstly, it is incomprehensible to us that no attempt has been made to spell out the functions and duties of the medical social worker, and specifically that the social worker is not given responsibility for the "counseling" which is one of the core services to be provided by the hospice. Since the regulations allow some volunteers to be considered "employees," the social worker's traditional functions could conceivably be given to volunteers whose training will be very minimal in relation to that of a qualified social worker (a graduate of a Masters degree program in social work plus two years of subsequent clinical experience). We believe that using volunteers as "counselors" could easily lead to very inadequate and potentially harmful counseling of families coping with death.

We know from our lengthy experience that counseling "to the patient and family to help in the adjustment to the patient's death" requires skills and sensitivities of the highest order. Counseling families dealing with the impending death of a loved one requires much more than offering a comforting hand. It is necessary to have a thorough grounding in psychodynamics, highlighting crisis intervention theory. The "counselor" must be empathetic and aware of the multiplicity of emotions that may be aroused by the impending death of the patient. At the same time, the "counselor" must be prepared for and able to deal with anger towards the patient by a family member, and with feelings of guilt.

Advanced diagnostic skills are necessary, along with a thorough understanding and appreciation of the patient/family's psychosocial background and history. There must also be expertise in knowing when to try to intervene and when not to, and how to engage the family should members be leary of entering the counseling process. Equally important is the "counselor's" understanding of him/herself in order to prevent imposing his/her own needs and value system.

What we have described is not within the armamentarium of Bachelors of Social Work (BSW's) or volunteers. BSW's are not offered as much in-depth learning experience to develop sufficient diagnostic and social casework skills, in contrast to those with Master's degrees. BSW's would need many years of clinical experience before they could be adequate counselors.

Secondly, we also take exception to medical social services being singled out as requiring "the direction of a physician." Social work counseling when illness and inevitable death are the basic issues does require that the social worker know from the doctor and nurse the latest information about the patient's condition and prognosis. However, this does not mean that the physician can or should direct the counseling which is really within the qualified social worker's area of expertise.

Thirdly, since the regulations do not specify who is to do the counseling (and bereavement counseling), we would assume the title "counselor" would be given to the person selected to perform this function. The irony - and danger - here, is that there is no uniform definition or standards for "counselor" in any state. <u>Should this so necessary hospice service be thrown open to an uncontrolled, undefined entity? Should Medicare coverage for hospice institutionalize inadequate, unprofessional and potentially dangerous counseling</u>?

We appreciate this opportunity to state our views, and would be pleased to respond to any questions you may have.

/maf

STATEMENT

of the

Home Health Services and Staffing Association

to the

Subcommittee on Health
The Honorable Dave Durenberger, Chairman

Committee on Finance
United States House of Representatives

Hearings on Proposed Medicare Hospice Regulation

September 15, 1983

Mr. Chairman and Members of the Subcommittee:

I am John Smith, Chairman of the Board of the Home Health Services and Staffing Association. HHSSA represents 16 tax-paying, investor-owned organizations that provide both home care services and supplemental nursing services through over 1000 offices in 44 states. We are pleased to have this opportunity to present this statement to the Senate Finance Committee on the proposed Medicare hospice regulation which would implement section 122 of Public Law 97-248, the Tax Equity and Fiscal Responsiblity Act of 1982. Let me say that while we support much of the proposed regulation, there are several questions which we would like to address.

Subcontracting

Under the proposed regulation, a hospice must ensure that substantially all of the four core services (nursing, physicians, counseling, and medical social services) are routinely provided directly by hospice employees, Use of contracted staff is permitted only during periods of "peak patient loads or under extraordinary circumstances." Services provided directly by the hospice should be adequate to meet the needs of the hospice's average patient load.

With respect to the other required, but not core, services (home health aides and homemaker services, physical therapy, occupational therapy and speech pathology services and inpatient care), the regulation provides that these may be furnished either directly by the hospice or through arrangements with another individual or entity. The proposed regulation allows subcontracting for non-core services without quantitative limitation, unlike the subcontracting provision for the required core services.

Further, the proposed regulation states that if subcontracting is used, the hospice must maintain "professional, financial and administrative responsibility" for the services.

Our position is that the wide latitude permissible under the statute should be given to hospices to contract for both core and non-core services. Sound management dictates that the capacities of existing community resources be utilized as much as possible in providing care to hospice beneficiaries. There is no justifiable reason to duplicate services which already exist. This is particularly true when the new program is expected to serve only 55,000 beneficiaries by 1987 (CBO estimate), while home health agencies had the capacity to serve an estimated 1.1 million persons in 1981. Subcontracting is clearly an important way to utilize existing capacities.

With respect to core services, the regulation does not take advantage of the latitude allowed by the statute for hospice programs to subcontract. The relevant statutory language imposes three requirements on core services subcontracting: the hospice must 1) "routinely" provide, 2) "directly", 3) "substantially all" of the four core services. These three terms are not defined in the statute. We believe the proposed regulation is too restrictive in its interpretation of these terms and propose the following definitions which are consistent with accepted usage and the needs of the hospice program.

1. "routinely" - as needed, except for emergencies, vacations and other staff absence and fluctuations in patient load which cannot economically be provided for by utilizing directly employed staff.

2) "directly" - by a person either 1) who is the full or part-time employee of the hospice, or 2) who, although the employee of another for tax and insurance purposes, discharges his or her professional duties under the professional supervision of the hospice program;

3) "substantially all" - enough to assure that the hospice program can control the nature and quality of the services being performed. A specific percentage should not be specified, in order to avoid the administrative rigidity that would follow.

Including these three definitions of key statutory terms in the regulation would provide helpful latitude to hospices to subcontract for nursing and other core services without sacrificing the control requirements imposed on hospice programs by the statute.

We also do not support the provision (Section 418.56) which appears to allow subcontracting with independent contractors for homemaker and home health aide services. In order to assure that the hospice is maintaining "professional, financial and administrative responsibility", as required by the proposed regulation, subcontracting for these services should be permitted only with organizations. Allowing individuals acting as independent contractors to provide homemaker and home health aide services may have the following disadvantages:

-- lowers the quality of care since there is no formal organization to regularly oversee and evaluate performance,

-- diminishes the ability of the hospice to exercise professional management responsibility over the delivery of services since it cannot rely on the management supervision normally exercised by an employer organization over such individuals.

Certification

Turning to the issue of certification of hospices as Medicare providers, the law specifies that hospices must undergo a separate certification procedures. In order to avoid unnecessary duplication, however, the law also mandates that where a provider has previously met standards required of certified Medicare providers, hospices will have to meet only such standards as are different from those already complied with.

We support this particular provision of the proposed regulation. Our members are already actively involved in providing care to terminally ill patients. In fact, some hospice programs are Medicare-certified home health agencies. We see no reason to tolerate unnecessary duplication of certification procedures for those already-certified Medicare providers who provide hospice services to their patients. With other provider organizations, we will bring to your attention any authorized or unnecessary certification requirements which may be imposed.

Conclusion

Because we represent an important segment of the community-based care provided in this country, we strongly support the promotion and expansion of hospice care. We want to make sure, however, that existing community resources, in home health agencies and elsewhere, are appropriately utilized whenever applicable to eliminate unnecessary effort and duplication. For this reason, the final Medicare regulation should provide as much flexibility as possible for hospice programs to subcontract for services with organizations already operating to bring care to the terminally ill. In addition, unnecessary duplication of the certification procedure for hospice programs previously certified as Medicare providers should be avoided and reflected as such in the final regulation.

We appreciate the opportunity to be able to present our views to you on the subject of the proposed Medicare hospice regualtion. Should you have any questions or wish additional information, we would be happy to respond.

Hospital Association of New York State at the Center for Health Initiatives
INCORPORATED 15 COMPUTER DRIVE WEST ALBANY, NEW YORK 12205 • (518) 458-7940

STATEMENT OF THE
HOSPITAL ASSOCIATION OF NEW YORK STATE

ON

MEDICARE HOSPICE REGULATIONS

PREPARED FOR A
PUBLIC HEARING HELD BY

SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

Washington, D.C.
September 13, 1983

The Hospital Association of New York State (HANYS) represents 350 voluntary and public hospitals and long term care facilities. Our membership comprises approximately thirty hospitals and long term care facilities providing hospice service including ten of the fourteen participants in the New York State Hospice Demonstration Program.

Our Association has long supported the hospice concept as a humane way of providing care to patients, and their families, during the final stages of a terminal illness. While we support federal and state initiatives to expand the availability of hospice, we are seriously concerned that efforts to regulate the concept are creating barriers to expansion and sacrificing certain basic principles.

New York State has been in the forefront of hospice development, with the establishment of an innovative demonstration program in 1978. We believe that the valuable insights and experience which have resulted from that program, should help guide this Committee in consideration of statutory modifications to the Medicare hospice benefit.

Under the New York State Hospice Demonstration Program, fourteen hospices were authorized for establishment, divided into three provider categories: community-based; hospital-based, scattered bed; and, hospital based, autonomous unit.

Twelve of these programs were reviewed in An Analysis and Evaluation of the New York State Hospice Demonstration Program, released by the New York State Department of Health in December of 1982, as required by State implementing legislation. Essentially, the evaluation concluded that there was a high satisfaction with hospice services, and that provision of care under the demonstration program was cost effective when compared to more traditional modes of care. It was based upon this evaluation, that legislation was enacted in New York State in 1983 making hospice a permanent part of State statute and providing for its licensure and certification. Appended to this statement is a description of the New York State Hospice Demonstration Programs as contained in the Department of Health Evaluation.

Some of the major conclusions of the New York State evaluation were:

- Based upon estimates of the cost of conventional care for terminally ill patients in other studies, all three hospice models are less expensive than conventional care for enrollment lengths of up to 120 days, and the overall savings generally increase with longer enrollments.

- The average charge per patient per day varies widely. Among community-based programs, the average is $76.35; while hospital-based, autonomous unit programs and hospital-based, scattered bed programs have averages of $89.36 and $115.67, respectively. The overall average is $95.10 per patient per day. Factors affecting the average charge per patient per day are the average inpatient charge per patient per day, the average home care charge per patient per day, and the relative utilization of inpatient care and home care. Also, the average charge per patient per day becomes higher as the length of enrollment decreases.

- The average charge per hospice patient in New York State is $5,385 ($2,939 for community-based programs; $5,254 for hospital-based, autonomous unit programs; and $8,792 for hospital-based, scattered bed programs). Three programs exceed the newly adopted federal $6,500 cap. All three programs are in the generally more expensive downstate area of New York State.

- The new federal hospice benefit mandates that the total number of inpatient days for each hospice program not exceed 20% of the aggregate calendar patient days of care for the program. For the twelve hospice programs in New York State, the average percentage of inpatient days is 24.8%.

Seven of the twelve programs exceed the 20% cap and four have more than 30% inpatient days.

The New York State hospice statute will take effect on January 1, 1984. The form of implementation, and thus the future of hospice in New York State, is directly dependent upon federal statute and regulation. We view both the Medicare hospice statute, and the proposed implementing regulations, as discriminatory against hospital-based programs and those patients most in need of care and lacking community support systems.

Upon review of the hospice demonstration programs outlined in the attachment to this statement, it is ironic to note that many of these programs would have difficulty, or be unable to continue as hospice providers under federal standards. These are the programs which have developed proven track records and serve as the model for hospice development in New York State.

Attached to this statement is a copy of the comments we have filed with the Health Care Financing Administration (HCFA) on the proposed implementing regulations, as published in the Federal Register of August 22, 1983. However, the regulations, as proposed, are so embedded in an inflexible statute which restricts the provision of hospice care, that the only way to move toward making hospice the benefit it was envisioned to be is to modify the existing statute.

Therefore, we urge the following statutory changes in the Medicare hospice benefit:

- Eliminate the 20% cap on inpatient utilization as a flagrant betrayal of the terminally ill most in need of care.

- Remove the core services requirement and require instead that the hospice directly provide counseling services, coordination and care planning across all settings, and at least one level of care (home care or inpatient care).

- Provide a positive incentive, or at least remove the current disincentives, for attending physicians to continue providing day-to-day medical care to their patients and to participate as hospice team physicians in care planning activities.

- Remove the professional management responsibility requirement and require instead that a hospice providing care under arrangements with other providers establish mechanisms that allow the hospice to meet its coordination/care planning responsibilities and to resolve any differences of opinion on the care to be provided to individual patients.

- Eliminate the requirement that the patient must sign a consent form stating he has six months or less to live and must waiver all Medicare benefits as psychologically traumatic and detrimental to the patient. Having no provisions for a legal guardian to elect hospice when a patient is too ill to comprehend or has brain metastasis is incongruous to the hospice concepts of caring for the patient and family as a unit.

- Require cost-based payment until the knowledge-base needed to design a workable prospective pricing system has been accumulated. If experimentation with prospective pricing for hospice services is viewed as desirable at this time, each hospice should be allowed to choose either cost-based reimbursement or prospective pricing. In addition, any experimentation with prospective pricing methods should explicitly address capitation methods of payment for hospice care.

- Eliminate the aggregate $6,500 cap amount, because its use is inappropriate unless modified into a true capitation payment with positive incentives for cost containment, not just negative sanctions.

The rationales for the above outlined recommendations have already been adequately stated by others, therefore, we shall not restate those arguments here.

In conclusion, existing statute erects barriers to the provision of hospice care and will restrict service to those who most probably have other resources. The worst fears of many will be realized. The program will be an add-on - creating a new market for care - providing benefits to those who have other financial resources and to a far lesser degree aiding some other people to remain at home more comfortably. Those without resources will return to acute care facilities for want of anywhere else to go. The promise that is hospice will not be fulfilled.

ATTACHMENT I

Detailed Description of Model Programs

The following are community based programs:

Genesee Region Home Care Association Hospice

The Genesee Region Home Care Association (GRHCA), Rochester, New York, a voluntary nonprofit certified home health agency, serves Monroe County and surrounding areas. The organization has been involved in the delivery of home hospice services since August 1977 under an experimental program with Blue Cross of Western New York. The association functions as the coordinator for referral, assessment and assignment of patients for the delivery of home care services through contracts with community based certified home health agencies.

The hospice program was approved by the Public Health Council as a scattered bed model and received its operating certificate in April 1981.

Inpatient care is provided through contracts with five area hospitals, and home care services are provided through contract with the Monroe County Department of Health and the Visiting Nurse Service of Rochester and Monroe County.

Palliative care teams function in each hospital and each team includes the GRHCA discharge planning nurse assigned to that hospital. There is minimal use of the inpatient facilities with a major emphasis placed on home care.

Full-time core staff include a patient care coordinator and a secretary. Part-time core staff include an administrator, director of patient services, social worker, medical director and secretary. The coordinator of volunteers is a volunteer. Volunteers are obtained from existing community agencies. Also, pastoral care is provided by volunteer clergy from the community. Individual and group bereavement services are offered to all families.

Genesee Region Home Care Association is one of two programs selected in New York State to participate in the Health Care Financing Administration Demonstration Program as a home care model and it has been primarily funded through the reimbursement for home care and hospice support services. Reimbursement for hospital services is at existing third party reimbursement rates. GRHCA has experienced rapid growth during the demonstration period.

Hospice Buffalo, Inc.

Hospice Buffalo, Inc., Buffalo, New York, was incorporated in New York State in January 1976. This organization was approved by the Public Health Council as a freestanding model with a palliative care unit in an acute care hospital to serve the population of northern Erie County. The palliative care unit was opened in the Buffalo General Hospital in April 1981. The completion of a freestanding unit at the Erie County Home and Infirmary is still pending final Department of Health approval for construction.

In January 1982, the organization was approved as a certified home health agency and began to provide home health care services to hospice patients.

Full-time core staff include an executive director and a patient care coordinator. Part-time core staff include a medical director, social worker and secretary. The volunteer coordinators and pastoral care coordinator are volunteers. Bereavement services include individual counseling and monthly group meetings are offered to all families in the program.

Hospice Buffalo, Inc. has a hospice demonstration program with Blue Cross of Western New York for reimbursement of both home care and inpatient services.

The hospice program that started initially as a volunteer organization has grown significantly during the demonstration with continued community support and a large volunteer component.

Hospice Care, Inc.

Hospice Care, Inc., Utica, New York, a private not-for-profit organization has functioned on a limited basis since 1977 in providing supportive and counseling services to patients and families primarily through the use of volunteers. In 1979, Hospice Care, Inc. became incorporated and was approved by the Public Health Council as a scattered bed model.

The program became operational in July 1981. Full-time core staff include a patient care coordinator and a secretary. An administrator and coordinator of volunteers are part-time core staff. In addition, the medical director, pastoral care coordinator and a social worker serve as volunteers.

Hospice inpatient care is arranged with four area hospitals and four long term care facilities participating in the hospice organization. Home care is provided by the two participating certified home health agencies, the Oneida County Health Department and the Visiting Nurse Association of Utica. There is a strong volunteer component with 35 trained volunteers actively serving in the hospice program. Bereavement services are available to families on an individual basis.

Participating hospitals, long term care facilities and certified home health agencies bill directly for their services. A contract with the local Blue Cross plan for a special hospice benefit is currently being negotiated. Grants and donations have been obtained to help defray the expenses of the paid staff.

Capital District Hospice, Inc. (Hospice of Schenectady)

The Capital District Hospice, Inc., Schenectady, New York, a private not-for-profit corporation serves Schenectady County and surrounding areas. Prior to the demonstration project, the organization, with a 40-member volunteer board, provided educational services to the terminally ill and the general public.

The hospice was approved by the Public Health Council as a freestanding model; however, due to high costs involved, a freestanding inpatient facility has not been established. Inpatient services are provided by contract with Ellis and St. Clare's Hospitals with home care services contracted with the Visiting Nurse Service Association of Schenectady. The organization has provided a coordinated array of hospice services since December 1980.

Home care is the major component of the program. Two full-time Visiting Nurse Service Association nurses located at the hospice provide nursing services.

Five full-time core staff include an executive director, patient care coordinator, pastoral care coordinator, director of volunteers, office manager and secretary. Two oncologists, one from each of the two hospitals, share the role of part-time medical director. A medical social worker serves on a part-time basis. Part of the service delivery is provided by 85 volunteers in the program. Public contributions and private funding are used to employ the professional staff. Bereavement services include a three-month followup assessment and educational and social meetings are available for all families who wish to participate.

The area Blue Cross plan developed a "hospice benefit" with a discrete hospice rate for hospice services. The General Electric Corporation, the largest local employer, provides hospice coverage for its employees as a part of its health insurance plan.

The hospital based, scattered bed programs are as follows:

Long Island Jewish/Hillside Medical Center Hospice

Long Island Jewish/Hillside Medical Center (LIJ/HMC), Queens, New York, a 693-bed teaching hospital, serves the counties of Nassau and Queens.

The hospice program was approved by the Public Health Council as a scattered bed model using existing beds in the facility and became operational in November 1980. Home care services are provided by contract with the Visiting Nurse Service of New York and are coordinated by the hospital's certified home health agency.

A hospice coordinator, who also functions as a volunteer coordinator, a medical social worker and secretary are employed as full-time core staff with a nurse coordinator and medical director employed as part-time core staff. Volunteer clergy share pastoral care services.

Bereavement services on an individual basis as well as weekly group sessions are available to families. Trained volunteers are also utilized actively in support group sessions as well as in inpatient and outpatient settings.

The project has access to direct reimbursement for hospice services delivered to patients with Blue Cross benefits.

North Shore University Hospital Hospice

North Shore University Hospital, Manhasset, New York, is a 598-bed teaching hospital. In 1978, grant monies were obtained to provide in-home services to cancer patients via a mobile van; this program served as the impetus for the development of the hospice program.

The hospice program was approved as a scattered bed model by the Public Health Council and became operational in August, 1980. Home health care services are delivered through the hospital's Home Care Department, a certified home health agency.

Full-time core staff include a nurse coordinator, a social worker, who also functions as a volunteer coordinator, and a secretary. Part-time staff include a hospice administrator and a medical director. Volunteer clergy from the community share the pastoral care coordinator responsibilities. Bereavement services are provided through weekly group meetings.

The hospice program serves primarily patients who have Blue Cross reimbursement.

St. Luke's/Roosevelt Hospital Center Hospice

St. Luke's/Roosevelt Hospital, New York, New York, a voluntary nonprofit 789-bed acute care facility, is located on the upper west side of New York City.

The hospital has operated a hospice program for terminally ill inpatients since 1975. A consultation team was available for symptom control and psychosocial support to the patient, family and primary care giver. The team also coordinated home health care through the facility's certified home health agency.

St. Luke's/Roosevelt was approved by the Public Health Council as a scattered bed model and received an operating certificate in June 1982. St. Luke's/Roosevelt Home Health Agency and the Visiting Nurse Service of New York provide the home health care services to the hospice patients.

Full-time core staff include a project coordinator, three clinical nurse specialists, a volunteer coordinator, social worker and secretary. Part-time core staff include a medical director, chaplain and clinical nurse specialist. Bereavement services are available on an individual basis.

The project is participating in the Blue Cross of Greater New York Hospice Demonstration and receives reimbursement for hospice services provided to the patients.

United Hospital Hospice

United Hospital, Port Chester, New York, a 308-bed hospital, serves the communities of Harrison, Port Chester, Mamaroneck and the Town and City of Rye.

The program was approved by the Public Health Council as a scattered bed model using existing medical/surgical beds. The hospice began delivering services in January 1980. Home care services are provided by the facility's hospital based certified home health agency and by contractual arrangements with other agencies.

Full-time core staff include an administrator, patient care coordinator, social worker and secretary. The volunteer coordinator is a part-time core staff member. The medical director and pastoral care coordinator are volunteers. The hospital has trained more than 80 volunteers in the hospice program. Bereavement services and monthly group meetings are available to families.

The hospice receives reimbursement for hospice services provided to the patients with Blue Cross benefits.

The programs designated as hospital based, autonomous unit programs are described below.

Cabrini Medical Center Hospice

Cabrini Medical Center, New York, New York, a 493-acute bed hospital, serves the counties of New York and surrounding areas.

The program, approved by the Public Health Council as an autonomous hospice model utilizing 15 new beds in a facility near the hospital, became operational October 15, 1980.

Due to the high costs and other problems associated with an off-site inpatient facility, the unit was relocated to the Medical Center. Home care services are provided through the hospital's certified home health agency.

Full-time core staff include a hospice administrator, director of volunteers, director of nursing, pastoral care coordinator, social worker, and secretary. Also, there is a part-time medical director. More than 50 volunteers provide services to patients and families. Bereavement services are available to families on an individual basis.

The hospice is one of two programs selected in New York State to participate in the federal Medicare demonstration program and has been primarily funded through federal demonstration waivers. A contract is being negotiated with Blue Cross to reimburse for hospice services.

Mercy Hospital Association Hospice

Mercy Hospital, Rockville Centre, New York, a 390-bed nonprofit hospital, serves areas on the south shore of Long Island. The hospital has been providing hospice services since 1978.

Mercy Hospital was approved by the Public Health Council as an autonomous model utilizing existing beds and operates an 18-bed hospice unit.

Full-time core staff include a director, nurse coordinator and secretary. The director of volunteers, pastoral care coordinator and social worker are part-time core staff. The medical director is a volunteer.

Home care services are provided through a contract with the Nursing Sisters Home Visiting Service. The volunteer component is organized to provide emotional support and companionship to persons in the inpatient unit and/or at home. Bereavement services are available on an individual basis as well as in group sessions held twice a month.

The program is participating in the Blue Cross of Greater New York Hospice Demonstration and receives reimbursement for hospice services provided to the patients with Blue Cross benefits.

Our Lady of Lourdes Memorial Hospital Hospice

Our Lady of Lourdes Memorial Hospital, Binghamton, New York, a 347-bed acute care hospital, serves Broome County and surrounding areas.

Prior to the demonstration, the hospital had an active program that provided palliative care to the terminally ill since 1974.

The hospice program was approved by the Public Health Council as an autonomous model using existing medical/surgical beds to provide hospice inpatient services. Home health care services are delivered by contract with the Broome County Department of Health.

The hospice program has fully implemented a coordinated array of hospice services. Full-time core staff include a director, patient care coordinator, medical social worker, volunteer coordinator and two secretaries. Part-time core staff include a medical director and pastoral care coordinator. In addition, the certified home health agency has designated a home care coordinator to participate in the program. A large volunteer component serves patients in both home care and inpatient settings. Bereavement counseling on a one-to-one basis is an integral part of the program.

A contract with the local Blue Cross Plan for a special hospice benefit is currently being negotiated to maximize third party reimbursement resources available to them.

St. Peter's Hospital Hospice

St. Peter's Hospital, Albany, New York, a 427-bed acute care facility, serves Albany County and surrounding areas. The hospice program was approved by the Public Health Council as an autonomous model with 10 new beds. The unit, commonly referred to as "The Inn" was renovated primarily through community fund raising efforts. The hospice program was opened in June, 1981. The home care component is provided by St. Peter's Hospital Home Care Department, which is a certified home health agency.

Full-time core staff include a medical director, program director, social worker, patient care coordinator, volunteer director, pastoral care coordinator and four secretaries.

A contract has been developed with the local Blue Cross Plan at the existing per diem rates for inpatient services and home health care visits. Volunteers are active in both inpatient and home care settings. Individual bereavement counseling as well as eight-week group sessions are available for families based on their specific needs.

The following three programs were not included in the evaluation because either they withdrew from the demonstration (New York Hospital) or no data were available (Beth Abraham Hospital and Metropolitan Jewish Geriatric Nursing Home Company).

New York Hospital

New York Hospital, New York, New York, a 757-bed not-for-profit institution was approved by the Public Health Council as a 12-bed autonomous model.

The institution indicated that it wished to voluntarily withdraw from the demonstration. Therefore, the Public Health Council formally disestablished the hospice project on January 23, 1981.

Beth Abraham Hospital Hospice

Beth Abraham Hospital, located in the Bronx, is a nonprofit skilled nursing facility of 504 beds affiliated with Montefiore Hospital and Medical Center

The hospice project was approved by the Public Health Council as an autonomous model, but is not yet operational.

Metropolitan Jewish Geriatric Nursing Home Company, Inc. Hospice

Metropolitan Jewish Geriatric Center (MJGC), Brooklyn, New York, a 915-bed nonprofit facility with skilled nursing and health related components, serves the New York counties and surrounding areas. The organization has a long term home health care program (LTHHCP), a geriatric day hospital and a senior citizen center.

The hospice program was approved by the Public Health Council as an autonomous model utilizing 10 existing beds and received an operating certificate in September 1980.

Metropolitan Jewish Geriatric Center currently provides social work services, individual and family counseling, non-palliative support, voluntary services, 24-hour emergency coverage and bereavement services but has not implemented a comprehensive hospice program. Home health care services and coordinated inpatient care are not yet provided.

ATTACHMENT II

Hospital Association of New York State
INCORPORATED at the Center for Health Initiatives
15 COMPUTER DRIVE WEST ALBANY, NEW YORK 12205 • (518) 458-7940

September 19, 1983

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President
GEORGE B ALLEN
Albany

Health Care Financing Administration
U.S. Department of Health and
Human Services
Room 132 East High Rise
Attention: BPP-241-P
6325 Security Blvd.
Baltimore, Maryland 21207

The Hospital Association of New York State (HANYS) represents 350 voluntary and public hospitals and long term care facilities. Our membership comprises approximately 30 hospitals and long term care facilities providing hospice services including ten of the fourteen participants in the New York State Hospice Demonstration Program.

Our Association has long supported the hospice concept as a humane way of providing care to patients, and their families, during the final stages of a terminal illness. While we support federal and state initiatives to expand the availability of hospice, we are seriously concerned that efforts to regulate the concept are creating barriers to expansion and sacrificing certain basic principles.

New York State has been in the forefront of hospice development with establishment of an innovative demonstration program in 1978 which has provided valuable insights and experience.

We view both the Medicare statute and the proposed implementing regulations as discriminatory against hospital-based programs and those patients most in need of care and lacking community support systems.

The comments that follow are offered in the context of existing statute, which we believe is in need of modification.

SERVICE PROVISIONS

Section 418.98, Condition of Participation - Short Term Inpatient Care.

The proposed paragraph (b) would limit inpatient utilization to 20% of the aggregate number of days in any twelve month period for beneficiaries with hospice election.

Section 418.302, Payment Procedures for Hospice Care.

The proposed paragraph (f) provides for a calculation of inpatient utilization and a payment penalty against the hospice for days in excess of the 20% limitation.

While we realize that the 20% inpatient limitation is mandated by statute, we believe it should be implemented with the maximum degree of flexibi~~lity~~ so as not to discriminate against beneficiaries who lack personal caregivers at home, or who are too ill to be cared for at home to any appreciable degree.

Data from New York State's hospice demonstration program indicates that seven of New York's twelve demonstration programs exceeded the 20% cap during the period (January to August, 1982) under review. The average degree of inpatient utilization was 24.8% for all programs. In addition, there was no significant variation amongst the three models tested: community-based, 23.2%; hospital-based scattered bed, 23.1%; and, hospital-based autonomous unit, 26.3%. The imposition of a limit upon inpatient utlization - in and of itself - is clearly a flawed concept, to apply it in an inflexible manner would only heighten its inherent discrimination against a certain class of beneficiaries.

The hospice concept is to provide comfort to the patient in the final stages of terminal illness and to keep the patient at home as long as possible. The long history of hospice has never incorporated an arbitrary cap on inpatient utilization.

HANYS Recommendation - Unless the statutory limitation is repealed, we would urge that you modify the proposed rigid application of the 20% limit on inpatient care as a certification requirement, by allowing hospice to work toward that goal and by not penalizing those hospices that exceed the limit due to their patient case mix.

Section 418.80, Condition of Participation - Core Services.

The proposed rule provides that a hospice must ensure that substantially all core services are routinely provided directly by hospice employees. Contracted staff is allowed during periods of peak patient loads or under extraordinary circumstances.

We believe that the regulatory interpretation of "must routinely provide directly substantially all" core services is too rigid. The degree to which hospices are able to directly provide core services varies; however, it would appear this provision erects barriers for the provision of services in rural communities and medically underserved urban areas.

Of New York State's ten hospital-based hospice demonstration programs, six have a separately certified home health agency under the provider parent. However, of 30 hospitals within New York State identified as offering hospice programs, only ten have a separately certified home health agency. It would appear that under the proposed rule, provider parents within New York State would not be allowed to utilize their separately certified home health agency as fulfilling one of the core service requirements, and would instead have to establish a new home health component within the hospice unit.

We believe that the coordination and intergration of service within the health delivery system, in pursuit of efficient delivery of care and cost effectiveness, is an important public policy goal. We are concerned that the rigid implementation of the statutory provision on core services contributes to the fragmentation of the health delivery system, and negatively impacts upon cooperative arrangements among providers in local communities. In addition, it would appear that the proposed regulations fail to recognize the unique ability of hospital-based programs to draw on resources within various departments of the institution.

HANYS Recommendation - We would recommend the removal of the restriction on use of the services of parent provider employees who are not assigned substantially full time to the hospice program and, modify the interpretation of the core services requirement as it pertains to physician services to allow provision of day-to-day medical services to hospice patients by their attending physicians.

Section 418.56, Condition of Participation - Professional Management.

The proposed rule requires that hospices maintain professional management responsibility for non-core services delivered through arrangement with other providers, including the execution of a legally binding written agreement with each such provider.

We are extremely concerned that this provision will subject hospitals, and other providers, which contract with hospices for services to certain legal liabilities. While the hospice must maintain a certain responsibility to the patient, for facilities that would provide inpatient care under such contracts, the legislation and regulation would increase their legal liabilities. It is important that this provision be enacted with a greater degree of flexibility than currently proposed.

HANYS Recommendation - The regulation should require mutually agreed upon procedures between the hospice and the contract provider that address coordination and planning of care and resolution of conflicting opinions, rather than mandating contractor compliance with hospice orders without regard to the other legal obligations of the hospital.

PAYMENT PROVISIONS

HANYS is similarly concerned over the regulatory thrust of the proposed payment mechanisms which would serve to govern the reimbursement of hospice services. Three general areas of concern are addressed in detail below. Specific concerns center upon the following:

- the regulatory stance regarding the establishment of a prospective payment system at this time;
- the methodology utilized in establishing the "cap" on total revenues; and,
- the potential shortfalls in the system which could reduce the capabilities of providers to provide the full range of services and settings needed to treat the terminally ill.

Section 418.301 through Section 418.306, Reimbursement for Hospice Care.

These subsections speak specifically to the immediate establishment of a prospective price-setting system of payment. As proposed, these regulations would seek to designate a series of different levels of hospice care, and would further extend to the establishment of discrete limitations on the payment to each of these separate treatment modalities.

We are extremely concerned over the posture taken by the Department of Health and Human Services (HHS) to move with such immediacy to establish a prospective rate-setting methodology before testing the appropriateness of such a vehicle against the costs which will accrue as the hospice movement develops to the extent envisioned by Congress.

Of special concern is the action taken which seemingly moves in a direction opposite of the one envisioned by Congress at the time of passage of the hospice legislation. Examination of the payment provision established in legislation clearly indicates that Congress intended to reimburse hospices at an amount "equal to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may provide." Additionally, the provision instructing the Secretary to assess the feasibility and advisability of a prospective reimbursement system and report such by January 1, 1986 clearly indicates that Congress did not expect or direct the Secretary to move to immediately develop a prospective rate system.

We would argue that a retrospective reasonable cost reimbursement system would prove to be a more workable and appropriate payment mechanism until such time as a relevant data set can be developed. Additionally, such a system would extend to hospices, the Medicare reasonable care reimbursement methodology utilized for payment to other types of providers.

HANYS Recommendation - Therefore we would recommend that the regulations be amended to provide for retrospective reimbursement, together with a requirement for reporting of full cost and utilization statistics during an initial three year trial benefit period.

Section 418.308 through Section 418.310, Limitation on the Hospice Payment.

These sections would establish a total payment cap on each hospice's payments by utilizing a number of factors and indices. Additionally, the regulations as proposed by the Department would institute an additional payment limit, which would be operationalized if, at the end of the year (designated as October 31) the Health Care Financing Administration (HCFA) determines that the hospice provided more than 20% of the aggregate days of care to Medicare beneficiaries in an inpatient setting. As proposed, if such is determined, a payment penalty will be imposed for the days in excess of the 20% limit.

In order to understand the significance of the proposal, one must be cognizant of its underlying premises. The cap amount is derived, and expressed, in terms of a formula, which was accorded a value of 40% of the regionally adjusted average Medicare per capita expenditure during the last six months of life, who both suffered from cancer and who utilized their Medicare benefits. Such a value of 40% of such total was accorded to hospice care on the belief that such represented the proper relationship between average hospice costs and the costs attributed to Medicare beneficiaries suffering from cancer.

We would argue that the institution of a capped limit presents an initiative to introduce several of the elements of a capitation model, but without the introduction of other critically related and necessary components of the capitation payment system.

Specifically, the creation of a limit must account for numerous actuarial factors. However, at present the only factor to be considered is geographic region. Variations in age, the degree of disability, duration and diagnoses will all significantly affect the cost of care but are in no way addressed, and as such could pose significant financial risk to the institutions, and consequent deleterious effects on the clients they seek to serve.

Compounding the dilemma is the fact that the demonstration data which was used in establishment of the four discrete capped limitations represents only 26 of the hospices operating nationwide; a mere fraction of the hospice. HANYS itself counts among its active membership more than thirty facilities providing hospice care and there exist in New York State several other agencies providing hospice service. Likewise, the hospice movement nationwide encompasses numerous providers in a variety of settings which operate in varying modalities. To determine limitations based upon an extremely limited sample who provide service to a mere 6,000 Medicare clients, fails to properly account for the vast variations. To use this limited data to develop regional differences only further accentuates the problems of those facilities which we represent.

Of additional concern is the realization that despite the inadequacy of the existing data base, HCFA intends to collect only a limited sample of cost and utilization data in the coming year. Two separate subissues emerge.

First, we would reiterate that the establishemnt of caps based upon a limited sample is inadequate and fails to properly serve to move hospice to the forefront of ameliorative measures as was envisioned by Congress. Secondly, we are confused by the Department's intention to utilize only sample data, when in fact, the regulations as enumerated in Subsection 418.310 require that each hospice must provide reports and keep records which the Secretary determines as necessary to administer the program.

HANYS Recommendation - We believe that the establishment of caps is in and of itself an inappropriate venture unless all aspects of capitation are adhered to. However, given the existing statutory mandate we will limit ourselves to recommendations relating to regulatory activities. Thus, we would strongly recommend that all existing hospice data be utilized in establishing the capped limits. Such a move would ensure that more accurate and equitable payment mechanisms would be developed.

Additionally, we would recomend that the Secretary begin to develop the capability to review and address the significant disparities among hospice providers which are directly attributable to differences in utilization and patient mix and would further encourage the Secretary to develop methodologies which would eventually allow for adjustments to the cap amounts which would take into account such variations as patient utilization, disability status, duration of care and diagnoses.

Section 418.302, Payment Procedures for Hospice Care - Special Considerations.

We have already addressed several of the concerns regarding this section, most particularly the Secretary's decision to move immediately to a prospective payment system, and we stand by our position that such should be accomplished only after completion of a feasibility study.

However, we would expand upon this by indicating that if such a prospective system is to be instituted, now or in the future, a number of modifications must be made in order to assure that the principles which guide the concept of hospice care will not be sacrificed.

Most particularly we are concerned that the proposed language will establish an inflexible regulatory system which is premised not on the needs of terminally ill patients and their families, but rather as a financial gatekeeping mechanism.

Home Respite: More specifically, the failure of the regulation to provide a payment mechanism for home respite care could change significantly the way we think about and treat the terminally ill of this nation. The hospice movement has long realized the therapeutic advantage of care in the individual's home, which is both the least restrictive and most humanistic environment. Failure to reimburse for such care will necessarily result in unnecessary early institutionalization which will directly clash with the overall philosophy of hospice. Similarly, such failure could pose financial difficulties for hospice providers who may find the absence of home respite a causative factor in exceeding the proposed 80/20 inpatient days limit, when inpatient days should by most experts' opinions be utilized in the care of acute pain and system management.

HANYS Recommendation - HANYS recommends that the Secretary revise the proposed discrete caps by establishing another level defined as home respite care which would be found on a continuum of care between routine home care and continuous home care. Such a change would better address the needs of both clients and facilities alike.

Special Procedures: Concern exists with regard to the apparent failure of the regulations to provide adequate financial coverage for special procedures which are occasionally necessary to properly manage symptoms and control the aspects of pain. Included among the tools available for client management are nerve blocks, chemotherapy and radiation.

As written, the regulations would seemngly indicate that such costs are built into the inpatient per diem rates. If such is true, then our concerns are twofold. First, many of these palliative measures are currently, and appropriately, being performed on an outpatient basis. Unless modifications are made to recognize such treatments within that modality, changes in practice are likely to occur which could again result in early and inappropriate institutionalization with its previously noted impact on facilities, and which could lead to a recalcitrance on the part of hospice providers to provide such palliative measures.

Secondly, the performance of such palliative measures on an inpatient basis would seemingly result in the piercing of the proposed $271 cap. While we are unble to provide HCFA with a projected dollar figure, we believe that this again serves as a strong argument for inclusion of all relevant data.

HANYS Recommendation - We would urge the Secretary to establish a separate payment rate for specific procedures (palliative surgery, radiation and chemotherapy) whether such services were provided on an inpatient or outpatient basis.

Home Care Cost Data: In establishing the rates for routine and continuous home care, HCFA utilized 1981 cost and utilization data from the 26 demonstration sites. Again we are concerned that data from conventional care settings were not considered, and are particularly concerned over HCFA's arguments as to why the use of an inflation index to update rates to more properly reflect 1984 costs have been rejected.

These arguments made by HCFA to dismiss the use of an inflationary factor appear to be very inconclusive as to their overall impact, and the failure to increase rates for inflation on the basis of this sketchy evidence in both unreasonable and more importantly can only serve to further erode the ability of hospice programs to maintain patients in their homes.

HANYS Recommendation - A cost base adjustment should be made to account for inflation in both the initial and all subsequent years.

Sincerely,

David A. Seaman

David Seaman
Director
Continuing Health Services

STATEMENT
OF THE
JOINT COMMISSION ON ACCREDITATION OF HOSPITALS
ON DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROPOSED RULES FOR IMPLEMENTING THE MEDICARE HOSPICE BENEFIT
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE
SENATE FINANCE COMMITTEE
SEPTEMBER 15, 1983

The Joint Commission on Accreditation of Hospitals (JCAH) appreciates the opportunity to present its views to the Subcommittee on the Department of Health and Human Services (DHHS) proposed rules for implementing the new Medicare hospice benefit. The JCAH surveys over 4,500 health care facilities, services and programs in the course of a year, and approximately 7,300 facilities, services and programs currently hold JCAH accreditation. Represented in this statistic are over 70% of the hospitals in the United States.

The JCAH is particularly concerned with the subject of hospice care. Our Board of Commissioners recently adopted standards for the accreditation of hospice programs and we anticipate the inauguration of an accreditation survey program in January 1984.

The development of these standards and the contemplated survey process was financed over the past several years with grant support from the W.K. Kellogg Foundation. An eighteen member advisory body of individuals with expertise in hospice care was appointed to assist in the development of this program. Proposed standards were subject to four field reviews and over 1,200 letters of comment were received and considered. The standards adopted represent the majority views of the hospice field.

It is our hope that the hospice accreditation activity of the JCAH will in time be recognized by DHHS in whole or in part for purposes of hospice provider Medicare certification. Our statement today is divided into two major sections, opportunities for regulatory improvement and opportunities for legislative improvement.

Opportunities for Regulatory Improvement

Our views on the proposed rules (48 Federal Register 38146-38175, August 22, 1983) follow.

Preamble

Section III.B. of the preamble to the NPRM notes:

> We are aware that the Joint Commission on Accreditation of Hospitals (JCAH) is developing standards for hospices and plans to initiate a survey effort to determine compliance with those standards. The details of the survey have not been determined. It would be premature to make a decision on deeming hospices accredited by the JCAH or by any other accreditation program until a survey process is begun and we gain experience to assess the efficacy of enforcement. Because of the sunset provision of the hospice benefit, we believe that it may be preferable to use State Medicare surveys so that a more accurate report based upon the specific provisions of the hospice benefit may be given to Congress in the limited time provided.

The JCAH certainly agrees that it is premature for the Department to make a decision on deeming hospices we accredit. We would observe however that to conclude the sunset provision of the hospice benefit makes it preferable to rely solely on State Medicare surveys is to suggest that the Congressional action to enable "deeming" was frivolous. A very reasonable argument can be made that the report required by Congress under Section 122 (i), PL 97-248 should address the entire hospice benefit structure, including the provider certification methodology and an evaluation of the utility of reliance on the activities of voluntary accrediting bodies. Considering the fact that Congress saw fit to make provision for reliance on such accrediting bodies with respect to certification of hospice providers it is reasonable to suppose that an evaluation of the utility of this provision is anticipated.

Section 405.1901 - The Certification Process

Section 1861(dd)(4)(A) of the Social Security Act provides that any entity that desires Medicare approval as a hospice and that is already approved as a provider of services (other than a hospice) will be considered to have met any of the requirements for hospice approval that are the same as those for the other provider approval. The preamble to the instant NPRM at Section III.E. notes that there is no requirement to address this issue because State survey agencies already follow this procedure for other types of dually certified providers. While this representation may be entirely accurate with respect to providers who are dually certified through a State survey it is not entirely clear that this would necessarily be the case where a provider is dually certified in part by virtue of accreditation by a national accrediting body and in part by a State survey agency. An example of this kind is the present situation where a hospital operating renal dialysis and transplantation services participates as a hospital provider by virtue of its JCAH accreditation but is subject to a Medicare certification survey with respect to the renal dialysis and renal transplantation services it provides. We respectfully suggest that the final regulations specifically address this matter either in the preamble or under this section. In this regard we have identified a limited number of additional requirements an accredited hospital should meet in connection with the provision of inpatient hospice services. Multiple program surveys and certification pressure add to the costs not only of the provider but also to program administration. Therefore the number of additional "hospice specific" items should be kept to a minimum. It would be our hope that State agency hospice certification activities in accreditation might be confined to such limited additional requirements.

Section 418.3 Definitions - Employee

Section III.C.3. of the preamble states that:

> In a case where a hospice is a separately certified unit of another organization, our definition of "employee" would require that the individual is assigned and works substantially full time for the hospice unit. This requirement ensures that the core services are provided by employees "dedicated" to the hospice but would not preclude them from providing services outside the hospital unit.

We believe the Department should entertain exceptions to this proposed policy. For example, a hospital which operates both a home health (agency) program and a hospice program may find it efficient and economical to use nurses in dual roles, i.e., provide nursing services to patients enrolled in the hospital's home health program and to provide home visits to patients enrolled in the hospice program. It seems reasonable to suggest that the patient loads of these two programs might vary over time and that it would be unreasonable to require as a matter of Federal policy that the hospital be prohibited from using its nurses in this flexible fashion. Data we gathered in connection with our study of hospices indicates that 42% of hospice providers experienced an average inpatient census which ranged from 1-6 patients. Clearly an inflexible approach to the issue of staffing is not cost effective.

There is even a more fundamental difficulty with this Federal specification and that is that it discourages the involvement of the patient's attending physician since his practice with respect to a hospice patient would either be subject to the oversight of the hospice physician or the physician would have to work "substantially full time" for the hospice. Continuity of care would undoubtedly be sacrified.

Section 418.74 - Central Clinical Records

As written, this specification might be interpreted as requiring that a hospital-based hospice program maintain separate and distinct clinical records on its hospitalized patients. We believe this matter needs clarification and recommend the proposed specification be modified to make it clear that what is intended is that the hospice program have separately identifiable and readily retrievable clinical records with respect to all hospice patients.

Section 418.96 - Medical Supplies

Drug Storage

Subsection (d) might be interpreted as requiring the specified drug storage and security in the patient's home. We recommend the preamble to the final regulations address this matter to make it clear that said specifications are not applicable to the home environment.

Controlled Drugs

Subsection (e) specifies that controlled drugs no longer needed by the patient, in the absence of specific State requirements, are to be destroyed by two hospice employees and a record made of such disposal. We strongly recommend that unless otherwise provided by law all unused controlled drugs be returned to the pharmacy of origin for disposition and a record of this transaction be retained by the hospice.

Parenteral Nutritional Products

It is noteworthy that the proposed rules do not address this important subject. We recommend as a minimum that the roles of hospice physicians and nurses and the roles which might be expected for pharmacy and dietary services provided either directly or under arrangement with respect to this matter be specified.

Section 418.98 - Short Term Inpatient Care

Subsection (a)(2) requires hospitals providing inpatient hospice care to

- design and equip areas for the comfort and privacy of each patient and family member;
- provide accommodations for family members to remain with the patient throughout the night in areas designated for hospice care;
- provide decor which is homelike in design and function in areas designated for hospice care; and
- provide unlimited arrangements whereby patients may be permitted to receive visitors, including small children.

It is our persuasion that all hospitals providing hospice care will comply with the spirit and intent of the instant requirements with or without Federal regulation. We are concerned about the subjectivity of these specifications and recommend they be deleted because we do not believe any two Federal inspectors could interpret these requirements consistently. At worst, this requirement could lead to costly construction projects, certificate of need problems and added health care costs.

Section 418.100 - Freestanding Hospices Providing Inpatient Care Directly

Nurse Staffing

Subsection (a)(2) appears to conflict with subsection (q). The former requires each shift to have a registered nurse who provides direct patient care except that in the case of respite care a registered nurse is necessary only during the day shift. Subsection (q) however, provides that the hospice must have a registered nurse to supervise the hospice health services full time, 7 days a week, on each shift. We subscribe to the latter requirement and submit that the fact that a patient may be admitted to an inpatient unit for purposes of providing respite to the family does not obviate the fragile nature of these patients or a rapid change in their condition... they are still terminally ill. For this reason we believe the availability of a licensed registered nurse is essential at all times.

Bathroom Facilities

Subsection (h) does not include a requirement that bathroom facilities in a freestanding hospice inpatient unit be equipped with a device for calling the staff member on duty. We feel such a requirement is essential for this vulnerable patient population.

Opportunities For Legislative Improvement

Confusion Between the Concepts of "Health and Safety Standards" and "Benefit Definition"

Heretofore the Social Security Act (hereinafter referred to as the Act) has generally defined a benefit and then specified the health and safety standards the "provider" of said benefit must meet (see Section 1861(e)(9) of the Act). The Tax Equity and Fiscal Responsibility Act of 1982, PL 97-248 departs from this established principle with respect to the hospice program.

Section 1861(dd)(2) of the Act specifies the following hospice provider conditions of participation (health and safety standards):

- provides all the following services directly versus under arrangement,
  - nursing care by or under the supervision of a licensed registered professional nurse,
  - medical social service under the direction of a physician,
  - physician services, and
  - counseling;
- provides professional management services for all hospice services furnished under arrangement; and

- provides assurances to the Secretary that no more than 20 percent of the aggregate days that an individual accrues under the hospice benefit are days of inpatient care.

If it is indeed appropriate to perpetuate these limits to the hospice benefit we recommend the Act be amended to include them as part of Section 1861(dd)(1). We make this recommendation for four reasons. First, our review of the hospice field over the past two years clearly demonstrates that services under arrangement may be of high quality and that services provided directly are not necessarily of consistent high quality. Second, there is absolutely no evidence that the 20 percent rule with respect to inpatient care has any relationship to patient health or safety. There is in fact some evidence that those hospice programs which currently exceed this artificial limitation are those caring for a disproportionate number of patients who have no primary careperson. Third, the fact the Act specifically exempts any institution which commenced operations as a hospice prior to January 1, 1975 from the inpatient day limitation suggests a Congressional understanding that such limitation is unrelated to patient health and safety considerations. Fourth, and last, there is a dearth of evidence to support a hypothesis that the hospice exercise of professional management over all hospice services will assure services of high quality. We would respectfully suggest the likelihood that services of high quality may be attained equally well through a variety of cooperative arrangements.

Disincentives to Physician Involvement

The hospice benefit as presently structured contains a number of significant disincentives for perpetuation of the health care support system attending a patient up to the point when he elects the hospice benefit. Such a separation may be attractive and beneficial for patients dissatisfied with heroic efforts to sustain them; however there are others who would wish to maintain the familiar network of support (especially their attending physician) even as they renounce aggressive curative treatment. These disincentives include:

- requirement for professional management of physician services by a hospice physician which sets the stage for conflict between a hospice physician and an attending physician who is not a hospice employee; and
- the financial constraints which necessitate that hospice management limit diverse physician involvement as employees except on a volunteer basis.

Conclusion

Mr. Chairman, the JCAH commends you and members of this Committee for examining the regulations the Secretary proposes for promulgation of the new Medicare hospice benefit.

It is our studied conclusion that hospice care is an evolving concept. The JCAH believes the legislation and regulations at issue today represent a constructive initial step in the continuing examination of mechanisms for providing appropriate care for terminally ill patients. We believe the most significant error that can be made with respect to this evolving program is to institutionalize it in a rigorous mode. We believe we have highlighted some of the rigidity which attends the instant legislation and implementing regulations. We trust that this Committee in its oversight role may inaugurate constructive flexibility with respect to the provision of the hospice benefit.

The JCAH thanks you for the opportunity to present its views.

The Commonwealth of Massachusetts
Department of Elder Affairs
38 Chauncy Street, Boston, Mass. 02111

MICHAEL S DUKAKIS
GOVERNOR

RICHARD H ROWLAND PhD
SECRETARY

COMMENTS

Re: Proposed Rules

42 CFR Parts 400, 405, 408, 409, 418, 420, 421, and 489

Medicare Program; Hospice Care

The Massachusetts Department of Elder Affairs, established by legislative authority in 1973 as the cabinet-level state office on aging, is very supportive of the provisions of Section 122 of the Tax Equity and Responsibility Act which require the availability of Medicare benefits for hospice care. We have been an advocate for health care options and programs and services which enhance the quality of life for older persons since our inception. Support for home care health services and support for caretaker family and friends is the backbone of our current service provisions and we are pleased that alternative methods of care will soon be available for advanced terminally ill elderly people who desire palliative treatment and who wish to remain at home for as long as possible. We have been aware of the limitations of Medicare-Part A coverage provisions for the terminally ill whose needs require specialized services not currently available or reimbursable.

We are also aware of the TEFRA provisions which define and limit the structures of hospice programs and Medicare benefits. Therefore, our comments in this testimony will address the substantive issues raised by the proposed rules which dictate the implementation of the TEFRA provisions.

1. <u>Subpart B- Eligibility, Election, and Duration of Benefits</u>

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418.24 (e) (2) Election of hospice care: Waiver of other benefits

418.24 (e) Elements of the election statement: Acknowlegement of understanding of certain waived Medicare services

Statements regarding hospice-covered, Medicare-waived and hospice-waived, Medicare-covered services are extremely confusing in TEFRA and the proposed rules governing Chapter IV of 42 CFR. Section 122 of the TEFRA states that the individual upon election of hospice benefits "would be deemed to have waived payments for certain other benefits except in exceptional and unusual circumstances as the Secretary may provide". Section 418.24 (e) (2) states that hospice-waived, Medicare-covered services can be covered under the hospice provision when these services are provided by the designated hospice, another hospice under arrangements, or by the individual attending physician when that physician is not an employee of the designated hospice or receiving compensation for these services. The supplementary information states that ultimately the Medicare fiscal intermediary makes the retroactive determination in each case as to whether the services received are covered under the hospice provision or whether these services are among those waived through the hospice election. The supplementary information further states that HCFA "may issue guidelines (re: coverage options) from time to time as experience warrants".

It is impossible for the terminally ill individual and/or the family member or other caregiver to understand these coverage and treatment options. Hospice care is intended to be palliative treatment offered to individuals through the recommendations of the interdisciplinary team. Curative procedures are sometimes necessary for pain control and symptom management. Curative procedures are sometimes necessary also to improve the weakened condition or quality of life for the terminally ill person.

The delivery of hospice care as intended could be realized if the language of 418. 24 (e) (2) was changed to read:

> "Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except if these services are rendered in accordance with the patient's care plan".

Terminally ill individuals could understand these provisions if the language of 418.26 (c) was changed to read:

> "Acknowledgement and acceptance of palliative procedures, instead of curative procedures unless such curative procedures are incorporative in the patient's care plan".

Implicit in this statement are recommendations to the Secretary that guidelines for palliative and curative procedures for specific terminal conditions be developed by a DHHS physician team. These guidelines would specify what procedures would be generally curative for specific conditions (and not likely to be initiated for hospice beneficiaries) and what procedures would be generally palliative (and likely to be initiated for hospice beneficiaries).

Implicit in this statement also is the understanding that curative procedures which are initiated external to the patient care plan are covered under the regular Medicare provsion and are subject to the patient deductible and co-insurance requirements.

Therefore, the terminally ill individual who elects hospice care could be given (orally, or in writing as appropriate) a description of both possible procedures.

We recommend other changes in the election statement which specify:

> "Acknowledgement and acceptance of waiver of curative procedures"

and

> "Acknowledgement of understanding of hospice election revocation rights at any time during an election period"

11. Subpart C- Conditions of Participation

418.50 (b) (1) Condition of Participation-General Provisions
Standard: Required Services

Although it is a TEFRA stipulation that all required services must be available on a 24-hour basis, we feel that the availability of all of the required services is not essential- particularly the availability of physical therapy, occupational therapy, and speech pathology services.

We feel that the TEFRA requirements can be met through dictating the 24-hour availability of essential services only. Essential services could be defined as synonymous with the core services and regulations could stipulate access to in-patient care, medical supplies, and emergency services as needed. We ask that HCFA explore this possibility as the required 24-hour availability of a non-essential service is costly.

418.80 Condition of Participation- Core Services

Although it is a TEFRA stipulation that a hospice provider must "routinely provide directly substantially all of each of the core services", we feel that the direct provision of all of these services by full-time employees is not essential.

We feel that it is essential that members of the interdisciplinary group be full-time employees in order to insure quality of care planning, and continuity and coordination. However, the provision of nursing, medical social services, and counseling services on an on-going basis could be realized through non-contractual employees who work less than full-time with the stipulation that continuity in staff-patient assignments be maintained for the entire period the patient is in the care of the designated hospice. We feel that this flexibility would permit greater service capability for hospice providers without jeopardizing quality of care and supervision requirements.

418.88 Condition of Participation-Counseling Services

We feel that a standard should be required for individual and family counseling services, as well as bereavement counseling. At a minimum, a supervision standard could be defined as medical social work supervision for both types of counseling. This would insure competent supervision and continuity of care under the direction of the medical social worker who knows the individual and family configuration. Counseling individuals who are dying requires considerable skill and on-going supervision and support.

418.94 Condition of Participation-Home Health Aide and Homemaker Services

We feel that standards should be required for the provision of homemaker service.

The Massachusetts Department of Elder Affairs establishes homemaker provider experience, training, and supervision requirements in its Home Care umbrella contracts and we would urge HCFA to require certain standards for this service. One possibility is the stipulation that hospice homemakers must meet any state certification requirements and if these do not exist, the standards of the National Homecaring Council would have to be met.

418.96 Condition of Participation-Medical Supplies

(b) Standard: Administration of pharmaceuticals (3)

The language of this provision should be changed to read:

"The patient or the primary caretaker if designated in the patient care plan"

This would permit the primary caretaker to administer medications in circumstances where the individual is not capable and insure adherence to the patient care plan.

(d) Standard: Drug Storage and Security

The language of this provision should be changed to permit access to drug storage by primary caregivers if designated in the patient care plan.

418.98 Condition of Participation- Short-term inpatient care

(b) Standard: Inpatient care limitation
(c) Standard: Exemption from limitation

We believe that flexibility should be permitted for certification requirements for all hospice programs as we question the waiver provision only for those hospice programs in operation before January 1, 1975. We feel that all programs that meet all of the other conditions of participation should be given the same amount of time to reach the 20% inpatient utilization rate. This would provide equity for all programs that seek certification.

III. Subpart D- Covered Services

418.204 (b) (3) Respite Care

We question the waiver of the frequency and number of respite care days for those hospice programs that began operation before January 1, 1975 as this would result in a dual system of hospice care. At a minimum, we feel that this exemption should be limited to a maximum of a two-year period only so that all certified hospice programs nationwide are providing the same service by October 1, 1985. This would promote equity among all service providers and permit greater reliability of data necessary for the Congressional study due January 1, 1986.

IV. Subpart E- Reimbursement Methods

418.302 Payment procedures for hospice care

We support the efforts of HCFA to establish a methodology for reimbursement which is not based on retroactive costs and which is more responsive to the mix and intensity of service than the pre-paid capitation approach. We recognize the disadvantages of these approaches as indicated in the supplementary information and we support the exploration of another method of predetermined fixed reimbursement. We also support the assignment of levels of care configuration as the basis for reimbursement during the initial years of Medicare hospice payment.

HCFA might want to consider however:

1) Reimbursement of the complete 24-hour continuous home care rate after the first 24-hour period followed by any consecutive 24-hour service periods

and

2) Provision for annual monitoring of payment rates to insure reasonableness and equity of predetermined rates

418.304 Payment to the hospice for physician services

We support the individual physician reimbursement mechanism as our interpretation of this provision is that 100% reimbursement of services performed by attending physicians is provided for hospice programs when these physicians are providing these services as employees or in accordance with the patient care plan. We support the separate Medicare-Part B reimbursement mechanism when these services are external to the patient care plan as indicated in our earlier comments regarding 418.24 (e) (2).

We ask, however, that the terminology "under arrangement" be fully defined in the final rules. If we are misinformed about our interpretation of "under arrangement", we would support the opinion of the other agencies who perceive separate attending physician reimbursement as a disincentive for involvement of these physicians as well as detrimental to the consistency of the patient care plan.

418.306 Determination of payment rates

We object to the intermediary determination of payment rates for local hospice programs. We feel that this is not a responsibility of fiscal intermediaries who serve as fiscal conduits , but instead a responsibility of HCFA to insure uniformity of hospice reimbursement in particular areas. We are aware that more than one intermediary may exist in a state where hospice programs are sub-divisions of parent Medicare-certified providers served by another intermediary.

418.308 (b) Limitation on amount of hospice payments.

Our previous comments in 418.98 and 418.204 (b) (3) state our concerns about the equity, the creation of a dual system, and the validity of study results if the full three-year exenption is granted for programs in operation before January 1, 1975.

Richard H. Rowland, Ph.D.
Secretary of Elder Affairs

RHR:BL/bl

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watertown·waltham·belmont
HOSPICE PROGRAM
[illegible] Mt. Auburn St., Watertown, MA 02172 tel. (617)[illegible]

TESTIMONY ON MEDICARE REGULATIONS REGARDING HOSPICE CARE

PRESIDENT
J. Donald Schumacher, M.S.

VICE PRESIDENT
Rachel Crystal, M.A., Ed.M.

TREASURER
Margaret Gibson

SECRETARY
Martha Glennon, B.S.N.

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Barbara Spivak, M.D.

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Michael Fuller, M.D.
Joann Gregorowicz, L.C.S.W.
Rabbi Earl A. Grollman, D.D.
Pedro Gutierrez
Thruston Hammer
Barbara Hugh, R.N., M.S.
Joseph P. MacDonald
Agnes McManus, R.P.T.
Jean Richardson, M.S.W.
Fay Schuch
Geri Schumacher, R.N.
Scott Swift, M.Ed.
Shirley Thompson, R.N., A.N.P.
Avery Weisman, M.D.

The major problem with the legislation that affects the coalition programs is the mandated provision of core services, especially expensive nursing services, by the hospice program itself. This is a total negation of the work that many providers have put into developing comprehensive, quality service networks. It has been possible for my program, and many others, to make agreements with these providers that ensure every bit of quality control that direct employ of a staff member would entail. These contractual arrangements have enabled my program to keep its budget under $100,000 per year, whereas under the new Legislation our budget will double, perhaps triple.

Items such as extended nursing visits; on-call nursing availability 24 hours per day; interdisciplinary team control of nursing assessments; care and time devoted to hospice clients (hospice nurses to be supervised by a senior registered nurse with oncology and home health experience) can be specified in written contracts between the hospice and a certified Medicare provider.delivering home health nursing. Since written contracts are allowed for inpatient nursing, it would seem consistent to allow for contracting of the same quality care for the home nursing service provision.

To reiterate, the requirement that the hospice programs provide core services themselves will possibly double or triple budgets; duplicate already existing quality services; encourage competition within communities where cooperation once existed; and, ultimately mean the closing of at least one-fourth of all existing programs as the smaller coalition-based programs do not have the monies to initially hire those services independent of contracting. The legislation is also prohibitive of new programs beginning, especially in areas where funds and resources are scarce.

It is difficult to estimate how many current programs contract for nursing services. However, legislators from at least seventeen states are co-sponsoring amendments to correct this legislation so that small community-based hospices will be allowed to seek Medicare certification to enable them to continue to serve the dying elderly and their families.

Although small community-based hospices may have been developed as free-standing, hospital-based or volunteer-based programs, we all share the same basic philosophy and goals of hospice care. We also all share the same need: to have the legislation amended to allow for contracting for nursing services.

If the law is not amended, at least one-fourth of all existing hospice programs will be forced to close. Many more will be forced to consider expensive legal restructuring that would be unnecessary if the law is so amended. These wasted funds would best be devoted to patient care and program development rather than further institutionalization of hospice services.

Small, community-based programs with large amounts of professional and volunteer effort have been able to develop quality hospice services reflective of their local communities. These collaborative efforts with local health care providers have united the resources of the entire community, professional and volunteer alike, serving dying people and continuing to support their families and friends throughout their bereavement.

To reiterate, H.R. 3588 introduced by Congressman Ratchford with twenty co-sponsors and Senate Bill 1511, introduced by Senator Jepson seek to rectify this problem and make hospice reimbursement more equitably available to the dying elderly in the United States.

J. Donald Schumacher, President
Board of Directors

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